AMA/Specialty Society RVS Update Committee
Renaissance Hotel, Chicago, IL
October 5-7, 2017

Meeting Minutes

I. Welcome and Call to Order

Doctor Peter Smith called the meeting to order on Friday, October 6, 2017 at 9:00 a.m. The following RUC Members were in attendance:

Peter K. Smith, MD	Amr Abouleish, MD, MBA*
Margie C. Andreae, MD	Allan Anderson, MD*
Michael D. Bishop, MD	Gregory L. Barkley, MD*
James Blankenship, MD	Kathleen Cain, MD*
Robert Dale Blasier, MD	Joseph Cleveland, MD*
Ronald Burd, MD	William D. Donovan, MD, MPH*
Jimmy Clark, MD	Jeffrey P. Edelstein, MD*
Scott Collins, MD	William E. Fox, MD, FACP*
Gregory DeMeo, MD	William F. Gee, MD*
Verdi. J DiSesa, MD, MBA	Michael J. Gerardi, MD, FACEP*
David C. Han, MD	Peter Hollmann, MD*
David F. Hitzeman, DO	Gwenn V. Jackson, MD*
Katharine Krol, MD	John Lanza, MD*
Timothy Laing, MD	Mollie MacCormack, MD, FAAD*
Walter Larimore, MD	Eileen Moynihan, MD*
Alan Lazaroff, MD	Daniel J. Nagle, MD*
M. Douglas Leahy, MD, MACP	Scott D. Oates, MD*
Alnoor Malick, MD	M. Eugene Sherman, MD*
Scott Manaker, MD, PhD	Holly Stanley, MD*
Bradley Marple, MD	Michael J. Sutherland, MD, FACS*
Julia M. Pillsbury, DO, FAAP	Timothy H. Tillo, DPM*
Gregory Przybylski, MD	G. Edward Vates, MD*
Marc Raphaelson, MD	Thomas J. Weida, MD*
Christopher K. Senkowski, MD, FACS	Robert M. Zwolak, MD, PhD*
Ezequiel Silva III, MD	
Norman Smith, MD	
Stanley W. Stead, MD, MBA	
James C. Waldorf, MD	*Alternate
Jennifer L. Wiler, MD, MBA	
George Williams, MD	

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

- Doctor Smith welcomed the following Member of the CPT Editorial Panel:
  - Kathy Krol, MD – CPT RUC Member

- Doctor Smith welcomed the following Observers:
  - Gerald Harmon, MD – AMA Board of Trustees, Chair

- Doctor Smith wished a fond farewell to the following departing RUC Advisor:
  - Jonathan Myles, MD – College of American Pathologists (CAP) Advisor for 11 years; recently elected to CAP Board of Governors

- Doctor Smith explained the following RUC established thresholds for the number of survey responses required:
  - Codes with ≥1 million Medicare claims = **75 respondents**
  - Codes with Medicare claims between 100,000-1 million = **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 presented the "Best RUC Reviewer" Award. This award was created in January 2017 to recognize that the success of the meeting, and its proceeding expeditiously and accurately, is dependent on the work that is done prior to the meeting. Doctor Smith and the staff review all the comments submitted prior to the meeting and provide a prize for the best two commenters. For this meeting, special attention was given to the reviewers' evaluation of Practice Expense (PE). The award was presented to the following RUC members:
  - Alnoor Malick , MD
  - Walt Larimore, MD

  Doctors Malick and Larimore were awarded this special recognition for their extensive comments provided on recommendations for the October 2017 RUC meeting. For their efforts, each was awarded one "get out of reviewing a RUC tab" for the January 2018 RUC meeting. The award must be redeemed within 24 hours of the assignments.

- Doctor Smith thanked everyone for their excellent reviewer preparation for the tabs for this meeting.

III. Director's Report

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

- The RUC will hold elections for the internal medicine and primary care rotating seats in January. The nomination process is now open, and nominations will be accepted until November 30th.

- If a RUC member or RUC alternate leaves the table, please stop by the staff table to let them know, so we do not wait for the 28th vote.

- We encourage you to use the RUC meeting mobile app. The RUC meeting mobile app is continuously updated. If you refresh from the home screen, you can see which tab the RUC is discussing. Also, on the mobile app, just click on the name of the session for more information.

- We do include all signed attestations, financial disclosures and confidentiality agreements in the RUC agenda material. See 00 Intro Materials and it is file 09 October 2017 DocuSign reports v2.

IV. Approval of Minutes from April 2017 RUC Meeting

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

V. CPT Editorial Panel Update (Informational)

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

- Alternative Payment Models (APMs)
  On Wednesday, July 26, the AMA hosted a day-long fly-in at the Hilton-Crystal City in Arlington, VA for a stakeholder discussion of the potential role of coding in APMs and to identify any other necessary solutions outside of coding and the CPT code set to be developed to help operationalize APMs (with referral to other areas of the AMA, if appropriate). More than 150 participants attended the meeting, representing the CPT Editorial Panel, insurers, medical specialties, and industry. The Panel collected useful comments from the participants that will be useful as we move forward to accommodate the CPT code set within APMs. Several questions were discussed regarding the roles of CPT/RUC with APM coding, with many areas lacking consensus. However, there was clear direction that CPT/RUC should remain engaged with the process and continue to gather information as APMs move forward. CPT is accepting applications for APM coding and will carefully consider any application it receives.

- CPT Editorial Panel Meeting Activity
  Since the April RUC meeting, the Panel met twice—in June and in September.
  June Meeting:
  - RUC member Greg Przybylski, MD, attended the June meeting as the RUC representative, in addition to RUC staff.
  - The Panel addressed about 50 code change requests at the June meeting.
  - Many of the codes addressed by the Panel in June are being addressed by the RUC at this meeting.

  September Meeting:
  - RUC was represented by staff at the September 2017 Panel meeting.
  - CCAs - The Panel addressed 42 coding requests at the September 2017 Panel meeting.
  - Follow up on RUC Referrals to CPT - The codes referred by the RUC to CPT that were addressed at the September meeting are PICC codes 36568, 36569, 36854; dilation of urinary tract code 50395; fluoroscopy code 76001; and electroretinography code 92275.
  - Literature Review Workgroup - The Literature Review Workgroup reconvened at the September Panel meeting. Two of the issues they discussed were: 1) whether or not literature should be required for CPT codes that only include practice expense as it is difficult to obtain literature on services that do not include physician work; and 2) requirements regarding studies with foreign versus US populations.

- 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.

- Digital Medicine Payment Advisory Group (DMPAG)
  DMPAG has identified several current services that are not described within CPT. This group has worked with CPT staff and CPT Panel members to bring forward proposals for new codes to the Panel. The Panel accepted several new codes for digital medicine services at the September meeting, and these will come to the RUC in January.

- February 2018 Meeting
  The next CPT Editorial Panel meeting will take place February 8-10, 2018 in San Diego. The submission deadline for code change applications for the February meeting is November 7, 2017.

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

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

- Announced leadership/management change for the Administration:
  - Doctor Don J. Wright, Acting HHS Secretary

  Note: Doctor Wright was replaced as acting Secretary by newly-confirmed Deputy Secretary Eric Hargan on October 10, 2017.

- Introduced staff from CMS attending this meeting:
  - Jamie Hermansen, Analyst
  - Karen Nakano, MD - Medical Officer
  - Patrick Sartini, Analyst
  - Pamela Villanyi, MD, ABFM, CPA, CPC - Medical Officer, Center for Program Integrity
  - Marge Watchorn - Deputy Director, Division of Practitioner Services

- The CY 2018 Final Rule for the Medicare Physicians' Payment Schedule will be released on time, on or around November 1st. Please come in and talk to CMS about any issues regarding codes or policies.

- A RUC member raised a point regarding the Physician Practice Information survey (PPI), and CMS suggested he and the RUC "follow all avenues" to bring the request forward. See further discussion under New Business/Other Issues (Tab 22).

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 last month to Palmetto. Doctor Haley commented that, once this contract has transitioned, the number of claims-paying contractors will be seven from what used to be sixty-four twenty years ago.

- As of October 1st, there are three new specialties that Medicare recognizes and that are now active in the system:
    - C7 Advanced heart failure transplant cardiology
    - C8 Medical toxicology
    - C9 Stem cell transplant and cell therapy

- New flu vaccine that is produced in self-culture: Flucelvax. CPT code 90756 was released on July 1, 2017 for implementation on January 1, 2018. CMS will implement vaccine code 90756 on January 1, 2018. Before January 1, 2018, claims should use the HCPCS (Healthcare Common Procedure Coding System) Q2039 when billing Medicare. A specific set of words are needed in the comment field in order for it to be recognized and paid correctly: Flucelvax 90756 equivalent.

- A year ago, Congress passed the 21st Century Cures Act. This will affect policy-making at CMS and at the local contractors. Draft instructions have been received; may slow process down at least for a brief period of time.

VIII. Washington Update - Medicare Physician Spending Growth for 2016: An Update with Final Estimates (Informational)

Dr. Kurt Gillis, AMA Principal Economist, provided an update on Medicare Physician Spending Growth for 2016 with Final Estimates. The presentation was given to review the analysis of Medicare Physician/Supplier Procedure Summary files (PSPS).

- "Early" estimates from the April RUC meeting based on claims for 2016 processed through December 31, 2016.
    - Spending and utilization growth for 2016 up sharply from recent years
    - Utilization growth up for nearly all types of service
    - More uncertainty in estimates than usual

- "Final" results based on more complete data (claims for 2016 processed as of June 30, 2017).
    - Utilization growth for 2016 <u>much lower</u> than in "early" estimates
    - Handout provided for detailed results

- Why are the "Early" and "Final" Estimates for 2016 so different?
    - "Early File" utilization is inflated to account for missing claims (those processed after December 31)
    - In recent years the "Early File" has been about 92% complete –spending and utilization for 2016 "Early File" inflated by about 8%
    - But the 2016 "Early File" was 93.4% complete –inflating it by 8% led to overestimate of spending and utilization for 2016

- Takeaways from "Final" Results
    - Utilization growth for 2016 is up slightly from recent years. <u>Not nearly as much as indicated in April though</u>. Still fairly low by historical standards
    - Upward trend in utilization growth for imaging, procedures and tests since 2012. 2016 growth roughly 2% to 3% for these services
    - Less of a trend for E&M– 2016 utilization growth of about 1%

- A RUC member asked if we have looked at utilization growth rates as a function of age. Dr. Gillis responded that these files are aggregated and do not contain age or other detailed information. He is awaiting the 2016 claims level data, which includes beneficiary information.

IX. Relative Value Recommendations for *CPT 2019:*

Fine Needle Aspiration (Tab 4)
Peter Manes, MD (AAO-HNS); Allan Glass, MD (ES); Swati Mehrotra, MD (ASC); Jonathan Myles, MD (CAP), Roger McLendon MD (CAP); and Felice A Caldarella, MD (AACE)

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. 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.

10021 ***Fine needle aspiration biopsy, without imaging guidance; first lesion***
The RUC reviewed the survey results from 158 physicians and agreed with the societies on the following physician time components: 10 minutes of pre-service time, 15 minutes of intra-service time and 8 minutes of post-service time. The RUC noted that the current times in the RUC database were from 1995 and resulted in an inappropriately low IWPUT of 0.034. Therefore, the drop in total time did not warrant a proportional change in work RVU as the previous times were not appropriate.

This service is typically performed with an Evaluation and Management (E/M) service. The specialties noted, and the RUC agreed, that although this service is typically performed with an E/M visit, the pre-service and post-service time is appropriate to account for the work that is distinct from what is performed during the E/M visit. The 10 minutes of pre-service time is appropriate to explain the procedure to the patient, including potential complications, obtain informed consent, position and prep the patient, and clean the biopsy site with disinfectant and inject local anesthesia and wait for it to take effect. The 8 minutes of post-service time is necessary to prepare a report of the procedure for the medical record. The slides and cell block solution are checked to insure proper sealing and transportability to pathology (either locally or via mail). The appropriate clinical history documents, labeling, and requisition forms are packaged in the sealed, transportable packaging and sent to the appropriate pathology agency. The patient is monitored for any evidence of hematoma, bleeding, drug reaction, or other complication(s).

The RUC reviewed the survey 25th percentile work RVU of 1.20 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 1.20, the RUC compared the survey code to MPC code 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU= 1.27, intra-service time of 15 minutes, total time of 25 minutes) and noted that both service involve a similar amount of physician work and have identical intra-service times. The RUC also compared the survey code to MPC code 99283 *Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity* (work RVU= 1.34, intra-service time of 18 minutes, total time of 30 minutes) and noted that the reference code has somewhat more intra-service and total time and that it was appropriate to value the survey code somewhat less than the reference code. **The RUC recommends a work RVU of 1.20 for CPT code 10021.**

10004 ***Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 125 physicians and agreed with the specialty societies on the following physician time components: 14 minutes of intra-service time. The RUC reviewed the survey 25th percentile work RVU of 0.80 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.80, the RUC compared the survey code to the 2nd key reference code 10036 *Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; each additional lesion (List separately in addition to code for primary procedure)* (work RVU=0.85, intra-service time of 14 minutes) and noted that both services have identical intra-service and total times involve a similar amount of physician work. The RUC also compared the survey code to MPC code 51797 *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)* (work RVU=0.80, intra-service time of 15 minutes) and noted that both services have very similar times and involve a similar amount of physician work. **The RUC recommends a work RVU of 0.80 for CPT code 10004.**

10005 ***Fine needle aspiration biopsy, including ultrasound guidance; first lesion***
The RUC reviewed the survey results from 203 physicians and agreed with the societies on the following physician time components: 10 minutes of pre-service time, 20 minutes of intra-service time and 9 minutes of post-service time. The RUC reviewed the billed together data for deleted code 10022 *Fine needle aspiration; with imaging guidance* and confirmed that it was not typically reported with an E/M service. Deleted code 10022 was bundled into new CPT codes 10005-10012.

The RUC reviewed the survey 25th percentile work RVU of 1.63 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 1.63, the RUC compared the survey code to MPC code 93351 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional* (work RVU= 1.75, intra-service time of 20 minutes total time of 35 minutes) and noted that both services have identical intra-service time, whereas the survey code involves 4 minutes more total

time. The RUC also compared the survey code to CPT code 75572 *Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)* (work RVU= 1.75, intra-service time of 20 minutes, total time of 40 minutes) and noted that both codes have identical intra-service times, very similar total times and involve a similar amount of physician work. **The RUC recommends a work RVU of 1.63 for CPT code 10005.**

10006 ***Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 200 physicians and agreed with the societies on the following physician time components: 15 minutes of intra-service time. The RUC reviewed the billed together data for deleted code 10022 *Fine needle aspiration; with imaging guidance* and confirmed that it was not typically reported with an E/M service. Deleted code 10022 was bundled into new CPT codes 10005-10012.

The RUC reviewed the survey 25th percentile work RVU of 1.00 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 1.00, the RUC compared the survey code to top key reference code 19084 *Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance* (work RVU= 1.55, intra-service time of 20 minutes, total time of 25 minutes) and noted that given the longer intra-service, and total time and increased physician work of performing both an image guided biopsy then an image guided localization device placement, 19084 is appropriately valued higher than 10006 with a slightly higher physician work intensity. The RUC also compared the survey code to MPC code 64480 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level* (work RVU 1.20, intra-service time of 15 minutes) and noted that both add-on codes have identical times, whereas the reference code is somewhat more technically demanding than the typical case for 10006, supporting the relative valuation between the two services. **The RUC recommends a work RVU of 1.00 for CPT code 10006.**

10007 ***Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion***
The RUC reviewed the survey results from 31 physicians and agreed with the societies on the following physician time components: 10 minutes of pre-service time, 27 minutes of intra-service time and 10 minutes of post-service time. The RUC reviewed the billed together data for deleted code 10022 *Fine needle aspiration; with imaging guidance* and confirmed that it was not typically reported with an E/M service. Deleted code 10022 was bundled into new CPT codes 10005-10012.

The RUC reviewed the survey 25th percentile work RVU of 2.23 and agreed that this value somewhat overvalues the physician work involved in performing this service. To determine an appropriate value for this service, the RUC noted that this service is currently reported with codes 10022 *Fine needle aspiration; with imaging guidance* (work RVU = 1.27) and 77002 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)* (work RVU = 0.54), which have a combined work RVU of 1.81. The RUC agreed that this value is appropriate for code 10007. To justify a work RVU of 1.81, the RUC compared the survey code to MPC code 99221 *Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive*

examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit (work RVU= 1.92, intra-service time of 30 minutes, total time of 50 minutes) and noted that the reference code involves slightly more intra-service time and total time, supporting a somewhat lower valuation for the survey code. The RUC also compared the survey code to MPC code 92004 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits* (work RVU= 1.82, intra-service time of 25 minutes, total time 40 minutes) and noted that the survey code involves more intra-service time and more total time. **The RUC recommends a work RVU of 1.81 for CPT code 10007.**

10008 ***Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 31 physicians and agreed with the societies on the following physician time components: 20 minutes of intra-service time. The RUC reviewed the billed together data for deleted code 10022 *Fine needle aspiration; with imaging guidance* and confirmed that it was not typically reported with an evaluation and management service. Deleted code 10022 was bundled into new CPT codes 10005-10012.

The RUC reviewed the survey 25th percentile work RVU of 1.50 and agreed that this value somewhat overvalues the physician work involved in performing this service. To determine an appropriate value for this service, the RUC reviewed how this service is currently reported with codes 10022 and 77002 which have a combined work RVU of 1.81. Although Medicare does not apply the multiple procedure reduction to this service currently, the specialties based their proposed value on if the multiple procedure reduction was applied to deleted code 10022, which would produce a combined work RVU with 77002 of 1.18 (0.64+0.54 = 1.18). To justify a work RVU of 1.18, the RUC compared the survey code to MPC code 64480 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.20, intra-service time of 15 minutes) and noted that the survey code involves more intra-service and total time, whereas the reference code involves a bit more complexity, and would value the codes appropriately to each other. The RUC also compared the survey code to top key reference code 19082 *Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance* (work RVU=1.65, intra-service time of 25 minutes, total time of 30 minutes) and noted that given the longer total time and increased work of doing both an image guided biopsy then image guided localization device placement, 19082 is appropriately valued higher than 10008 with a slightly higher physician work intensity. **The RUC recommends a work RVU of 1.18 for CPT code 10008.**

10009 ***Fine needle aspiration biopsy, including CT guidance; first lesion***
The RUC reviewed the survey results from 91 physicians and agreed with the societies on the following physician time components: 15 minutes of pre-service time, 35 minutes of intra-service time and 12 minutes of post-service time. The RUC reviewed the billed together data for deleted code 10022 *Fine needle aspiration; with imaging guidance* and confirmed that it was not

typically reported with an E/M service. Deleted code 10022 was bundled into new CPT codes 10005-10012.

The RUC reviewed the survey 25th percentile work RVU of 2.43 and agreed that this value appropriately accounts for the physician work involved. The RUC also noted that this is the aggregate work value for the two CPT codes that are being bundled into this new code. To justify a work RVU of 2.43, the RUC compared the survey code to CPT code 99204 *Office or other outpatient visit for the evaluation and management of a new patient…*(work RVU= 2.43, intra-service time of 30 minutes, total time of 45 minutes) and noted that the survey code involves more intra-service time and total time. The RUC also compared the survey code to CPT code 75574 *Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)* (work RVU= 2.40, intra-service time of 30 minutes, total time of 50 minutes) and noted that the survey code involves more intra-service and total time. **The RUC recommends a work RVU of 2.43 for CPT code 10009.**

10010 ***Fine needle aspiration biopsy, including CT guidance; each additional lesion (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 91 physicians and agreed with the societies on the following physician time components: 25 minutes of intra-service time. The RUC reviewed the billed together data for deleted code 10022 *Fine needle aspiration; with imaging guidance* and confirmed that it was not typically reported with an E/M service. Deleted code 10022 was bundled into new CPT codes 10005-10012.

The RUC reviewed the survey 25th percentile work RVU of 1.65 and agreed that this value appropriately accounts for the physician work involved. The RUC noted that this is a much lower valuation than current reporting. To justify a work RVU of 1.65, the RUC compared the survey code to the 2nd key reference code 19082 *Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)* (work RVU= 1.65, intra-service time of 25 minutes) and noted that both services have identical intra-service time. Although the reference code has somewhat more total time, 67 percent of the survey respondents that selected 19082 as their key reference code indicated the survey code was a more intense and complex service to perform, supporting a slightly higher IWPUT for the survey code. **The RUC recommends a work RVU of 1.65 for CPT code 10010.**

10011 ***Fine needle aspiration biopsy, including MR guidance; first lesion***
The RUC reviewed the survey results from 13 physicians and noted that the number of survey responses collected did not reach the minimum threshold. The specialties noted that this service is projected to have very low utilization and based on AMA staff recommendation, have kept their survey open to collect more responses. For the January meeting, the ACR requested Research Subcommittee approval to perform a targeted survey for MR-guided FNA, CPT codes 10011-10012. ACR has reached out to the Society of Abdominal Radiology (SAR) as a potential sample pool and is hoping to coordinate with them. The Research Subcommittee approved for the specialty to use a random sample of SAR membership along with a random sample of ACR membership. **The RUC recommends an interim designation to contractor price CPT code 10011.**

10012 ***Fine needle aspiration biopsy, including MR guidance; each additional lesion (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 13 physicians and noted that the number of survey responses collected did not reach the minimum threshold. The specialties noted that this service is projected to have very low utilization and based on AMA staff recommendation, have kept their survey open to collect more responses. For the January meeting, the ACR requested Research Subcommittee approval to perform a targeted survey for MR-guided FNA, CPT codes 10011-10012. ACR has reached out to the Society of Abdominal Radiology (SAR) as a potential sample pool and is hoping to coordinate with them. The Research Subcommittee approved for the specialty to use a random sample of SAR membership along with a random sample of ACR membership. **The RUC recommends an interim designation to contractor price CPT code 10012.**

Affirmation of RUC Recommendations
The RUC affirmed the recent RUC recommendations for CPT codes 76942, 77002 and 77012. The relativity within the family remains correct.

77021 ***Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation***
For CPT code 77021, the RUC recommends for the specialty to survey this code, as the RUC had last reviewed this service in the year 2000. It was noted that Urology is one of the top providers for 77021 and should be involved in the valuation of this service.

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.

Practice Expense
The Practice Expense Subcommittee reviewed the proposed compelling evidence arguments and accepted them as follows:

	PE Compelling Evidence for Fine Needle Aspiration									
Components of PE Compelling Evidence	**10021**	**10004**	**10005**	**10006**	**10007**	**10008**	**10009**	**10010**	**10011**	**10012**
• Evidence that patient population has changed.	**No**	**No**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
• Evidence that technology has changed clinical staff time.	**No**	**No**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
• Evidence that previous practice expense inputs were based on one specialty, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data.	**No**	**No**	**Yes**	**Yes**	**No**	**No**	**No**	**No**	**No**	**No**

Summary of revisions made by the Practice Expense Subcommittee relative to the original proposal from the specialties:

- Added additional time to the clinical staff time to reflect the typical amount of time for preparing supplies
- Verified the top specialty for each service in the office setting, including, in the office setting, that ENT was top provider for 10021, endocrinology for 10022 and rehab medicine for 77002 and urology for 76942 and 77021.
- Extensively deleted supplies that were duplicative of the biopsy tray, excessive personal protection gear, eliminated microscope slides that were already included in the pathology codes for reviewing the biopsy specimens
- Deleted additional ultrasound needles that were not typical
- Eliminated the PACS from the appropriate specialties where a PACS system was not present in the physician's office.
- Increase from 2 to 3 is now typical for the number of needle passes also changes the supplies for several of the codes

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

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

Knee Arthrography Injection (Tab 5)
Kurt Schoppe, MD (ACR); Daniel Wessell, MD, PhD (ACR); and Gregory Nicola, MD, (ASNR)

In 2008, CPT code 27370 was initially identified on the high volume growth screen. In February 2009, this procedure was referred to CPT for possible deletion of 73580 and 27370 and creation of a new code accurately describing the procedure that is being performed, including the radiologic guidance in the procedure codes. In October 2009, the RUC recommended that the specialty society develop a CPT Assistant article to address misuse reporting of arthrography codes. In October 2013, CPT code 27370 appeared on the second iteration of the high volume growth screen. The RUC recommended to survey. At the February 2014 CPT Editorial Panel meeting this services was editorially revised. In October 2015, AMA staff re-ran the Harvard valued codes with utilization over 30,000 based on 2014 Medicare claims data and this service was identified. The RAW determined that this service will be placed on the next level of interest form to survey. This service was also identified as a service on the third iteration of the high volume growth screen. In October 2016, the RUC went through the history of this code. The specialty societies explained that the high volume growth for this procedure is likely due to its being reported incorrectly as arthrocentesis or aspiration. The correct reporting of those services is CPT code 20610 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance* (work RVU= 0.79). The RUC extensively discussed the appropriate options to address the rising inappropriate utilization of this procedure. The RUC noted that deleting this code and then bundling it into the arthrography base procedures would not be ideal because it would involve edits to over 70 codes. The RUC also discussed that this procedure could become an add-on code. However, the RUC came to an agreement that this code should be referred to CPT for deletion and be replaced by a new code. The members agreed that this is the most efficient way to stem the rising inappropriate volume. The RUC recommended that CPT code 27370 be referred to the CPT Editorial Panel for deletion and be replaced with a new code. In June 2017, the CPT Editorial Panel deleted the injection of contrast for knee arthrography code, 27370, and replaced it with a new code, 27369, to report injection procedure for knee arthrography or enhanced CT/MRI knee arthrography.

27369 ***Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography***
The RUC reviewed the survey results from 34 physicians and agreed with the following physician time component: pre-service time of 8 minutes, intra-service time of 15 minutes, and post-service time of 5 minutes, for a total of 28 minutes. The RUC reviewed the recommended work RVU of 0.96 which is below the survey 25th percentile but is the existing work RVU for the deleted code, 27370 *Injection of contrast for knee arthrography* (work RVU= 0.96). The RUC agreed that this value appropriately accounts for the physician work involved. To justify the work RVU of 0.96, the RUC reviewed CPT code 27370 and noted that both services should be valued identically rather than seeking the survey 25th percentile, which would have necessitated a compelling evidence argument. The RUC agreed that the survey code work RVU should reflect that of the deleted code and the survey code physician time component should parallel the physician times of the top key reference service code, 23350 *Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography* (pre-service time of 8 minutes, intra-service time of 15 minutes, and post-service time of 5 minutes), noting that the top key reference code involves an identical amount of both intra-service time and total time, as well as a similar amount of physician work, further supporting a work RVU of 0.96 for the survey code. **The RUC recommends a work RVU of 0.96 for CPT code 27369.**

CPT Referral
At the October 2017 RUC meeting, code 27369 *Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography* was discussed. In an effort to support accurate reporting for codes 20610, 20611, it was suggested that the parenthetical note currently placed under new code 27369 also be placed after the deletion note for code 27370.

(For arthrocentesis of the knee or injection of any material other than contrast for subsequent arthrography, see 20610, 20611)

Practice Expense
The specialty society originally recommended 14 minutes of clinical staff time for clinical activity CA021, *Perform procedure/service---NOT directly related to physician work time.* The PE Subcommittee determined that this was clinical staff time spent assisting the physician not working independently and moved the clinical staff time to clinical activity CA018, *Assist physician or other qualified healthcare professional---directly related to physician work time (100%).* This change caused the time to increase from 14 to 15 minutes because it is directly tied to the physician work intra-service time of 15 minutes. The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee for CPT code 27369.

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.

Breast MRI with Computer-Aided Detection (Tab 6)
Kurt Schoppe, MD (ACR); Daniel Wessell, MD, PhD (ACR); and Gregory Nicola, MD, (ASNR); Dana Smetherman, MD, FACR (ACR) and Lauren Golding, MD (ACR)

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 preparation to survey CPT codes 77058 and 77059, the specialty societies noted that the clinical indications had changed for these exams. Additionally, the technology had advanced such that there were changes in physician work, practice expense, and work flow. Further, these codes did not parallel the structure of other MRI codes. Finally, computer-aided detection (CAD) had become typical for the without and with contrast examinations. The RUC recommended CPT code 77058 and 77059 be referred to the CPT Editorial Panel. In June 2017 the CPT Editorial Panel deleted codes 0159T, 77058, and 77059 and created two new codes to report breast MRI without contrast and two new breast MRI without and with contrast material codes (including computer-aided detection).

Compelling Evidence
The specialty society presented compelling evidence for codes 77048 and 77049. The society noted that their compelling evidence argument is based on a change in patient population and change in technology. This code family was last valued by the RUC in 1995 with both 77058 *MRI breast; unilateral* and 77059 *MRI breast; bilateral* assigned a work RVU of 1.63, with total times of 50 and 55 minutes respectively. At that time, the indications for breast MRI were far more limited and were not even sufficiently differentiated between the assessment of implant integrity and the detection and evaluation of breast cancer to necessitate the creation of separate CPT codes. As dynamic contrast enhanced sequences became available, MRI has proven to be the most sensitive tool for detection of breast cancer. These developments were made possible by the development

of new software, hardware, and physician skill. Some of this additional physician work and practice expense was initially described in a Category III code, 0159T, which has been used since July 2006. The specialty society believes that 0159T now meets all the requirements of a Category I Code, including FDA approval, widespread usage by many physicians across the United States, being performed with frequency consistent with intended clinical use, and documented clinical efficacy in the literature. This Category III code has been bundled with the unilateral and bilateral breast MRI without and with contrast material (77048 and 77049). The RUC accepted that there is compelling evidence for codes 77048 and 77049.

77046 ***Magnetic resonance imaging, breast, without contrast material; unilateral***
The RUC reviewed the survey results from 49 physicians and agreed with the following physician time component: pre-service time of 5 minutes, intra-service time of 25 minutes, and post-service time of 5 minutes. The RUC reviewed the recommended work RVU of 1.45 which is the survey 25th percentile and agreed that this value appropriately accounts for the physician work involved. The RUC compared CPT codes 74176 *Computed tomography, abdomen and pelvis; without contrast material* (work RVU= 1.74, pre-service time of 5 minutes, intra-service time of 22 minutes, and post-service time of 5 minutes) and 74177 *Computed tomography, abdomen and pelvis; with contrast material(s)* (work RVU=1.82, pre-service time of 5 minutes, intra-service time of 25 minutes, and post-service time of 5 minutes) and noted that the recommended work RVU for the surveyed code is appropriately less than the top two key reference services. Additionally, the RUC also reviewed MPC code 92014 *Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits* (work RVU= 1.42, pre-service time of 5 minutes, intra-service time of 24 minutes, and post-service time of 8 minutes) and noted that these services require similar physician work and time to perform, further supporting a work RVU of 1.45 for the surveyed code. **The RUC recommends a work RVU of 1.45 for CPT code 77046.**

77047 ***Magnetic resonance imaging, breast, without contrast material; bilateral***
The RUC reviewed the survey results from 49 physicians and agreed with the following physician time component: pre-service time of 5 minutes, intra-service time of 30 minutes, and post-service time of 5 minutes. The RUC reviewed the recommended work RVU of 1.60 which is the survey 25th percentile and agreed that this value appropriately accounts for the physician work involved. The RUC compared the survey code to CPT code 78452 *Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection* (work RVU= 1.62, pre-service time of 10 minutes, intra-service time of 20 minutes, post-service time of 10 minutes, and total time of 40 minutes) and noted that both services have similar work RVUs and identical total physician time, and therefore should be valued similarly. The RUC also reviewed CPT code 73719 *Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s)* (work RVU= 1.62, pre-service time of 10 minutes, intra-service time of 20 minutes, post-service time of 10 minutes, and total time of 40 minutes) and noted that both services also have similar work RVUs and identical total physician time, further supporting the recommended value of 1.60 for the survey code. **The RUC recommends a work RVU of 1.60 for CPT code 77047.**

77048 ***Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD- real time lesion detection, characterization and pharmacokinetic analysis) when performed; unilateral***

The RUC reviewed the survey results from 49 physicians and agreed with the following physician time component: pre-service time of 8 minutes, intra-service time of 32 minutes, and post-service time of 8 minutes. The RUC reviewed the recommended work RVU of 2.10, the survey 25th percentile and agreed that this value appropriately accounts for the physician work involved. To justify the work RVU of 2.10, the RUC referenced the most commonly chosen key reference services, codes 74178 *Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions* (work RVU= 2.01, pre-service time of 5 minutes, intra-service time of 30 minutes, and post-service time of 5 minutes) and 71552 *Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequences* (work RVU= 2.26, pre-service time of 7.5 minutes, intra-service time of 24 minutes, and post-service time of 10 minutes) and noted that the survey code has 2 more minutes of intra-service time and 6 more total minutes of pre and post-service time compared to code 74178. CPT code 74178 is also an MPC code. The recommended value for the survey code is appropriately higher than code 74178 at 2.10, compared to 2.01 for the key reference service. Additionally, code 71552 has less intra-service time and less total time compared to the survey code, but more overall intensity/ complexity and a higher work value. Both key reference and MPC services support the recommended value for the surveyed code. **The RUC recommends a work RVU of 2.10 for CPT code 77048.**

77049 ***Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD- real time lesion detection, characterization and pharmacokinetic analysis) when performed; bilateral***

The RUC reviewed the survey results from 49 physicians and agreed with the following physician time component: pre-service time of 8 minutes, intra-service time of 42 minutes, post-service time of 8 minutes, and a total time of 58 minutes. The RUC reviewed the recommended work RVU of 2.30 which is the survey 25th percentile and agreed that this value appropriately accounts for the physician work involved. To justify the work RVU of 2.30, the RUC referenced CPT code 75557 *Cardiac magnetic resonance imaging for morphology and function without contrast material;* (work RVU= 2.35, pre-service time of 10 minutes, intra-service time of 40 minutes, post-service time of 10 minutes, and total time of 60 minutes) and noted that both services have similar intra-service times and similar total physician times. The recommended work RVU and the physician time of the survey code is slightly lower than the reference code, therefore a work RVU of 2.30 for the survey code is appropriate. To further support a work RVU of 2.30 for the survey code, the RUC also reviewed CPT code 99386 *Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years* (work RVU= 2.33, pre-service time of 10 minutes, intra-service time of 40 minutes, post-service time of 10 minutes, and total time of 60 minutes) and noted that both services involve similar physician work, further supporting a work RVU of 2.30 for the survey code. **The RUC recommends a work RVU of 2.30 for CPT code 77049.**

Practice Expense

The PE Subcommittee made the following modifications to the PE spreadsheet:

- **77048:** Removal of SG021 (bandage, strip 0.75in x 3in [Bandaid]), removal of SG053 (gauze, sterile 2in x 2in), removal of SG079 (tape, surgical paper 1in [Micropore]), and removal of SJ043 (providone swabsticks [3 pack uou])

- **77049:** Removal of SG021 (bandage, strip 0.75in x 3in [Bandaid]), removal of SG053 (gauze, sterile 2in x 2in), removal of SG079 (tape, surgical paper 1in [Micropore]), and removal of SJ043 (providone swabsticks [3 pack uou])

The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee for CPT codes 77048 and 77049.

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.

Neurostimulator Services (Tab 7)
Marianna Spanaki, MD, PhD (AAN); Alexander Mason, MD (CNS); Marc Nuwer, MD PhD (ACNS); Peter Pahapill, MD (CNS)

In October 2013, CPT code 95971 was identified in the second iteration of the High Volume Growth screen and the RUC recommended to survey for January 2014. In January 2014, the RUC recommended that CPT codes 95971, 95972 and 95973 be referred to the CPT Editorial Panel to address the entire family regarding the time referenced in the CPT code descriptors. Specifically, the descriptor for code 95972 specifies "first hour" but survey results indicate that the majority of physicians reporting this code take less than 30 minutes. Per CPT rules, since the midpoint of the specified time is not exceeded, the code is not reportable in the majority of circumstances under which the service is performed. The relevant specialties were asked to submit a code change proposal for CY 2016 to more definitely address the concern and make the codes more consistent with current practice. The specialties anticipated two separate families; one for peripheral nerve root stimulators and another for spinal cord stimulators. In June 2017, the CPT Editorial Panel revised codes 95970, 95971, and 95972, deleted codes 95974, 95975, 95978, and 95979 and created four new codes for analysis and programming of implanted cranial nerve neurostimulator pulse generator, analysis, and programming of brain neurostimulator pulse generator systems and analysis of stored neurophysiology recording data. Introductory guidelines were also revised extensively.

95970 ***Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve neurostimulator pulse generator/transmitter, without programming***
The RUC reviewed the survey responses from 62 neurologists and neurosurgeons and determined that the current work RVU of 0.45 appropriately accounts for the work required to perform this service. The survey respondents indicated a slightly higher work RVU but the specialty societies indicated that the work has not changed for this service. The specialty societies reduced the pre-service time, which accounts for this service being reported with an Evaluation and Management (E/M) service. The RUC recommends 3 minutes pre-service, 7 minutes intra-service and 5 minutes post-service time. The RUC noted that this service had never been surveyed and the previous total time of 19 minutes was Harvard time. The RUC notes that the current survey time now appropriately allocates the pre-, intra- and post-service time.

The RUC compared 95970 to the top key reference service 62368 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming* (work RVU = 0.67 and 27 minutes total time) and agreed that the surveyed service requires less physician work and time to perform. The RUC also reviewed MPC codes 99281 *Emergency department visit for the evaluation and management of a patient…* (work RVU = 0.45 and 13 minutes total time) and 76857 *Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)* (work RVU = 0.50 and 17 minutes total time), which support the recommended work RVU. **The RUC recommends a work RVU of 0.45 for CPT code 95970.**

95976 ***Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional***
The RUC noted 95976 is defined as simple programming of cranial nerve neurostimulator (adjustment of 1-3 parameters) versus deleted code 95974 which was time based and defined as the first hour of programming. **The RUC recommends that the specialty societies develop a CPT Assistant article to direct providers on when to report simple versus complex cranial nerve neurostimulator services.**

The RUC reviewed the survey responses from 57 neurologists and neurosurgeons and determined that the survey 25th percentile work RVU of 0.95 appropriately accounts for the work required to perform this service. The specialty societies reduced the pre-service time, which accounts for this service being reported with an E/M service. The RUC recommends 3 minutes pre-service, 11 minutes intra-service and 10 minutes post-service time. The specialty societies indicated and the RUC agreed that the 10 minutes required for the post-time includes reviewing all the parameters, documenting final program measurements and any other relevant clinical information obtained during the programming session, reducing side effects and making treatment adjustments. The physician will also address patient and family questions about planned therapy and re-educate the patient and family on the use of the patient device. The RUC confirmed that the physician times appropriately mirror other similar services.

The RUC compared 95976 to the top key reference service 95816 *Electroencephalogram (EEG); including recording awake and drowsy* (work RVU = 1.08 and 5 minutes pre-service, 15 minutes intra-service and 6 minutes post-service time) and agreed with the survey respondents that the surveyed service is similar, but somewhat more intense and complex to perform. Thus, the survey 25th percentile work RVU appropriately places CPT code 95976 relative to the top key reference service. The RUC also reviewed MPC codes 92012 *Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient* (work RVU = 0.92 and 25 minutes total time) and 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.97 and 23 minutes total time), which support the recommended work RVU. All three services involve a similar amount of total time and physician work. For additional support the RUC referenced code 78265 *Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit* (work RVU = 0.98 and 25 minutes total time). Thus, the survey 25th percentile work RVU appropriately places CPT code 95976 relative to the top key reference service and other similar services. **The RUC recommends a work RVU of 0.95 for CPT code 95976.**

95977 ***Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional***
The RUC noted 95977 is defined as complex programming of cranial nerve neurostimulator (adjustment of more than 3 parameters) versus deleted code 95975, which was a time-based add-on code defined as each additional 30 minutes of programming. **The RUC recommends that the specialty societies develop a CPT Assistant article to direct providers on when to report simple versus complex cranial nerve neurostimulator services.**

The RUC reviewed the survey responses from 56 neurologists and neurosurgeons and determined that the survey 25th percentile work RVU of 1.19 appropriately accounts for the physician work required to perform this service. The specialty societies reduced the pre-service time, which accounts for this service being reported with an E/M service. The RUC recommends 3 minutes pre-service, 17 minutes intra-service and 10 minutes post-service time. The specialty societies indicated and the RUC agreed that the 10 minutes required for the post-time include reviewing all the parameters, documenting final program measurements and any other relevant clinical information obtained during the programming session, reducing side effects and making treatment adjustments. The physician will also address patient and family questions about planned therapy and re-educate the patient and family on the use of the patient device. The RUC confirmed that the physician times appropriately mirror other similar services.

The RUC noted that the top to key reference services were disparate compared to this service. Therefore, as a better comparison, the RUC compared 95977 to MPC codes 99308 *Subsequent nursing facility care, per day, for the evaluation and management of a patient* (work RVU = 1.16, 15 minutes of intra-service time and 31 minutes total time) and 12013 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU = 1.22, 15 minutes of intra-service time and 27 minutes total time), which support the recommended work RVU as the survey code involves somewhat more intra-service and total time and a comparable amount of physician work. For additional support, the RUC referenced code 93975 *Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study* (work RVU = 1.16, 20 minutes of intra-service time and 30 minutes total time) and 67810 *Incisional biopsy of eyelid skin including lid margin* (work RVU = 1.18, 13 minutes of intra-service time and 27 minutes total time). Thus, the survey 25th percentile work RVU appropriately places CPT code 95977 relative to the top key reference service and other similar services. **The RUC recommends a work RVU of 1.19 for CPT code 95977.**

95983 ***Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator /transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional***
The RUC noted 95983 is defined as the first 15 minutes of programming for brain neurostimulator versus deleted code 95978, which was defined as the first hour of programming. The specialty societies indicated that programming for brain neurostimulators is always complex therefore it is unnecessary for a simple versus complex coding structure. **The RUC noted the**

CPT coding conventions when reporting timed codes and recommends that the specialty societies develop a CPT Assistant article to direct providers on how to correctly report the brain neurostimulator services.

The RUC reviewed the survey responses from 56 neurologists and neurosurgeons and determined that the survey 25th percentile work RVU of 1.25 appropriately accounts for the work required to perform this service. The specialty societies reduced the pre-service time, which accounts for this service being reported with an E/M service. The RUC recommends 3 minutes pre-service, 15 minutes intra-service and 10 minutes post-service time. The specialty societies indicated and the RUC agreed that the 10 minutes required for the post-time include documenting final program measurements and any other relevant clinical information obtained during the programming session, reducing side effects and making treatment adjustments. The physician will also address patient and family questions about planned therapy and re-educate the patient and family on the use of the patient device. The RUC confirmed that the physician times appropriately mirror other similar services.

The RUC noted that the top to key reference services were disparate compared to this service. Therefore, as a better comparison, the RUC reviewed MPC codes 12013 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU = 1.22, intra-service time of 15 minutes and 27 minutes total time) and 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27, 15 minutes of intra-service time and 25 minutes total time), which required similar physician time, work, intensity and complexity. For additional support, the RUC referenced similar codes 70488 *Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27 and 15 minutes of intra-service time and 25 minutes total time) and 92614 *Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording;* (work RVU = 1.27 and 15 minutes of intra-service time and 28 minutes total time). Thus, the survey 25th percentile work RVU appropriately places CPT code 95983 relative to other similar services. **The RUC recommends a work RVU of 1.25 for CPT code 95983.**

95984 ***Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)***
The RUC noted 95984 is defined as an add-on service for each additional 15 minutes of brain neurostimulator programming versus the deleted code 95979 which was defined as each additional 30 minutes. The specialty societies indicated that programming for brain neurostimulators is always complex therefore it is unnecessary for a simple versus complex coding structure. **The RUC noted the CPT coding conventions when reporting timed codes and recommends that the specialty societies develop a CPT Assistant article to direct providers on how to correctly report the brain neurostimulator services.**

The RUC reviewed the survey responses from 48 neurologists and neurosurgeons and determined that the survey 25th percentile work RVU of 1.00 appropriately accounts for the work required to perform this service. The RUC recommends 15 minutes intra-service time. The RUC compared the surveyed code to the top to key reference service 64645 *Chemodenervation of one extremity; each additional extremity, 5 or more muscles (List separately in addition to code for primary*

procedure) (work RVU = 1.39 and 15 minutes of intra-service time) and noted that the survey respondents indicated the surveyed code is more intense and complex to perform but 64645 requires more technical skill. Therefore CPT code 64645 appropriately requires slightly more work than 95984. The RUC reviewed 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 total time) and 64480 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.20 and 15 minutes total time), which required similar physician time, work, intensity and complexity. Thus, the survey 25th percentile work RVU appropriately places CPT code 95984 relative to the top key reference service and other similar services. **The RUC recommends a work RVU of 1.00 for CPT code 95984.**

95971 ***Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming***

95972 ***Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord~~,~~ or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional***

The specialty societies indicated that at the June 2017 CPT Editorial Panel meeting, a code change application was submitted for editorial changes only to the descriptors for CPT codes 95971 and 95972. These codes were previously surveyed and reviewed by the RUC in April 2015. The RUC recommended physician work RVUs of 0.78 for 95971 and 0.80 for 95972. There has been no change in the physician work since the survey. The specialty societies who perform this procedure did not believe it needs to be re-surveyed at this time. **The RUC affirmed the current work RVU of 0.78 for CPT code 95971 and 0.80 for CPT code 95972.**

Gastric Neurostimulator Services
The specialty societies indicated and the RUC agreed that CPT codes 95980, 95981 and 95982 are not part of this family of services. There was no specialty society interest to survey these services. The RUC confirmed that the physician work and time for these services are appropriate relative to other neurostimulator services.

Practice Expense
The specialty societies removed all the clinical staff time and the PE reviewed the remaining equipment time. The RUC recommends the practice expenses without modification as submitted by the specialty societies and approved by the PE Subcommittee.

Work Neutrality
The RUC's recommendation for this code is work neutral.

Refer to CPT Assistant
The RUC noted 95976 is defined as simple programming of cranial nerve neurostimulator (adjustment of 1-3 parameters) versus deleted code 95974 which was time based and defined as the first hour of programming and 95977 is defined as complex programming of cranial nerve neurostimulator (adjustment of more than 3 parameters) versus deleted code 95975, which was a time-based add-on code defined as each additional 30 minutes of programming. **The RUC recommends that the specialty societies develop a CPT Assistant article to direct providers on when to report simple versus complex cranial nerve neurostimulator services.**

The RUC noted 95983 is defined as the first 15 minutes of programming for brain neurostimulator versus deleted code 95978, which was defined as the first hour of programming and 95984 is defined an add-on service for each additional 15 minutes of brain neurostimulator programming versus the deleted code 95979 which was defined as each additional 30 minutes. The specialty societies indicated that programming for brain neurostimulators is always complex therefore it is unnecessary for a simple versus complex coding structure. **The RUC noted the CPT coding conventions when reporting timed codes and recommends that the specialty societies develop a CPT Assistant article to direct providers on how to correctly report the brain neurostimulator services.**

<u>Psychological and Neuropsychological Testing (Tab 8)</u>
Kevin Kerber, MD (AAN); Steve Krug MD, (AAP); Lynn Wegner, MD (AAP); Stephen Gillaspy, PhD (APA); Randy Phelps, PhD (APA) and Neil Pliskin, PhD (APA)
Facilitation Committee #1

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-day 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. The testing practice has been significantly altered by the growth and availability of technology. The current codes do not reflect the multiple standards of practice and therefore result in confusion about how to report the codes. The RUC recommended the entire psychological and neuropsychological testing codes be referred to the CPT Editorial Panel for revision. CMS also requested that the entire family of services be reviewed. In September 2016, the CPT Editorial Panel created seven codes to differentiate technician administration of psychological testing and neuropsychological testing from physician/ psychologist administration and assessment of testing; and deleted codes 96101-96103, 96111, 96118, 96119, 96120. In January 2017, organizations representing psychiatry, psychology, neurology, pediatrics and speech pathologists conducted a survey for the January 2017 RUC and HCPAC Review Board meetings. During this effort, it became apparent that further CPT revisions were required. Survey respondents were unable to articulate the work at the 60 or 30 minute coding increments and there is significant concern regarding the duplication of pre- and post- work as several units of service would be reported. Therefore, the organizations submitted a letter to the CPT Editorial Panel and the RUC to rescind the coding changes summarized below for CPT 2018. 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 of codes 96101-96103, 96111, 96118, 96119, 96120.

96112 ***Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour***

The RUC reviewed the specialty societies' recommendation of 2.60, the current value of to be deleted CPT code 96111 *Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report* (work RVU = 2.60 and 5 minutes pre-time, 60 minutes intra-service time and 30 minutes post-time), and determined that the survey data did not support that recommendation. The RUC reviewed the survey responses from 48 pediatricians, neurologists and psychologists and noted the survey 25th percentile was 2.48 work RVUs and median was 3.13 work RVUs. The RUC understood that this service is typically performed on a pediatric patient on the autism spectrum, which may be more intense and complex to test than the previous typical patient. However, the survey data did not indicate an increase. Therefore, using magnitude estimation the RUC determined that a work RVU of 2.50, crosswalked to CPT code 90847 *Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes* (work RVU = 2.50 and 5 minutes pre-service, 50 minutes intra-service and 21 minutes post-service time) was appropriate. Additionally, a work RVU of 2.50 was recommended for codes 96130 and 96132, which require the same physician time and similar work to perform. For additional support the RUC referenced similar services 90846 *Family psychotherapy (without the patient present), 50 minutes* (work RVU = 2.40 and 50 minutes intra-service time) and 95954 *Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase* (eg, thiopental activation test) (work RVU = 2.45 and 5 minutes pre-service, 60 minutes intra-service and 5 minutes post-service time). Based on initial comments from the RUC, the specialty societies modified the pre- and post-service times to be consistent with this family of services and other similar services. The RUC recommends 5 minutes pre-service, 60 minutes intra-service and 5 minutes post-service time for CPT code 96112. **The RUC recommends a work RVU of 2.50 for CPT code 96112.**

96113 ***Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)***

The RUC reviewed the survey responses from 43 pediatricians, neurologists and psychologists and determined that the survey respondents overestimated the physician time and work required to perform this service. The RUC expressed concerned about the intensity of this add-on service related to the intensity of the base code. Therefore, the RUC recommends that CPT code 96113 be crosswalked to CPT code 96570 *Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)* (work RVU of 1.10 and 30 minutes intra-service time). The RUC recommends 30 minutes for CPT code 96113. For additional support the RUC referenced CPT code 52442 *Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)* (work RVU = 1.20 and 25 minutes intra-service time), which is valued slightly higher because it is more intense and complex to perform. **The RUC recommends a work RVU of 1.10 for CPT code 96113.**

96116 ***Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour***
The RUC reviewed the survey responses from 53 neurologists and psychologists and determined the current work RVU of 1.86 appropriately accounts for the work required to perform this service. The RUC recommends 5 minutes of pre-service, 60 minutes of intra-service and 5 minutes of post-service time. Based on initial comments from the RUC, the specialty societies modified the pre- and post-service times to be consistent with this family of services and other similar services. The RUC confirmed that this service will not be reported with an Evaluation and Management (E/M) service. For additional support, the RUC referenced similar services 92524 *Behavioral and qualitative analysis of voice and resonance* (work RVU = 1.50 and 60 minutes intra-service time) and 95864 *Needle electromyography; 4 extremities with or without related paraspinal areas* (work RVU = 1.99 and 50 minutes intra-service time). **The RUC recommends a work RVU of 1.86 for CPT code 96116.**

96121 ***Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)***
The RUC reviewed the survey responses from 53 neurologists and psychologists and determined that the survey respondents overestimated the physician work required for this service. Therefore, the RUC recommends that CPT code 96121 be crosswalked to CPT code 99356 *Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for primary procedure)* (work RVU = 1.71 and 60 minutes intra-service time). The RUC recommends 60 minutes of intra-service time for CPT code 96121. For additional support, the RUC referenced add-on code 90836 *Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)* (work RVU = 1.90 and 48 minutes total time). **The RUC recommends a work RVU of 1.71 for CPT code 96121.**

96132 ***Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour***
The RUC reviewed the survey responses from 140 neurologists and psychologists and determined that the survey respondents overestimated the physician time for this service. Based on initial comments from the RUC, the specialty societies modified the pre- and post-service times to be consistent with this family of services and other similar services. The RUC confirmed that this service will not be reported with an Evaluation and Management (E/M) service. The RUC also confirmed that psychological testing evaluation service, CPT code 96130 and neuropsychological testing evaluation service, CPT code 96132 are distinct and separate services and will not be reported together on the same day. The RUC recommends 5 minutes of pre-service, 60 minutes of intra-service and 5 minutes of post-service time for CPT code 96132. Using magnitude estimation the RUC determined that a work RVU of 2.50, crosswalked to CPT code 90847 *Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes* (work RVU = 2.50 and 5 minutes pre-service, 50 minutes intra-service and 21 minutes post-service time) was appropriate. Additionally, a work RVU of 2.50 was recommended for codes 96112 and 96130, which require the same physician time and work to perform. For additional support the RUC

referenced similar services 90846 *Family psychotherapy (without the patient present), 50 minutes* (work RVU = 2.40 and 50 minutes intra-service time) and 95954 *Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase* (eg, thiopental activation test) (work RVU = 2.45 and 5 minutes pre-service, 60 minutes intra-service and 5 minutes post-service time). **The RUC recommends a work RVU of 2.50 for CPT code 96132.**

96133 ***Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)***
The RUC reviewed the survey responses from 138 neurologists and psychologists and determined that the survey respondents overestimated the physician work and time for this service. The RUC recommends 60 minutes of intra-service time. Using magnitude estimation the RUC determined that a work RVU of 1.90, crosswalked to CPT code 90836 *Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)* (work RVU = 1.90 and 48 minutes total time) was appropriate. Additionally, a work RVU of 1.90 was recommended for code 96131, which require the same physician time and work to perform. For additional support the RUC referenced similar services 88323 *Consultation and report on referred material requiring preparation of slides* (work RVU = 1.83 and 60 minutes intra-service time), 95864 *Needle electromyography; 4 extremities with or without related paraspinal areas* (work RVU = 1.99 and 50 minutes intra-service time) and 92640 *Diagnostic analysis with programming of auditory brainstem implant, per hour* (work RVU = 1.76 and 60 minutes intra-service time). **The RUC recommends a work RVU of 1.90 for CPT code 96133.**

96X11 ***Psychological 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***
The RUC reviewed the survey responses from 143 neurologists and psychologists and determined that the issue with this service was that the primary providers were not surveyed (primary care and nurse practitioners).This service describes a single test that is currently reported with 96103 *Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report* (work RVU = 0.51, 8 minutes pre-service, 8 minutes intra-service and 14 minutes post service time) or 96120 *Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report* (work RVU = 0.51, 8 minutes pre-service, 8 minutes intra-service and 14 minutes post service time). The RUC did not believe this single test will typically require 30 minutes. The RUC agreed the new coding structure for the other psychological and neuropsychological tests accurately describe testing performed by psychologists and neurologists, whereas the test as described in CPT code 96X11 will be a single test conducted by primary care physicians and nurse practitioners. **The RUC recommends an interim value of 0.51 for CPT code 96X11 and 8 minutes pre-service, 8 minutes intra-service and 14 minutes post service time (the current value and physician times as that of 96103 and 96120) and resurvey the correct providers for January 2018. The specialty societies should submit a revised vignette to the Research Subcommittee prior to survey.**

Practice Expense
CPT codes 96113, 96121, 96132 and 96133 require no direct practice expense inputs.

96110 ***Developmental screening (eg, developmental milestone survey, speech and language delay screen) with scoring and documentation, per standardized instrument***
96127 ***Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument***
CPT code 96127 was reviewed in April 2014. At that time the RUC recommended 15 minutes of staff time for clinical activity, *Perform procedure/service---NOT directly related to physician work time.* This time was subsequently refined by CMS and reduced to 7 minutes. The PE Subcommittee reviewed this service as part of the family at the October 2017 RUC meeting and determined that 6 minutes is the appropriate time for this clinical activity. To maintain consistency across the family, clinical activity, *Perform procedure/service---NOT directly related to physician work time* in CPT code 96110 was also reduced from 15 to 6 minutes.

96112 ***Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour***
CPT codes 96112 requires no clinical staff time. There is 1 equipment item, EQ087 *cognitive abilities testing software (Woodcock Johnson)* allocated to this service. The time that the item is in use is not directly related to the clinical activity time and is typically in use for 10 minutes while the physician or other qualified health care professional administers the test.

96116 ***Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour***
CPT code 96116 includes an equipment item SK050, *neurobehavioral status forms, average*, that is an average of a variety of neurobehavioral tests. The PE Subcommittee requested that the specialty societies that utilize this supply item work together to determine the 3 most typical tests and submit paid invoices to CMS to facilitate updated pricing.

96132 ***Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour***
96133 ***Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)***
96X11 ***Psychological 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***
CPT codes 96132, 96133 and 96X11 require no clinical staff time. The PE Subcommittee removed all supplies and equipment related to printing. The PE Subcommittee determined that equipment item ED021, *computer, desktop, w-monitor* is an indirect expense for this service.

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

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

X. CMS Request/Relativity Assessment Identified Codes

Bronchoscopy (Tab 9)
Katina Nicolacakis MD (ATS), Alan Plummer, MD (ATS), Robert DeMarco, MD (CHEST) Kevin Kovitz, MD (CHEST) and Omar Hussain, MD (ATS)

A list of all services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2009 through 2014 was assembled by AMA Staff. The query resulted in the identification of 12 services. In January 2017 the RUC recommended that these services be surveyed for October 2017. CPT code 31623 was one of the 12 services identified in this high volume growth screen and CPT code 31624 was added as part of the bronchoscopy family.

31623 ***Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings***
The RUC reviewed the survey results from 83 pulmonologists and determined that it was appropriate to maintain the current work RVU of 2.63, which is below the survey 25th percentile. The RUC discussed the pre-service times (10 minutes evaluation time, 5 minutes positioning time, and 5 minutes scrub/dress/wait time) and confirmed the removal of moderate sedation. Pre-service package 1-FAC Straightforward Patient Procedure with no sedation/anesthesia was selected due to the coding changes that removed moderate sedation from all services. The pre-service evaluation time was reduced by 3 minutes consistent with the survey median and 4 minutes was added to the standard positioning time consistent with the survey median to provide for positioning/repositioning of IVs and the bronchoscopy equipment. The pre-service scrub/dress/wait time was adjusted to below the median 10 minutes to 5 minutes consistent with CPT code 31622. Post-service package 8A IV sedation/simple procedure was selected and adjusted by 10 minutes consistent with the survey median time of 15 minutes. The RUC agreed that the survey median intra-service time of 30 minutes accurately reflects the time required to perform this service and is consistent with the current median time of CPT 31622. The RUC recommends 20 minutes pre-service time, 30 minutes intra-service time and 15 minutes immediate post-service time and noted that CMS already reduced the current value to 2.63 as part of the removal of moderate sedation for all services, so further reduction is not necessary.

The RUC compared CPT code 31623 to key reference service CPT code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU = 2.53 and 30 minutes intra-service time) and noted that both services have identical intra-service time, however the survey code involves more total time, justifying the higher work value. The survey results support the reference service code in terms of relativity, intensity and complexity measures. The RUC agreed that the overall intensity/complexity measures for CPT code 31623 are generally the same or greater than 31622.

For additional support, the RUC compared the survey code to CPT code 43227 Esophagoscopy, flexible, transoral; with control of bleeding, any method (work RVU = 2.89, intra-service time of 30 minutes, total time of 63 minutes) and noted that both codes have identical intra-service time and similar total time. **The RUC recommends a work RVU of 2.63 for CPT code 31623.**

31624 ***Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage***
The RUC reviewed the survey results from 90 pulmonologists and determined that it was appropriate to maintain the current work RVU of 2.63, which is below the survey 25th percentile. The RUC discussed the pre-service times (10 minutes evaluation time, 5 minutes positioning time, and 5 minutes scrub/dress/wait time) and confirmed the removal of moderate sedation. Pre-service package 1-FAC Straightforward Patient Procedure with no sedation/anesthesia was selected due to the coding changes that removed moderate sedation from all services. The pre-service evaluation time was reduced by 3 minutes consistent with the survey median and 4 minutes was added to the standard positioning time consistent with the survey median to provide for positioning/repositioning of IVs and the bronchoscopy equipment. The pre-service scrub/dress/wait time was adjusted to below the median 10 minutes to 5 minutes consistent with CPT code 31622. Post-service package 8A IV sedation/simple procedure was selected and adjusted by 10 minutes consistent with the survey median time of 15 minutes. The RUC agreed that the survey median intra-service time of 30 minutes accurately reflects the time required to perform this service and is consistent with the current median time of CPT 31622. The RUC recommends 20 minutes pre-service time, 30 minutes intra-service time and 15 minutes immediate post-service time and noted that CMS already reduced the current value to 2.63 as part of the removal of moderate sedation for all services, so further reduction is not necessary.

The RUC compared CPT code 31624 to key reference service CPT code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU = 2.53 and 30 minutes intra-service time) and noted that both services have identical intra-service time, however the survey code involves more total time, justifying the higher work value. The survey results support the reference service code in terms of relativity, intensity and complexity measures. The RUC agreed that the overall intensity/complexity measures for CPT code 31624 are generally the same or greater than 31622. **The RUC recommends a work RVU of 2.63 for CPT code 31624.**

Practice Expense
The Practice Expense Subcommittee modified the direct practice expense inputs by approving 1 minute of clinical staff time for clinical activity CA029, *check dressings, catheters, wounds* and removing supply item SJ016, *denture cup*. The PE Subcommittee discussed that these modifications deviate from the base code, 31622. The RUC recommends the direct practice expense inputs with modifications as reviewed and approved by the PE Subcommittee.

<u>Transcatheter Aortic Valve Replacement (Tab 10)</u>
Richard Wright, MD (ACC); James Levett, MD (STS); Stephen Lahey, MD (AATS); Cliff Kavinsky, MD (SCAI); Thad Waites, MD (ACC);

In 2005, the AMA RUC began the process of flagging services that represent new technology or new services as they were presented to the Committee. In October 2016, the Relativity Assessment Workgroup reviewed codes that were flagged October 2011 – April 2012, with 3 years of available Medicare claims data (2013, 2014 and preliminary 2015 data). The Workgroup determined that the technology for these services is evolving, 400 cardiology centers now provide these services and have shifted from being provided in academic centers to now private centers. The RUC recommended that 33361-33366 be resurveyed for physician work and practice expense. The RUC did not believe there would be a change in physician work or practice expense for the add-on services and recommends that 33367, 33368 and 33369 be removed from the new technology list as there is no demonstrated diffusion.

At the October 2017 RUC meeting, the specialty societies requested that this item be tabled and sent to the Research Subcommittee to develop a methodology that can be used to reliably value this unique set of codes which mandates the participation of two physicians and modifier 62 for the procedure. 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 also each of them is performing the service and post-operative visit concurrently, this requirement has a direct impact on accurate valuation and interpretation of code components (various types of work per unit time; time spent by each provider) which makes valuing them 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 them how specifically these data points would be used in conjunction with the RUC survey data.

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 other business discussion, the RUC agreed that specialties should 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.**

Injection-Eye (Tab 11)
David B. Glasser, MD (AAO); John T. McAllister, MD (AAO) and John Thompson, MD (ASRS)

In the Final Rule for 2017, CMS finalized the list of 000-day global services reported with an Evaluation and Management (E/M) service 50 percent of the time or more, on the same day of service, same patient, by the same physician, that have not been reviewed in the last five years with Medicare utilization greater than 20,000.

67500 ***Retrobulbar injection; medication (separate procedure, does not include supply of medication)***
The RUC reviewed the survey results from 47 ophthalmologists and determined that the survey 25th percentile work RVU of 1.18 accurately reflects the physician work necessary for this service. The pre-service time for evaluation substantially increased for this code while the intra-service time has not changed. The specialty noted that CPT code 67500 is not itself performed with an office visit but is reported alone 84% of the time. The RUC recommends pre-service package 6 unmodified, as the procedure is not typically done on the same day as an office visit and an interim history and dilated exam are required to assess the extent of the disease and the need for the procedure. The RUC recommends the following time components: 17 minutes evaluation time, 1 minute positioning time, 5 minutes scrub/dress/wait time, 5 minutes intra-service time, and 5 minutes post-service time. The RUC compared the survey code to top key reference code 67028 *Intravitreal injection of a pharmacologic agent (separate procedure)* (work RVU = 1.44, intra-service time of 5 minutes) and noted that the survey code is appropriately valued lower because the reference code is an intra-occular injection while the survey code is extra-occular. While both procedures are high-risk, the specialty attested that the survey code should not be valued at the same level as the key reference service. The RUC agreed that the 25th percentile work RVU better reflects the intensity and complexity of the service.

The RUC compared the survey code to MPC codes 12013 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU = 1.22) and 36620 *Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous* (work RVU = 1.15) and agreed that the survey code fits appropriately between these comparison codes. The RUC acknowledged that there are few MPC or recently reviewed 000-day global codes with intra-service times of 5 minutes, and none that match the intensity or complexity of a retrobulbar injection. **The RUC recommends a work RVU of 1.18 for CPT code 67500.**

67505 *Retrobulbar injection; alcohol*
The RUC reviewed the survey results from 29 ophthalmologists and determined that the survey code should be valued the same as CPT code 67500 with a work RVU of 1.18, below the survey 25th percentile. The RUC discussed that the number of survey respondents falls below the survey threshold. The RUC typically requires a resurvey if below the threshold, however, there were only 201 procedures performed in the Medicare population in 2016 and a resurvey would not warrant additional results. Therefore, the RUC is recommending the same work RVU as CPT code 67500. The specialty indicated that the survey code is almost identical in work to 67500 but it is in a blind eye. The RUC agreed that the survey code has similar work as CPT code 67500 despite differences in pre-service evaluation time as supported by the survey. The RUC recommends utilizing the work value of 67500 with the following time components: 10 minutes evaluation time, 1 minute positioning time, 5 minutes scrub/dress/wait time, 5 minutes intra-service time, and 5 minutes post-service time.

The RUC compared the survey code to MPC code 36620 *Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous* (work RVU = 1.15) while acknowledging that there are few good comparator codes with intra-service times of 5 minutes, and none that match the intensity or complexity of a retrobulbar injection. **The RUC recommends a work RVU of 1.18 for CPT code 67505.**

67515 *Injection of medication or other substance into Tenon's capsule*
The RUC reviewed the survey results from 43 ophthalmologists and recommends a work RVU of 0.84, crosswalking 67515 to the work of CPT code 65222 *Removal of foreign body, external eye; corneal, with slit lamp* (work RVU = 0.84, 7 minutes intra-service time and 15 minutes total time) and falls well below the survey 25th percentile. Pre-service package 6 was used and further reduced because the procedure is typically performed on the same day as an office visit. The RUC examined the pre-service times for potential overlap with E/M and recommends 3 minutes evaluation time, 1 minute positioning time, 1 minute scrub/dress/wait time, 3 minutes intra-service time, and 5 minutes of immediate post-service time. The specialty indicated that the intra-service portion of the procedure itself has not changed over the past 12 years despite the decrease in survey time. However, the RUC noted that the recommended decrease in work is reflective of the decrease in intra-service time. The RUC further noted that CPT code 67515 is less intense than the other codes in the family and should be valued less.

To further support a work RVU of 0.84, the RUC compared the survey code to CPT code 67820 *Correction of trichiasis; epilation, by forceps only* (work RVU = 0.71, 5 minutes intra-service time and 15 minutes total time) and CPT code 20527 *Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)* (work RVU = 1.00, 5 minutes intra-service time and 18 minutes total time). The RUC recommends a crosswalk of 0.84 work RVUs to CPT code 65222 and believes that it appropriately ranks this procedure within this family of services. **The RUC recommends a work RVU of 0.84 for CPT code 67515.**

RUC Database Flag
The RUC recommends to flag CPT code 67505 as "do not use" for validation of work as 67505 physician time and work recommendations are based on only the 29 survey respondents who performed this service in the past 12 months.

Practice Expense
The Practice Expense Subcommittee accepted the argument for compelling evidence based on a change in practice equipment with the Atkinson needle becoming the standard of care. The RUC recommends the direct practice expense inputs with modifications as reviewed and approved by the PE 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.

Echo Exam of Eye Thickness (Tab 12)
David B. Glasser, MD (AAO) and Charlie Fitzpatrick, OD (AOA)

A RUC member requested that the Relativity Assessment Workgroup review services with negative intra-service work per unit of time (IWPUT) as a possible screen. AMA Staff gathered 2016 estimated Medicare utilization over 10,000 for RUC reviewed codes and over 1,000 for Harvard valued and CMS/Other source codes with a negative IWPUT, which resulted in 21 services identified.

76514 ***Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)***
The RUC reviewed the survey results from 55 ophthalmologists and optometrists and determined that it was appropriate to maintain the current work RVU of 0.17 which is the survey 25th percentile. The RUC questioned the reductions in time reflected in the survey. The median survey intra-service time of 3 minutes is 2 minutes less than the current value. The specialties explained that while the steps in the procedure are unchanged since it was first valued, the workflow has changed. With the advent of smaller, portable, easier to use pachymeters, the technician now typically takes the measurements that used to be taken by the physician. The intra-service time was reduced by two minutes to account for the technician performing this service. The remaining three minutes of intra-service time reflects the more intense cognitive work performed by the physician after the measurements are taken. The survey pre-service time was 3 minutes. Since the procedure is typically done on the same day as an office visit, this was reduced to 1 minute of evaluation time to discuss the test with the patient and place an order in the medical record. The survey immediate post-service time was reduced from 3 minutes to 1 minute to enter the findings into the medical record and explain the implications to the patient. The RUC recommends 1 minute evaluation pre-service time, 3 minutes intra-service time and 1 minute immediate post-service time. The RUC discussed these changes in time and determined that the reductions effectively address the negative IWPUT issue. To support the recommendation, the RUC examined the top key reference service, CPT code 92145 *Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report* (work RVU = 0.17 and 5 minutes intra-service time) and noted that the recommended total intra-service time for the survey code is 2 minutes less but represents the same overall work. Additionally, the overall intensity/ complexity rating was identical or somewhat more relative to the key reference code.

For additional support, the RUC compared the survey code to the following MPC codes: 71010 *Radiologic examination, chest; single view, frontal* (work RVU = 0.18), 73120 *Radiologic*

examination, hand; 2 views (work RVU = 0.16), and CPT code 73080 *Radiologic examination, elbow; complete, minimum of 3 views* (work RVU = 0.17) and noted that all three codes have an identical intra-service time of 3 minutes and total time of 5 minutes as the survey code. The RUC recommends maintaining the current work RVU at the survey's 25th percentile. **The RUC recommends a work RVU of 0.17 for CPT code 76514.**

In addition, the RUC noted that "a final, written report" is required for CPT code 76514. The CPT guidelines under Diagnostic Ultrasound state, "For those codes whose sole diagnostic goal is a biometric measure (ie, 76514, 76516, and 76519), permanently recorded images are not required. A final, written report should be issued for inclusion in the patient's medical record."

Practice Expense
The Practice Expense Subcommittee accepted the argument for compelling evidence based on the change in practice from the physician typically performing the service to the ophthalmic technician. The RUC recommends the direct practice expense inputs with modifications as reviewed and approved by the PE Subcommittee.

Coronary Flow Reserve Measurement (Tab 13)
Richard Wright, MD (ACC); Clifford Kavinsky, MD (SCAI) and Thad Waites, MD (ACC)

AMA Staff assembled a list of all services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2009 through 2014. The query resulted in the identification of 12 services, including CPT code 93571. In January 2017, the RUC recommended that these services and associated family codes be surveyed for October 2017.

93571 ***Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 65 physicians and recommend 15 minutes of intra-service time. The RUC reviewed the specialty society recommended current value and 25th percentile work RVU of 1.80 and determined that the 5 minutes reduction in intra-service time was not accounted for in a reduction in work RVU. Therefore, for the RUC recommends a crosswalk to CPT code 15136 *Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU= 1.50 and intra-service time of 15 minutes). The RUC noted that both services have identical intra-service times and require the same amount of physician work. The RUC noted the lack of ZZZ global period codes with similar work RVUs and intra-service times as the survey code and agreed that a crosswalk to code 15136 is appropriate. For additional support, the RUC also reviewed CPT code 58611 *Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)* (work RVU= 1.45 and intra-service time of 13.5 minutes) and noted that the survey code has more intra-service time, justifying the higher work RVU. The RUC notes that CMS did not accept the original RUC recommendation for work from May 1998, therefore the previous survey time does not directly correlate with the current valuation. The RUC agrees that the crosswalk is an appropriate estimation of the relativity of this code to other services with 15 minutes intra-time. **The RUC recommends a work RVU of 1.50 for CPT code 93571.**

93572 ***Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 65 physicians and recommend 11 minutes of intra-service time. The RUC noted that the survey intra-service time decreased by 4 minutes, thus the work RVU should decrease. The RUC recommends a crosswalk to CPT code 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 intra-service time of 10 minutes). Both services require the same physician work and similar time to perform. The RUC notes that CMS did not accept the original RUC recommendation for work from May 1998, therefore the previous survey time does not directly correlate with the current valuation. The RUC agrees that the crosswalk is an appropriate estimation of the relativity of this code to other services with 11 minutes intra-time. **The RUC recommends a work RVU of 1.00 for CPT code 93572.**

Practice Expense
There are no direct PE inputs because these services are only performed in the facility setting.

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

XI. Emerging CPT/RUC Issues Workgroup (Tab 14)

Doctor Chris Senkowski, Co-Chair, summarized the Emerging CPT/RUC Issues Workgroup report:

Doctor Senkowski informed the RUC that the Emerging Workgroup was provided with a summary of the July 2017 CPT Fly-In meeting on APMs regarding AMA/CPT and RUC involvement with APMs and resulting bullet points on the issue moving forward. Doctor Krol provided the Workgroup with a summary of the upcoming CPT actions on telemedicine and remote monitoring at the September 2017 CPT meeting: Interprofessional Internet Consultation, Chronic Care Remote Physiologic Monitoring and Pulmonary Wireless Pressure Sensor Services. Lastly, Doctor Hollmann provided an update on the objectives of the Digital Medicine Payment Advisory Group (DMPAG).

The RUC approved the Emerging CPT/RUC Issues Workgroup Report.

XII. Practice Expense Subcommittee (Tab 15)

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

- **Practice Expense Subcommittee Executive Session**
  The Practice Expense Subcommittee started off the meeting with a short executive session.

- **Practice Expense Subcommittee Innovations**
  The Practice Expense Subcommittee has implemented the following technical innovations and process changes for the October 2017 RUC meeting:

- The updated PE spreadsheet (implemented at the April 2017 RUC meeting) now includes direct cost dollar amounts for clinical activities, supplies and equipment. This means there is an increase in compelling evidence votes and the driver is the net changes in cost, recognizing that there is not a direct correlation between this cost and the final PE RVU for a number of technical reasons including indirect PE, specialty scaling factors and averaging across specialties.
- Electronic voting to facilitate dissent in a less public manner and also to help expedite discussion if needed.
- Increased use of claims data with custom queries of the CMS 5% claims data file.

- **Obtain Consent Workgroup**
  The Obtain Consent Workgroup provided a recommendation on the standard clinical staff time to obtain consent for MR services. The Workgroup recommended a standard time of 5 minutes, 7 minutes and 7 minutes for MR codes without, with and with and without contrast respectively, for the clinical activity, *provide education/obtain consent*, in the non-facility setting. The PE Subcommittee approved the recommendation of the Workgroup.

- **Exam Light Workgroup**
  The Exam Light Workgroup discussed several issues related to exam lights in the room. Going forward the PE Subcommittee will be taking a careful look at which exam lights are being used for what services and for the correct times separate from any associated evaluation and management services. The PE Subcommittee approved the recommendations of the Workgroup.

- **CT Guided Needle Biopsy 77012**
  The PE Subcommitee reviewed the CT guided needle biopsy issue, CPT code 77012, earlier in the meeting. This code was sent back to the PE Subcommittee by the RUC at the last RUC meeting. The PE Subcommittee recognized that bundling of this service and CPT code 32405 *Biopsy, lung or mediastinum, percutaneous needle* coming out of the RAW. The other studies identified for potential duplication were determined by the PE Subcommittee to be immaterial because of low volume and few minutes.

- **Discussion of PE Section of RUC Comment Letter on NPRM**
  Because of time limitations the PE Subcommittee was not able to discuss the PE section of the RUC HCPAC Comment Letter on the Notice of Proposed Rulemaking (NPRM). Doctor Manaker requested that CMS engage the RUC in a brief discussion of the physical therapy codes that were covered in the NPRM, reminding the RUC that last year the PE Subcommittee spent a half day reviewing the physical therapy codes. The services were identified by the RUC for being high volume and many of them are billed together more than 75% of the time. The services were also identified as part of CMS' high expenditure screen. The PE Subcommittee spent a lot of time looking at the claims data to determine which codes are billed together and how the multiple procedure payment reduction (MPPR) rules applied to the codes. The work carved out lots of clinical staff minutes that could have potentially redistributed millions of dollars in the MFS and prevented a decrease in the conversion factor due to not achieving the goals of the potentially misvalued code initiative. In the NPRM CMS did not implement the PE Subcommittee's recommendations. A representative of CMS stated that they could not say anything more then was in the Proposed Rule, which was an express concern that the MPPR, which is statutory, would have a negative impact on the specialties, when combined with the cuts of the RUC.

  The RUC approved the Practice Expense Subcommittee Report.

XIII. Research Subcommittee (Tab 16)

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

- **The Subcommittee reviewed and accepted the June 2017 Research Subcommittee conference call report.**

- In lieu of a separate conference call, the Research Subcommittee reviewed code-specific specialty requests for the January 2018 RUC meeting in person during the October 2017 RUC meeting.

- **Request for Review of Proposed Vignettes and Targeted Samples**
  - **Electrocorticogram (96X00)**

The Research Subcommittee reviewed the vignette submitted by the specialty societies and approved it as follows:

96X00 Electrocorticogram from an implanted brain neurostimulator pulse generator/transmitter, including recording, with interpretation and report by a physician or qualified health care professional, up to 30 days

Research-Approved Vignette: A 30-year-old woman with medically refractory partial onset seizures occurring several times per month **has been** ~~**is**~~ treated with a surgically implanted intracranial responsive neurostimulator. Stored electrocorticograms (ECoG) ~~**are reviewed to determine whether neurostimulator programming or patient management changes are needed.**~~ **are interpreted.**

The Research Subcommittee approved for the specialty to use the targeted sample described above along with a random sample, with summary data reported separately and together.

  - **Dual-energy X-ray absorptiometry (DXA) (77081)**

The Research Subcommittee reviewed the vignette submitted by the specialty society and approved it as follows:

77081 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)

Research-Approved Vignette: A 55-year-old female with primary hyperparathyroidism being evaluated for possible treatment presents for bone mineral density evaluation of the distal radius.

MR Elastography (76X01)
The Research Subcommittee reviewed the vignette submitted by the specialty society and approved it as follows:

76X01 Magnetic resonance (e.g., vibration) elastography
Research-Approved Vignette: A **55-year-old** ~~**22-year-old**~~ male with a BMI of 38 presents with fatigue. Lab testing shows elevated lipids and ALT. Recent abdominal ultrasonography showed evidence of hepatic steatosis. The patient's qualified health **professional** ~~**provider**~~ is

concerned that the patient may have progressed to non-alcoholic steatohepatitis and MR elastography is performed as a non-invasive measure of liver fibrosis.

For the January 2018 meeting, the ACR requested to perform a targeted survey for MR Elastography, CPT code 76X01. The society proposed to reach out to the Society of Abdominal Radiology (SAR) as a potential sample pool and are hoping to coordinate with this society. **The Research Subcommittee approved for the specialty to use a random sample of SAR membership along with a random sample of ACR membership, with summary data reported separately and together.**

Radioactive Tracer (38792)
The Research Subcommittee reviewed the vignette submitted by the specialty society and approved it as follows:

38792 Injection procedure; radioactive tracer for identification of sentinel node
Research-approved Vignette: A 55-year-old female with a diagnosis of malignant neoplasm of the breast undergoes injection of a radiotracer for localization of the lymph nodes prior to sentinel node biopsy [reported separately] and local excision [reported separately].

MR-Guided Fine Needle Aspiration (10X11-10X19)
For the October 2017 RUC meeting the ACR, along with several other societies, surveyed the Fine Needle Aspiration code family which contained CPT codes 10021, and 10X11-10X19. By the submission deadline, the specialties achieved the minimum number of required surveys for all codes except for 10X18 and 10X19, MR-guided FNA, which have low utilization and were only surveyed by the ACR and the SIR. To date, both of our surveys remain open.

For the January meeting, the ACR requested to perform a targeted survey for MR-guided FNA, CPT codes 10X18-10X19. ACR has reached out to the Society of Abdominal Radiology (SAR) as a potential sample pool and are hoping to coordinate with them. **The Research Subcommittee approved for the specialty to use a random sample of SAR membership along with a random sample of ACR membership, with summary data reported separately and together.**

US Elastography (767X1-767X3)
For the January 2018 meeting, the ACR requests to perform a targeted survey for US Elastography, CPT codes 767X1-767X3. The society plans to reach out to both the Society of Radiologists in Ultrasound (SRU) and Society of Abdominal Radiology (SAR) to expand the sample pool for this survey and are hoping to coordinate with these societies. **The Research Subcommittee approved for the specialty to use a random sample of SAR and SRU membership along with a random sample of ACR membership, with summary data reported separately and together.**

Contrast-Enhanced Ultrasound (76X0X, 76X1X)
For the January 2018 meeting, the ACR requested to perform a targeted survey for Contrast-Enhanced Ultrasound, CPT codes 76X0X and 76X1X. The society plans to reach out to both the Society of Radiologists in Ultrasound (SRU) and Society of Abdominal Radiology (SAR) to expand the sample pool for this survey and are hoping to coordinate with these societies **The Research Subcommittee approved for the specialty to use a random sample of SAR and SRU membership along with a random sample of ACR membership, with summary data reported separately and together.**

- **Dilation of Urinary Tract (52334, 74485)**

The Research Subcommittee reviewed the vignettes submitted by the specialty society:

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

PROPOSED VIGNETTE: A patient has a large renal stone. A guide wire for percutaneous nephrostomy is placed by the retrograde method for guidance and targeting.

The Research Subcommittee requested for the specialty society to resubmit the vignette for electronic review with the typical age and gender. No other issues were raised regarding the proposed vignette.

74485 Dilation of nephrostomy, ureters, or urethra, radiological supervision and interpretation
PROPOSED VIGNETTE: A patient with a ureteral stricture undergoes dilation of the ureter with imaging. Radiologic supervision and interpretation of images is done during and immediately following dilation.

The Research Subcommittee requested for the specialty society to resubmit the vignette for electronic review with the typical age and gender. The Research Subcommittee noted that the typical patient for this procedure was proposed as ureters as this RS&I code can be performed with different codes, in addition to the 52334. The specialty confirmed that dilation of the ureter is typical.

Transurethral Destruction of Prostate Tissue (538X3, 53850, 53852)
AUA requested to use a targeted survey and as well as a random survey for CPT codes 538X3, 53850 and 53852. The Society will be requesting names from industry for each of these codes to use for the targeted surveys if approved by this committee. **The Research Subcommittee approved for the specialty to use a targeted sample along with a random sample, with summary data reported separately and together.**

- **Electroretinography (92X71, 92X73);** *Targeted Sample Request only*
For new Electroretinography codes 92X71 and 92X73, AAO requested to use a targeted survey as these services are almost exclusively performed in academic centers with full retina services and large retina practices. They estimated that approximately 500 eye care providers perform these services nationally. They requested approval to us a targeted sample of a US-based member list provided by the International Society for Clinical Electro-physiology of Vision (ISCEV) and large retina facilities (both community and academic). They also request to use vendor lists from three manufacturers. The society did not think a random survey of their members would be appropriate because of the potential for members to confuse this new service with an existing but different service (see below). **The Research Subcommittee approved the specialty request to use a targeted sample from industry lists, all US members of ISCEV and large retina practices.**

A subcommittee member suggested for the societies to consider proposing custom language for the survey distribution email to clarify for the survey respondents that this service is distinct from another similar service. This was not mandated by the

subcommittee; the specialty may submit new request to Research for electronic review of proposed language if they desire. The Subcommittee noted that the survey template should include the CPT introductory language and parentheticals, as is the case for all work surveys.

The Research Subcommittee Vice Chair noted that the Subcommittee does not currently have explicit guidance on when it is appropriate to only use a targeted survey and when it is appropriate to use both a targeted and a random sample together. **The Subcommittee agreed to discuss this general issue at the January 2018 meeting.**

- **Request for Review of Proposed Vignettes**
  - **Exploration of Artery/Vein (35761)**

The Research Subcommittee reviewed the vignette submitted by the specialty society and approved it as follows:

35761 Exploration (not followed by surgical repair), with or without lysis of artery; other vessels
Research-approved Vignette: A **35 year old male** ~~**patient**~~ arrives in the emergency department with active upper ~~**arm**~~ extremity hemorrhage after accidentally running into a ~~**plate**~~ glass window with outstretched arm. **Emergency** ~~**Emergent**~~ exploration of the brachial artery is performed, but no brachial artery injury is present.

- **Biopsy or Excision of Inguinofemoral Node(s) (3853X)**

The Research Subcommittee reviewed the vignette submitted by the specialty society and approved it as follows:

3853X Biopsy or excision of lymph node(s); open, inguinofemoral node(s).
Research-Approved Vignette: A 65 year old has a previously confirmed squamous cell carcinoma of the vulva that is distant (more than 2cm) from the midline. An inguinofemoral lymph node(s) excision is performed. **(Note: Interoperative mapping is reported separately.)**

- **Fibrinolysins Screen (85390)**

The Research Subcommittee reviewed the vignette submitted by the specialty society and approved it as follows:

85390 Fibrinolysins or coagulopathy screen, interpretation and report
Research-approved Vignette: A 65 year old **female** presents with symptoms of sepsis**.** ~~**due to peritonitis following a ruptured bowel.**~~ The patient demonstrates diffuse bleeding, **significant thrombocytopenia** ~~**platelet counts of less than 30,000 per milliliter**~~, and elevated prothrombin time- international normalized ratio (PT-INR) and activated partial thromboplastin time (PTT). A fibrinolysin screening panel is ordered.

Flow Cytometry (88184-5)

The Research Subcommittee reviewed the vignettes submitted by the specialty society and approved them as follows:

88184 Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker
Research-approved Vignette: A 35-year-old female presents with petechiae and pancytopenia. A peripheral blood smear demonstrates numerous blasts. Flow-cytometry immunophenotyping is performed to assist in the classification of the acute leukemia.

88185 Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (List separately in addition to code for first marker)
Research-approved Vignette: A 35-year-old female presents with petechiae and pancytopenia. A peripheral blood smear demonstrates numerous blasts. Flow-cytometry immunophenotyping is performed to assist in the classification of the acute leukemia.

- **Peripheral Vascular Rehabilitation (93668)**

The Research Subcommittee reviewed the vignettes submitted by the specialty societies and approved it as follows:
93668 Peripheral arterial disease (PAD) rehabilitation, per session
Research-approved vignette: 66-year-old male with ischemic claudication has a ~~**positive**~~ atherosclerosis risk factor profile that includes a high prevalence of diabetes, prior tobacco use, hypertension, and hypercholesterolemia. ~~**Suffers co-morbid atherosclerotic syndromes including manifestations of coronary artery disease (transient ischemic attacks or stroke).**~~ Patient is referred for supervised exercise therapy to treat symptomatic peripheral artery disease.

- **Request for Review of Proposed Vignettes and RUC Survey Modification**
- **Congenital cardiac catheterization dilution studies (93561-2)**

The Research Subcommittee reviewed the vignettes submitted by the specialty societies and approved them as follows:

93561 Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization, with cardiac output measurement (separate procedure)
Research-Approved Vignette: A 12-year-old boy with D-Transposition of the great arteries ~~**who**~~ underwent surgical repair in infancy. He now presents with progressive fatigue and dyspnea. He is known to now have an intact atrial and ventricular **septa** ~~**septum**~~ following his previous surgical repair. ~~**Attempts at calculating cardiac index by Fick equation are felt to be erroneous due to the many assumptions (assumed VO2, inability to obtain a direct pulmonary venous saturation due to patch repair of the atrial septum) which lead to a cardiac index that is seemingly inaccurate.**~~ Thermodilution studies are performed during a separately reported cardiac catheterization.

93562 Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output
Research-approved Vignette: A 3-year-old girl with history of prematurity, chronic lung disease, and a previously repaired ventricular septal defect presents to cardiology for evaluation of pulmonary hypertension. She is taken to the cardiac catheterization lab for diagnostic right and left heart catheterization as well as pulmonary vaso-reactivity resting. ~~**The purpose of the repeated thermodilution studies is to accurately assess**~~

~~**for changes in the cardiac index resulting from changes in the pulmonary and systemic vascular resistances.**~~ During the separately reported cardiac catheterization, thermodilution studies are performed.

The societies requested RSC guidance on changing the global period for these two services to ZZZ. As this decision is outside of the Subcommittee's purview (the CPT Editorial Panel and CMS would instead need to be involved), AMA staff will assist the specialties with this issue separately.

Pulmonary Wireless Pressor Sensor Services (332X0, 9XXX2)

The Subcommittee requested to use a targeted sample of interventional cardiologists who perform this service. As this list would be derived from ACC and SCAI's memberships, Research Subcommittee approval is not required.

To develop work RVU recommendations for new code 9XXX2, ACC and SCAI requested Research Subcommittee approval to modify the XXX Imaging & Diagnostic survey tool to add a sentence to the instructions for Question 2 reminding respondents that the code is inclusive of all work during the billing period. "**Please keep in mind this code includes ALL interpretation(s), trend analysis, and report(s) undertaken for the weekly review.*" The Subcommittee expressed reservation with the language originally proposed thinking it might confuse respondents with the term "weekly". **Instead, the Research Subcommittee approved for the following custom language to be added to the end of the physician time survey question: "*Please note, this service is performed over a 30-day period."**

Separately, the Research Subcommittee requested for AMA RUC staff to notify AMA CPT staff that the descriptor should state "professional" instead of "provider" for QHP.

- **Request for Applying Recent RUC Recommendation for Deleted Code to New CPT Code**
- **Gastrostomy Tube Replacement (43X63-43X64)**

The specialty societies requested that the Research Subcommittee allow the use of April 2017 RUC approved values for CPT code 43760 (*Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance*) for newly number code 43X63 (*Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract*) that was approved at the September 2017 CPT Editorial Panel at the request of the American College of Surgeons. **The Research Subcommittee noted that it <u>does not</u> support the specialty's proposal to use the RUC-approved 43760 values and practice expense for new code number 43X63. The Research Subcommittee agreed that the Specialties must conduct a new RUC survey for this new CPT code as part of the family of the new codes. The RUC will review this service at the January 2018 RUC meeting.**

- **Request for Review of Proposed RSL and Targeted Sample**
- **Leadless Pacemaker Procedures (33X05-33X06)**

Heart Rhythm Society
American College of Cardiology

The societies requested the Subcommittee's approval to conduct a targeted survey of individuals known to provide leadless pacemaker services in tandem with a random survey. Leadless pacemakers were granted FDA approval in 2016. Few physicians have been trained to conduct the relevant implantation and removal procedures. Only one manufacturer has an FDA-approved device that will use these codes. A second manufacturer is doing clinical trials. They were seeking guidance from the Subcommittee on whether they should pursue targeted surveys lists from both manufacturers or only from the FDA-approved manufacturer. **The Research Subcommittee approved for the specialty to use a targeted sample of the vendor list from the manufacturer that has full FDA approval along with a random sample of their members, with summary data reported separately and together. The Subcommittee does not approve the use of a vendor list from the separate manufacturer with the device still undergoing clinical trials and does not yet have FDA approval.**

The Research Subcommittee also reviewed the specialty's proposed 090-day global reference service list and recommended for the societies to consider adding another 090-day global service with an RVU below the current lowest code. Codes suggested for consideration included 33222, 33233 and 33241.

- **Request for Review of Proposed Survey Modifications**
- **Remote Chronic Care Remote Physiologic Monitoring (994X9)**

American College of Cardiology

One Research Subcommittee reviewer noted that they compared this proposal to the survey instrument utilized for chronic care management code 99490 and noted that the template has several similarities which were appropriate. The Subcommittee discussed the proposed survey template changes for new CPT code 994X9 and agreed that the proposed language was appropriate as submitted. **The Research Subcommittee approved the proposed custom survey language without modification as follows:**

Total-service period

Over the course of a calendar month, the practice receives regular reports of physiologic data for a patient. Clinical staff review the results and, utilizing a treatment plan, make adjustments in therapy as necessary under the direction of a physician or qualified health care professional. During the month, there are at least 20 minutes spent on the activities outside of a day of a reported E/M service. During the month, there is at least one interactive contact (eg phone) with the patient or caregiver.

NOTE: Do not include time spent on Evaluation and Management services or other specific chronic care management or monitoring services.

Question 2a: Clinical Staff Time

How much CLINICAL STAFF time (ie RN, LPN, MTA) is required per patient treated for each of the following steps in patient care related to this service? It is important to be as precise as possible. For example, indicate 3 or 6 minutes instead of rounding to 5 minutes or indicate 14 or 17 minutes instead of rounding to 15 minutes. Indicate your CLINICAL STAFF's time for the survey code below. *(Refer to definitions.)*

Total time spent by clinical support staff (ie RN, LPN, medical technician) in a calendar month:
_____ minutes

Question 2b: Physician or QHP Time

How much of your own time is required per patient treated for each of the following steps in patient care related to this procedure? It is important to be as precise as possible. For example, indicate 3 or 6 minutes instead of rounding to 5 minutes or indicate 14 or 17 minutes instead of rounding to 15 minutes. Indicate your time for the survey code on the front cover. ***(Refer to definitions.)***

Total time spent by you in a calendar month: _____ minutes

VERY IMPORTANT

Question 6

Based on your review of all previous questions, please provide your estimate work RVU (to the hundredth decimal point) for the survey code:

For example, if the survey code involves the same amount of physician work as the reference service you choose, you would assign the same work RVU. If the survey code involves less work than the reference service you would estimate a work RVU that is less than the work RVU of the reference service and vice versa. This methodology attempts to set the work RVU of the survey service "relative" to the work RVU of comparable and established reference services. Please keep in mind the range of work RVUs in the reference service list when providing your estimate.

Note, for this question, only include the work you perform. DO NOT include the work provided by support staff, such as RNs, LPNs, medical secretaries, receptionists and technicians, as their RVUs and work are measured separately from this survey process.

Please Click Here to View a PDF of the CPT Introductory Language for the New and Revised Chronic Care Remote Physiologic Monitoring CPT Codes

- **Pre and Post Time Packages (continued from April 2017 RSC Meeting)**
  - **Pre-service Package Definitions**

For the October 2017 meeting, the Subcommittee continued its discussion pertaining to potentially renaming the pre-service time packages to better align their titles with their time components. Several Subcommittee members expressed reservation with eliminating the concept of Straightforward vs. Difficult patient. It was noted that the difference between packages 1 and 2 is the length of the history and exam which does not completely align with the difficulty of the procedure, but instead with how many factors need to be considered as part of the evaluation. Several Subcommittee members also noted that a concrete definition for straightforward vs. difficult would be challenging. Several Subcommittee members expressed interest in making changes to the current pre-time packages, noting that more packages may be needed for increased granularity. For example, it was noted that there is currently no package for straightforward patient/straight forward procedure with anesthesia care.

The Research Subcommittee agreed that a pre-service and post-service time package workgroup should be formed to discuss this issue further. The Subcommittee will seek interest in participation on this workgroup.

- **Non-facility Post-service Time Packages**

  At the October 2016 meeting, the Time-Intensity Workgroup observed that there is currently no standard post-time package for office setting. The Workgroup agreed that a series of post-time packages for the office setting should be considered. As the Time-Intensity Workgroup, which previously reported to the Research Subcommittee, has been sunset and its responsibilities have been assigned back to Research, this item was added to the Subcommittee's agenda for consideration. After reviewing the below analysis provided by AMA Staff at the April 2017 meeting, the Subcommittee expressed general interest in developing non-facility post-time packages. The Subcommittee noted they would continue the discussion at the October 2017 RSC meeting. Following a brief discussion, **the Research Subcommittee agreed that the pre-service and post-service time package workgroup should be formed to discuss this issue further.**

- **Survey Instrument (new items)**

  - **Instructions for when respondent does not agree with vignette**

  The survey instructions currently do not have prominent instructions stating that survey respondents should value the services based on the provided typical patient. AMA Staff had drafted proposed language for the Subcommittee's consideration (for inclusion on the first page where the typical patient is listed for RUC online survey tool). Following some revisions, the Research Subcommittee approved the new survey instructions as underlined in red below:

  IMPORTANT: Please check CPT codes for procedures/services that you have experience performing or are familiar with. You will be surveyed about each code you select.

  Note: If you think the vignette patient does not represent your typical patient, please do the following:

  1) Complete the survey using the typical patient/vignette described below AND
  2) explain in the following section how your typical patient differs from the typical patient described in this survey

  Once you have made your selection(s), please click the "Next" button below to continue.

  The Research Subcommittee also requested for AMA Staff to perform an analysis for the January 2018 RUC Meeting regarding how often in the past few years codes had less than 50 percent agreement with the provided vignette.

  - **Instructions to not include work for performing Moderate Sedation**

  With the recent unbundling of Moderate sedation services from all procedures formerly listed in CPT Appendix G, the RUC survey does not yet explicitly emphasize that this work is no longer bundled with surgical services. AMA staff has drafted the following proposed addition to the pre-

service period definitions for 000-day, 010-day and 090-day global codes for the Subcommittee's consideration. **The Subcommittee approved the proposed language as follows:**

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 (~~also known as~~ conscious) sedation services (reported with CPT codes 99151-99157).

- **Review of survey instrument warnings on zero intra-service time and work RVUs and data trimming instructions**

At the April 2017 RUC meeting, A RUC member raised the point that through the survey process, it is possible to input zero minutes for intra-service time. AMA staff explained current warning instructions from Qualtrics ask the survey respondent to confirm that they wish to indicate zero. The RUC Chair requests that the Research Subcommittee review instructions to societies regarding trimming of entries of zeros and other outlier data, as well as other relevant changes.

The Research Subcommittee recommended for the RUC online survey tool to have a hard stop which prohibits respondents from putting zero minutes of intra-service time or 0.00 work RVUs. These should be accompanied by an appropriate error message noting that a work RVU of 0.01 or intra-service time of 1 minute is the lowest value that is allowed.

The Subcommittee did not recommend any revisions to the current RUC survey data trimming rules.

- **Standard Survey Language Solutions for Time-Based Codes**

Following the June Research Subcommittee conference call, a Subcommittee 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.

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 pull together examples of language used in the past and also noted that they would continue discussing this issue at the January 2018 meeting.**

- **000-day global codes typical billed with E/M Services (new item)**

  At the April 2017 RUC meeting, during *Other Business,* a RUC member requested that methodological issues related to 000-day global codes typically billed with E/M be referred to the Research Subcommittee. The RUC member had requested for Research to study and examine issues related to the overlap of 000-day global codes with E/M and recommend potential solutions that would improve the RUC's methodology and comfort level with dealing with those issues. The Research Subcommittee had a relatively brief discussion on this issue. One Subcommittee member noted their observation that sometimes when pre-service and/or post-service times are reduced to account for overlap with an E/M service, the work RVU is not also reduced to account for this change. That Subcommittee member and others noted that the adjusting of pre-service and post-service minutes does not necessarily warrant a proportional reduction in work RVU and should be handled on a case by case basis. **The Subcommittee agreed they would continue discussing this issue at the January 2018 RUC meeting.**

- **Appropriate Summary Data for RUC-approved Extant Data Sources – Informational Only**

  At the April 2017 Research Subcommittee meeting, as part of its review of TVT Registry for TAVR, the Subcommittee also discussed whether mean or median summary data would be more appropriate for the Registry summary data. **The Subcommittee requested that the specialties provide to the RUC both the median and mean summary data from the extant database.** The Subcommittee also requested for AMA staff to also seek consultation within the AMA on this question to better inform the RUC. Following up on this discussion, AMA RUC staff met with AMA Director of Economic and Health Policy Research Carol Kane, PhD and Senior Economist Kurt Gillis, PhD. Dr. Kane and Dr. Gillis recommend for specialties to 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.

  The RUC approved the Research Subcommittee Report.

XIV. Multi-Specialty Points of Comparison (MPC) Workgroup (Tab 17)

Doctor Alan Lazaroff, Chair, provided a summary of the Multi-Specialty Points of Comparison (MPC) Workgroup report:

The MPC Workgroup members reviewed proposals from several specialties for codes to be added to or removed from the MPC list. Representatives from the specialty societies attended the meeting to provide clarity and answer questions from workgroup members.

The MPC Workgroup recommends that the following CPT codes be added to the MPC list moving forward:

20611
64635
64644
36475
37253
36476

The MPC Workgroup recommends that the following CPT codes be deleted from the MPC list moving forward:

11100
71010
71020
74020

The RUC approved the Multi-Specialty Points of Comparison Workgroup Report.

XV. Professional Liability Insurance (PLI) Workgroup (Tab 18)

Doctor James Blankenship, Chair, provided a summary of the Professional Liability Insurance (PLI) Workgroup report:

The RUC comment letter on the CY 2018 Proposed Rule focused on three areas of PLI: Low Volume Services, Premium Crosswalks and the Cardiology Surgical Risk Factor. A highlight was the CMS proposal to implement a long sought RUC recommendation to use service-level overrides in order to determine the specialty mix for low volume procedures. These overrides will be based on the expected specialty and will utilize a list of expected specialty overrides based on the recommendations of the RUC.

The PLI Workgroup was in strong agreement that CMS should be able to obtain premium information for all Medicare physician specialties, and other health care professionals and facility providers, in all states. In the comment letter, concern was expressed with the adequacy of the premium data and the RUC recommended that CMS consider delaying implementation of the new premium data.

The PLI Workgroup will discuss data collection efforts with representatives from Acumen and CMS at the next RUC meeting**.** The discussion will also include two new issues that were identified in the Workgroup's review of new issues addressed by specialty society comment letters: Calculating a national average PLI premium for each specialty by Work RVU vs. Population weighting; and PLI premium data for facility providers. Doctor Blankenship welcomed suggestions from around the table, and staff noted that the Medical Liability Monitor had been contacted concerning premium data collection. MLM indicated that trends are tracked at a high level but that premium data is not collected and collated at the specialty level.

Finally, Doctor Smith commented that the PLI is directly related to the RVW value and expressing PLI as a percentage of RVW allows you to review codes within your specialty to detect low volume code errors. Specialty society staff should be observant in identifying low volume codes that have had an incorrect PLI risk factor assigned.

The RUC approved the Professional Liability Insurance Workgroup Report.

XVI. Relativity Assessment Workgroup (Tab 19)

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

A. Re-Review of Services

Doctor Collins informed the RUC that the Workgroup reviewed action plans for services that were flagged for review at later date after additional utilization was available, CPT assistant articles were published or additional information was gathered. Fifteen code families were

flagged and action plans were submitted for review. **The Workgroup reviewed the following and recommends:**

Issue	CPT Code	Recommendation
Complex Wound Repair	13120	Review in 3 years (October 2020)
	13121	
	13122	
Stab Phlebectomy of Varicose Veins	37765	Survey for April 2018
	37766	
Cystourethroscopy	52214	Maintain and remove from this flag. Any issues that remain are in the commercial side and all appropriate efforts have occurred.
	52224	
	52234	
	52235	
	52240	
Injection of Anesthetic Agent	64415	Maintain and remove from this flag. Utilization appropriate and for 64447 there is an appropriate increase due to the management of chronic pain, knee surgery and aging population.
	64445	
	64447	
Contrast X-Ray of Knee Joint	73580	Review in 3 years (October 2020) and show data for the total joint replacement codes in correlation with this service.
Ultrasound Guidance for Needle Placement	76942	Review action plan for January 2018.
Urinary Cytopathology	88120	Maintain and remove from flag. The utilization is decreasing appropriately.
	88121	
	88365	
	88367	
	88368	
Electro-oculography	92270	Maintain and remove from flag. Utilization appropriately decreased significantly.
Treatment of Swallowing Dysfunction	92526	Review in 3 years (October 2020)
Evaluation of Swallowing Function	92610	Review in 3 years (October 2020). Possible miscoding is currently being investigated.
Audiology Services	92626	Refer to CPT May 2018 and CPT Assistant
Percutaneous Transluminal Coronary Thrombectomy	92973	Maintain and remove from flag. Utilization decreased appropriately.
Laser Treatment – Skin	96920	Review in 2 years (October 2019)
	96921	
	96922	
Debridement	97597	Maintain and remove from flag.
	97598	
Advance Care Planning	99497	Review in 2 years (October 2019)
	99498	

B. New Technology/New Services – Action Plan Review (8 issues)

Doctor Collins indicated that in September 2005, the RUC began a process of flagging services that represent new technology as the codes were presented to the Committee. Codes were flagged from October 2012-April 2013 with three years of available Medicare claims data (2014, 2015 and preliminary 2016 data). **The Workgroup reviewed action plans submitted by the specialty societies and recommends:**

CPT Code	Recommendation
21011-28047	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
66183	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
77293	Review in 3 years (October 2020)
88375	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
93583	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
99487	Review in 3 years (October 2020)
99489	Review in 3 years (October 2020)
99490	Review in 3 years (October 2020)
99495	Refer to Research Subcommittee January 2018 to possibly modify the survey. Survey for April 2018.
99496	Refer to Research Subcommittee January 2018 to possibly modify the survey. Survey for April 2018.
99497	Review in 2 years (October 2019)
99498	Review in 2 years (October 2019)

C. Negative IWPUT – Action Plan Review (22 codes)

A RUC member suggested that the Relativity Assessment Workgroup review services negative intra-service work per unit of time (IWPUT) as a possible screen. AMA Staff gathered 2014 and 2015 Medicare utilization over 1,000 with negative IWPUT. The Workgroup reviewed this list of codes and determined that it should be revised for negative IWPUT with Medicare utilization over 10,000 for all services or over 1,000 for Harvard valued and CMS/Other source codes. Twenty-two services were identified and placed on the level of interest for action plans to review at the October 2017 meeting.

The Workgroup reviewed the action plans submitted by the specialty societies and recommends:

CPT Code	Recommendation
20005	Survey for April 2018
22310	Survey for April 2018
26020	Survey for April 2018
26055	Survey for April 2018
26160	Survey for April 2018
27220	Survey for April 2018

33015	Refer to CPT for deletion. If additional specialty societies do not agree to submit a coding change application for deletion then this service should be surveyed.
33025	Survey for April 2018 (identify any additional codes in this family via LOI process).
35761	Survey for January 2018
38792	Survey for January 2018
40808	Survey for April 2018 (identify any additional codes in this family via LOI process).
46500	Survey for January 2018
76376	Survey for April 2018
76514	Surveyed for Oct 2017
77081	Survey for January 2018
85390	Survey for January 2018
90911	Survey for April 2018
92225	Refer to CPT February 2018/RUC April 2018
92548	Refer to CPT September 2018/RUC January 2019
93561 93562 (f)	Survey for January 2018
95024	Maintain. IWPUT is not for low work RVU codes and a resurvey of work would not result in a change in work RVU from the current value of 0.01
95870	Maintain. This service was recently surveyed, April 2012. At that time the survey supported a higher work RVU however, there was no compelling evidence to support an increase for this service.
96154	Survey for April 2018

D. Site of Service Anomaly – Action Plan Review (20926)

AMA Staff reviewed services with anomalous sites of service when compared to Medicare utilization data. One service was identified, CPT code 20926, in which the Medicare data from 2013-2016e indicated that it was performed less than 50% of the time in the inpatient setting, yet include inpatient hospital Evaluation and Management services within the global period. The specialty societies submitted an action plan and indicated that they believe the site of service issue is due to miscoding. The CPT manual includes a parenthetical that was added in 2011 that states (For injection(s) of platelet rich plasma, use 0232T) which resulted in some decrease in utilization for a few years, but now the utilization is creeping up again. The specialty societies believe the typical patient related to this code would be treated in a facility setting and that the site of service anomaly, for both the outpatient and the office setting is the result of miscoding. The specialty societies propose to address this miscoding by developing a CPT assistant article and possible introductory language to emphasize correct coding. **The Workgroup recommends that CPT code 20926 be referred to the CPT Editorial Panel for the May 2018 CPT Editorial meeting to add/revise the introductory language and referred to CPT Assistant for education on when to report this service.**

E. Surveyed by One Specialty – Now Performed by a Different Specialty

AMA Staff re-examined services that were surveyed by one specialty and are now performed by a different specialty based on 2016 estimated Medicare utilization over 1,000. Eight codes were identified. **The Relativity Assessment Workgroup recommends CPT code 92548 (which is already identified via the be referred to the Negative IWPUT screen) be referred to the CPT September 2018/RUC January 2019 meeting and action plans for codes 11981, 20225,**

62270, 62368, 64590, 97598 to review in greater detail at the January 2018 Relativity Assessment Workgroup meeting. The Workgroup recommends removing CPT code 96127 from this screen as this is a PE only code and is being reviewed at the October 2017 RUC meeting.

F. CMS/Other Source – Utilization over 30,000

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 recommends action plans for all 34 services review in greater detail at the January 2018 Relativity Assessment Workgroup meeting (codes 70210, 70220, 70250, 70360, 70480, 72132, 72190, 73000, 73010, 73020, 73701, 74240, 74246, 74250, 74270, 75625, 75726, 75774, 76098, 76604, 77073, 77075, 77077, 88141, 92585, 94200, 95831, G0124, G0279, G0364, G0365, G0396, G0446, G6002).**

G. Low IWPUT

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 services with an IWPUT of 0.0224 or lower. **The Workgroup determined that it would like to pare down the data to better assess whether this is an appropriate screen. The Workgroup determined that the Workgroup Chair should work with AMA staff to develop additional screening criteria such as services greater than 30,000 in Medicare utilization, over 5 (or perhaps 10 to 15) minutes of intra-service time, specified Medicare allowed charges amount, RUC surveyed more than 5 years ago, etc. The Workgroup will review an abbreviated list in January 2018.**

H. Reported Together 75% or More

Maintaining the consistency with previous iterations, AMA staff used the 2016 estimated 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 requests action plans for further review whether a code bundle solution should be developed for these services.**

I. Other Issues

The Workgroup will work with the PE Subcommittee to brainstorm possible practice expense screens for the identification of potentially misvalued services.

The RUC approved the Relativity Assessment Workgroup Report.

XVII. RUC HCPAC Review Board (Tab 20)

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

- **Relative Value Recommendations for CPT 2019**

Psychological and Neuropsychological Testing
Stephen Gillaspy, PhD (APA); Renee Kinder, MS, CCC-SLP (ASHA); Randy Phelps, PhD (APA); Neil Pliskin, PhD (APA)

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-day 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. The testing practice has been significantly altered by the growth and availability of technology. The current codes do not reflect the multiple standards of practice and therefore result in confusion about how to report the codes. The RUC recommended the entire psychological and neuropsychological testing codes be referred to the CPT Editorial Panel for revision. CMS also requested that the entire family of services be reviewed. In September 2016, the CPT Editorial Panel created seven codes to differentiate technician administration of psychological testing and neuropsychological testing from physician/ psychologist administration and assessment of testing; and deleted codes 96101-96103, 96111, 96118, 96119, 96120. In January 2017, organizations representing psychiatry, psychology, neurology, pediatrics and speech-language pathology conducted a survey for the January 2017 RUC and HCPAC Review Board meetings. During this effort, it became apparent that further CPT revisions were required. Survey respondents were unable to articulate the work at the 60 or 30 minute coding increments and there is significant concern regarding the duplication of pre- and post- work as several units of service would be reported. Therefore, the organizations submitted a letter to the CPT Editorial Panel and the RUC to rescind the coding changes summarized below for CPT 2018. 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.

Assessment of Aphasia and Cognitive Performance Testing

96105 ***Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour***
The HCPAC reviewed the survey responses from 130 speech language pathologists and determined that it was appropriate to maintain the current work RVU of 1.75. The HCPAC agreed with the specialty society's expert panel that the median survey time and work RVU were not appropriate because the service has not changed significantly since it was last surveyed in 2009. In addition, CPT code 96105 is a per hour code, which is reflected in the survey 25th percentile. Medicare data shows that this code is a low-volume procedure and typically only billed once per date of service. The HCPAC recommends 4 minutes pre-service time, 60 minutes intra-service time, and 10 minutes of immediate post-service time. The specialty recommended an increase from 5 to 10 minutes of immediate post-service time. The specialty society indicated and the HCPAC agreed that the increase from 5 minutes post-service time to 10 minutes of post-service time is due to the complexity of communicating information and instructions to patients with a communication disorder and their caregivers. This will also ensure consistency with the rest of the family.

The RUC HCPAC Review Board recommends the current work RVU of 1.75, which is comparable in time and intensity to CPT code 92640 *Diagnostic analysis with programming of auditory brainstem implant, per hour* (work RVU = 1.76, total time = 69 minutes). For additional

support, the HCPAC compared the survey code to key reference service CPT code 92607 *Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour* (work RVU = 1.85, intra-service time = 60) and MPC code 92540 *Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording* (work RVU = 1.50, intra-service time = 60) and noted that the survey code is appropriately bracketed by these two services. **The RUC HCPAC Review Board recommends a work RVU of 1.75 for CPT code 96105.**

96125 ***Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report***

The HCPAC reviewed the survey responses from 137 speech language pathologists and determined that it was appropriate to maintain the current work RVU of 1.70. The HCPAC agreed with the specialty society's expert panel that the survey times were not appropriate because the service has not changed significantly since it was last surveyed in 2009. In addition the survey median intra-service time of 60 minutes supported CPT code 96125 as a per hour code. Medicare data shows that this code is typically only billed once per date of service. The HCPAC recommends 4 minutes pre-service time, 60 minutes intra-service time, and 10 minutes of immediate post-service time. The specialty recommended an increase from zero immediate post-time to 10 minutes of immediate post-service time. The specialty society indicated and the HCPAC agreed that the increase from zero post-service time to 10 minutes of post-service time is due to the complexity of communicating information and instructions to cognitively-impaired patients and their caregivers. This is also consistent with CPT code 96105 and will ensure consistency with the rest of the family.

The RUC HCPAC Review Board recommends the current work RVU of 1.70, which is comparable in time to CPT code 92640 *Diagnostic analysis with programming of auditory brainstem implant, per hour* (work RVU = 1.76, intra-service time = 60 minutes), but is less intense to perform and should be valued slightly lower. For additional support, the HCPAC compared the survey code to CPT code 92607 *Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour* (work RVU = 1.85, intra-service time = 60) and MPC code 92540 *Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording* (work RVU = 1.50, intra-service time = 60) and noted that the survey code is appropriately bracketed by these two services. **The RUC HCPAC Review Board recommends a work RVU of 1.70 for CPT code 96125.**

Testing Evaluation Services

96130 ***Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour***

The HCPAC reviewed the survey responses from 68 psychologists and determined that the survey respondents overestimated the provider time for this service. Based on initial comments from the HCPAC, the specialty societies modified the pre- and post-service times to be consistent

with this family of services and other similar services. The HCPAC confirmed that this service will not be reported with an Evaluation and Management (E/M) service. The HCPAC also confirmed that neuropsychological testing evaluation service, CPT code 96132 and psychological testing evaluation service, CPT code 96130 are distinct and separate services and will not be reported together on the same day. A representative of CMS raised concerns about the assumptions used for budget neutrality. The HCPAC assured CMS that the Relativity Assessment Workgroup (RAW) will reexamine the services in one year if the actual figures are more then ten percent different then the assumptions. The HCPAC recommends 5 minutes of pre-service, 60 minutes of intra-service and 5 minutes of post-service time for CPT code 96130. Using magnitude estimation the HCPAC determined that a work RVU of 2.50, crosswalked to CPT code 90847 *Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes* (work RVU = 2.50 and 5 minutes pre-service, 50 minutes intra-service and 21 minutes post-service time) was appropriate. Additionally, a work RVU of 2.50 was recommended for codes 96112 and 96132, which require the same provider time and work to perform. For additional support the HCPAC referenced similar services 90846 *Family psychotherapy (without the patient present), 50 minutes* (work RVU = 2.40 and 50 minutes intra-service time) and 95954 *Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase* (eg, thiopental activation test) (work RVU = 2.45 and 5 minutes pre-service, 60 minutes intra-service and 5 minutes post-service time). **The HCPAC recommends a work RVU of 2.50 for CPT code 96130.**

96131 ***Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)***
The HCPAC reviewed the survey responses from 65 psychologists and determined that the survey respondents overestimated the provider work and time for this service. The HCPAC recommends 60 minutes of intra-service time. Using magnitude estimation the HCPAC determined that a work RVU of 1.90, crosswalked to CPT code 90836 *Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)* (work RVU = 1.90 and 48 minutes total time) was appropriate. Additionally, a work RVU of 1.90 was recommended for code 96133, which require the same provider time and work to perform. For additional support the HCPAC referenced similar services 88323 *Consultation and report on referred material requiring preparation of slides* (work RVU = 1.83 and 60 minutes intra-service time), 95864 *Needle electromyography; 4 extremities with or without related paraspinal areas* (work RVU = 1.99 and 50 minutes intra-service time) and 92640 *Diagnostic analysis with programming of auditory brainstem implant, per hour* (work RVU = 1.76 and 60 minutes intra-service time). **The HCPAC recommends a work RVU of 1.90 for CPT code 96131.**

Test Administration and Scoring

96136 ***Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes***
The HCPAC reviewed the survey responses from 147 psychologists and determined that the survey respondents overestimated the provider time for this service. Based on initial comments from the HCPAC, the specialty societies modified the pre- and post-service times to be consistent with this family of services and other similar services. The specialty society noted and the HCPAC agreed that the provider time and intensity of 96136, essentially a data gathering code, should be less than the time and intensity of the psychological/neuropsychological evaluation

services (96130 and 96132). In addition to the difference in work of the codes, 96136 is a 30 minute code while 96130 and 96132 are 60 minute codes.

A representative of CMS raised concerns that this work was previously billed using 96102 which had 15 minutes of provider time for each hour of technician work and the recommendation for 96136 is 30 minutes of provider work at only 0.05 RVUs more. The specialty societies clarified that previously this procedure was typically billed as 96101 (work RVU = 1.86), which included both data gathering and evaluation services. In the revised codes, 96130 will be used for the evaluation service and 96136 will be used for the data gathering service. The HCPAC recommends 3 minutes of pre-service, 30 minutes of intra-service and 3 minutes of post-service time for CPT code 96136. Using magnitude estimation the HCPAC determined that a work RVU of 0.55, crosswalked to CPT code 97605 *Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters* (work RVU = 0.55 and 3 minutes pre-service, 20 minutes intra-service and 5 minutes post-service time) was appropriate. The specialty acknowledged that the crosswalk code times for 97605 do not completely align with the recommended times for 96136 and it remains the most appropriate crosswalk give the limited pool of codes. For additional support the HCPAC referenced CPT codes 88312 *Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)* (work RVU = 0.54 and 24 minutes intra-service time), and 88104 *Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation* (work RVU = 0.56 and 24 minutes intra-service time). **The HCPAC recommends a work RVU of 0.55 for CPT code 96136.**

96137 ***Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, each additional 30 minutes (List separately in addition to code for primary procedure)***
The HCPAC reviewed the survey responses from 148 psychologists and determined that the survey respondents overestimated the provider work and time for this service. The specialty society noted and the HCPAC agreed that the provider time and intensity of 96137, essentially a data gathering code, should be less than the time and intensity of the psychological/neuropsychological evaluation services add-on codes (96131 and 96133). In addition to the difference in work of the codes, 96137 is a 30-minute code while 96131 and 96133 are 60-minute codes and 96137 should be valued less than its base code, 96136. The HCPAC recommends 30 minutes of intra-service time. Using magnitude estimation the HCPAC determined that a work RVU of 0.46, crosswalked to CPT code 96152 *Health and behavior intervention, each 15 minutes, face-to-face; individual* (work RVU = 0.46 and 24 minutes total time) was appropriate. The specialty society acknowledged that this crosswalk is not a ZZZ code, noting that there were limited codes available for comparison. For additional support the HCPAC referenced CPT code 93016 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report* (work RVU = 0.45 and 19 minutes total time). **The HCPAC recommends a work RVU of 0.46 for CPT code 96137.**

Practice Expense
CPT code 96125 includes an equipment item SK050, *neurobehavioral status forms, average*, that is an average of a variety of neurobehavioral tests. The PE Subcommittee requested that the specialty societies that utilize this supply item work together to determine the 3 most typical tests and submit paid invoices to CMS to facilitate updated pricing. CPT codes 96130 and 96131 require no direct practice expense inputs.

96136 ***Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes***
96137 ***Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, each additional 30 minutes (List separately in addition to code for primary procedure)***
CPT codes 96136 and 96137 require no clinical staff time. The PE Subcommittee removed all supplies and equipment related to printing. The PE Subcommittee determined that equipment item ED021, *computer, desktop, w-monitor* is an indirect expense for this service. 0.165 of each of three supply items: WAIS-IV Record Forms, WAIS-IV Response Booklet #1 and WAIS-IV Response Booklet #2 is allocated for each code. This is because the service typically requires 3 hours. Each code is 30 minutes, so the typical billing would be one unit of the base code (96136) and 5 units of the add-on code (96137) to equal the typical three hours. One supply item is needed each time the service is performed so in the typical billing scenario 1 item of each of the three supplies will be allocated.

96138 ***Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes***
96X11 ***Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)***
CPT codes 96138 and 96X11 are practice expense only codes to be used when a technician rather than a provider performs the service. The PE Subcommittee removed all supplies and equipment related to printing. The PE Subcommittee determined that equipment item ED021, *computer, desktop, w-monitor* is an indirect expense for this service. 0.165 of each of three supply items: WAIS-IV Record Forms, WAIS-IV Response Booklet #1 and WAIS-IV Response Booklet #2 is allocated for each code. This is because the service typically requires 3 hours. Each code is 30 minutes, so the typical billing would be one unit of the base code (96138) and 5 units of the add-on code (96X11) to equal the typical three hours. One supply item is needed each time the service is performed so in the typical billing scenario 1 item of each of the three supplies will be allocated.

96146 ***Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only***
CPT code 96146 is a practice expense only code to be used when the service is automated. The specialty had recommended a new supply item, CANTAB Mobile (per single automated assessment), however the PE Subcommittee determined that since it is a software license it is more appropriately classified as equipment. The time that the item is in use is not directly related to the clinical activity time and is typically in use for 10 minutes while the patient takes the test. The specialty had recommended an iPad as a new equipment item; however it was removed as it is commercially available for less than $500.

The HCPAC recommends the direct practice expense inputs as reviewed and modified by the Practice Expense Subcommittee.

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

The RUC filed the HCPAC Report.

XVIII. Anesthesia Workgroup (Tab 21)

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

Review analysis comparing the physician work component of anesthesia base units to work RVUs

Doctor DiSesa indicated it has been ten years since the last review/validation of anesthesia services and that the objective is to try and link the anesthesia services to physician services in some way so as to assure proper relativity. The Workgroup reviewed the most frequently reported 32 anesthesia codes and compared these codes to the top surgical codes with which they are reported. The Workgroup had the following concerns/issues:

1. Concern with the range of intensities of surgical codes reported with each anesthesia code. AMA staff will work with ASA staff to compare for all 32 codes the surgical code IWPUT to the Post-Induction Period Procedure Anesthesia (PIPPA) to review the extent of correlation and to determine whether there is a need for more granularity.

2. Concern that anesthesia services need to be identified via the potentially misvalued code process. For example, if surgical codes for which the work largely has decreased due to efficiencies or review via the potentially misvalued process, the associated anesthesia code may need to be reviewed as well.

The Workgroup determined it must first validate the 2007 methodology to identify a set of anchor codes. AMA staff noted that 8 of the top 32 anesthesia codes have a single top surgical code that is reported at least 50% of the time. 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 goal is to have these data available for review at the January 2018 Anesthesia Workgroup meeting.

AMA staff will gather the top 5 surgical services for each of the top 32 anesthesia codes and display the surgical codes IWPUT compared to the PIPPA of the anesthesia codes for review at the January 2018 Workgroup meeting.

The RUC approved the Anesthesia Workgroup Report.

XIX. New Business/Other Issues (Tab 22)

- A RUC member proposed that **the RUC request that CMS** explore using existing funds dedicated to refining the RBRVS to conduct a survey to better define the practice expense inputs. Accordingly, the following language was included in the October 2017 RUC Recommendations cover letter to CMS:

Accuracy of Practice Expense Data

Section 220 of the Protecting Access to Medicare Act of 2014 (PAMA), allocates funds for CMS "…to collect and use information on physicians' services in the determination of relative values." The types of information collected may include "Overhead and accounting information for practices of physicians and other suppliers." The RUC and HCPAC encourage CMS to use these funds to conduct an updated survey on practice expense data. In 2007 and 2008, the AMA conducted the Physician Practice Information survey, along with 72 medical specialty societies and other health care professional organizations. The

PPIS is multispecialty, nationally representative, PE survey of both physicians and non-physician practitioners (NPPs) paid under the PFS using a survey instrument. The survey collected physician practice expense data that was used by CMS to confirm the accuracy of practice expense data in the Medicare Physician Fee Schedule. It would be extremely beneficial for CMS to conduct a similar survey a decade later to confirm the accuracy of practice expense data, given the many changes that have occurred since that time (e.g., the widespread adoption of certified electronic health record technology with its associated maintenance and staffing costs).

- A RUC member requested that the following issue be **referred to the Research Subcommittee:** Provide guidelines/rules on how to select appropriate crosswalks. Doctor Smith suggested reviewing actions from the past few meetings.

- **Referral to the Administrative Subcommittee on the issue of Category I codes.** Discuss if codes that have a very low response rates (under 30) should automatically be recommended for carrier pricing.

The RUC adjourned at 12:05 p.m. on Saturday, October 7, 2017.

Members: Doctors Christopher Senkowski (Co-Chair, RUC), Kathy Krol (Co-Chair, CPT), David Hitzeman (Vice Chair), Daniel Buffington, Pharma, MBA, Gregory DeMeo, Leisha Eiten, AuD, CCC-A, David Han, Peter Hollmann, Christopher Jagmin, M. Douglas Leahy, Mollie MacCormack, Scott Manaker, Jeremy Musher, Randy Phelps, PhD, Jordan Pritzker, Marc Raphaelson, Phillip Rodgers, Donald Selzer, and G. Edward Vates.

I. Summary and Discussion of CPT Fly-In on Alternative Payment Models (APMs)

The Workgroup was provided with a summary of the CPT Fly-In meeting on APMs prepared by CPT staff. Members of the Workgroup noted that the session was helpful in initiating a discussion related to potential coding needs related to APMs. A Workgroup member questioned whether the CPT Editorial Panel was currently accepting code change applications to identify gaps in coding within various payment models. Doctor Krol encouraged the submission of code change applications for any services not currently identified.

II. Telemedicine/Remote Monitoring Update

CPT actions on Telemedicine/Remote Monitoring at the Sept 2017 CPT Meeting

Doctor Krol indicated that the CPT Editorial Panel approved three coding change applications on telemedicine and remoting monitoring:

- Interprofessional Internet Consultation (AAP, ACP, IDSA, ES)
- Chronic Care Remote Physiologic Monitoring (ACC)
- Pulmonary Wireless Pressure Sensor Services (ACC, SCAI)

A Workgroup member questioned if the CPT Editorial Panel considered if these services are reported with an Evaluation and Management (E/M) service and the time of the physician versus technician when developing these codes. Doctor Krol assured that the Panel created these codes to ensure that there is not overlap with other E/M or care management codes. Additionally, AMA Staff indicated that questions will be added to the survey, after approval by the Research Subcommittee, to specifically ask how much time is required by the physician/qualified health care provider versus other clinical staff. These three issues will be presented at the January 2018 RUC meeting.

Update on Digital Medicine Payment Advisory Group (DMPAG)

Doctor Hollmann, Co-Chair of the DMPAG, provided an overview of the Advisory group. A Power Point presentation was included in the agenda materials. Doctor Hollmann made the following points:

- The DMPAG objectives are broader than telemedicine as defined by Medicare. For example, the Advisory Group has discussed remote monitoring, services that are not considered to be telemedicine by CMS.
- The composition of the DMPAG includes: 2 CPT Editorial Panel members, 1 CPT Advisor, 2 RUC members, physicians who are leaders in telemedicine for large institutions and systems, representatives from individuals in the digital medicine industry are also included.
- To date, the DMPAG has submitted code change applications for internet consultations and remote monitoring. The DMPAG will continue to identify issues that are of concern to a broader stakeholder community.

Workgroup members were supportive of the DMPAG's efforts and shared examples of other telehealth needs including psychiatric care; palliative care in the home; and follow-up care to major surgical procedures.

Members Present: Scott Manaker, MD, PhD, (Chair), David C. Han, MD (Vice Chair), Kathy Krol, MD (CPT Resource), Gregory L. Barkley, 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, Ezequiel Silva, III, MD, W. Bryan Sims, DNP, APRN-BC, FNP, Thomas Weida, MD, Adam Weinstein, MD

Practice Expense Subcommittee Innovations
The Practice Expense Subcommittee has implemented the following innovations and process changes for the October 2017 RUC meeting:

- The updated PE spreadsheet (implemented at the April 2017 RUC meeting) now includes direct cost dollar amounts for clinical activities, supplies and equipment
- Electronic voting
- Increased attention to billed together data for evaluation and management services in the nonfacility setting
- Increased attention to the dominant provider in the nonfacility setting

Obtain Consent Workgroup
The Obtain Consent Workgroup met via conference call on July 18th, 2017 to discuss whether or not the typical clinical activity time of 7/9/9 for without contrast, with contrast and without and with contrast respectively are appropriate for clinical activity, *provide education/obtain consent,* which was previously *Provide pre-service education/obtain consent* or *Provide pre-service education/obtain consent/ Interview patient for contraindications* for MR services.

The Workgroup members discussed the extensive pre-MRI safety screening done by the ordering physician and their clinical staff; and prescreening performed by the clerical staff in the radiology office over the phone and sometimes in the waiting room prior to arrival in the MRI suite. The safety checklist and/or questionnaire most often administered by clerical staff are usually done to prevent waste of valuable MRI time. The Workgroup then discussed whether or not the informal time standard of 7/9/9 should be implemented as a formal time standard for clinical activity, *provide education/obtain consent* for MR services. A Workgroup member explained that for magnetic resonance (MR) procedures in the non-facility setting much of the staff time is devoted to the pre-service education which is captured within the same clinical activity, *provide education/obtain consent*. Extensive education is necessary because MR is a long test that can have complicating factors. The Workgroup discussed that it is appropriate to have this on one line item of the spreadsheet because the two tasks occur together and complement each other; however it is important that enough time is allocated to complete both tasks.

The Physician is also allocated time for obtain consent in the physician work and a member of the Workgroup stated that they did not believe that the physician had any role in obtain consent. The member continued that, although it might be different for interventional procedures, from personal experience when having an MRI, the Radiologist did not leave the reading room to obtain consent. AMA staff clarified that there is no physician work time allocated for obtain consent for imaging services and that time is only allocated for non-imaging procedural services. One of the radiology RUC advisors further explained the extensive work that goes into the pre-service safety questionnaire and the detailed discussion of that questionnaire and any other safety

issues on the day of the service. AMA staff clarified that the clinical activity where the potential standard would be applied is the work that takes place within the service period when the patient is in the office for the study. The Advisor further explained that after the patient is checked in and taken into the center to change clothes, the Technologist will sit down with the patient and have a bi-directional conversation addressing the safety checks line by line; this is "provide education/obtain consent". The Advisor also explained that the extra 2 minutes included for MR services done with contrast is to explain the safety concerns around gadolinium contrast agents and if appropriate administer the screening forms to determine if the patient has mild kidney problems that have not been diagnosed. Another radiology advisor offered further information about the education for studies with contrast, including explaining to the patient not to be startled, and to remain still, when they experience warming sensations or a metallic taste during contrast injection, and to notify the Technologist of any pain in their arm during the study.

The Workgroup members discussed the time of 7/9/9 and determined that the increment of 2 minutes for "with contrast" codes are appropriate, but were uncomfortable with the 7 minutes for the base code. One Workgroup member suggested 4 minutes. The Workgroup compared the code to the recently reviewed colonoscopy code, CPT code 45378 *Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)* with 3 minutes in the service period for the non-facility and 5 minutes in the pre-service period for the facility for the clinical staff to *provide education and obtain consent*. The Workgroup thought that 3 minutes was not enough time but using the colonoscopy code as a starting point determined that 5 minutes is appropriate. The Workgroup recommended a standard time of 5 minutes, 7 minutes and 7 minutes for MR codes without, with and with and without contrast respectively, for the clinical activity, *provide education/obtain consent,* in the non-facility setting.

The Workgroup discussed the possibility of scheduling another call to discuss the broader issues apart from imaging services for this clinical activity. Ultimately it was determined that the original issue had been sufficiently addressed and that the Workgroup would present this standard to the RUC at the October meeting and refrain from any further recommendations at this time. If the PE Subcommittee determines that there is utility in reconvening the Workgroup at a later date to further examine this clinical activity for non-imaging codes the group will reconvene.

The Workgroup recommended a standard time of 5 minutes, 7 minutes and 7 minutes for MR codes without, with and with and without contrast respectively, for the clinical activity, *provide education/obtain consent,* in the non-facility setting. The PE Subcommittee approved the recommendation of the Workgroup.

Exam Light Workgroup

The Exam Light Workgroup met via conference call on August 1st, 2017 to discuss the equipment items: exam light (EQ168), xenon light source (EQ167) and fiberoptic headlight w-source light (EQ170). The main issue is that at the last RUC meeting it became clear that the PE Subcommittee had fairly routinely been allocating the exam light (EQ168) to a service when it is billed on the same day as an E/M service because it was thought to be standard equipment. Many of these procedures may legitimately require the exam light to perform the service and/or it may be typical equipment in an exam room for the dominant specialty, however this determination should be based on these two factors and not an incorrect assumption that it is part of the E/M standard package. Taking these two factors into account it may be that none of the lights are included in services inappropriately, however it is important that the Subcommittee is evaluating the service based on the correct assumptions.

The Workgroup reviewed an analysis of the cost to Medicare for the light sources. A Workgroup member brought up that if you look at the economic impact there are services that are not billed with an E/M that may not need an exam light. The Workgroup member suggested focusing on the high expense codes. The same Workgroup member also questioned the need for the exam light in every room, stating that his office has roughly three lights that are only utilized when needed. A different PE Subcommittee member gave the example that dermatology offices, typically have the exam light (EQ168) in every exam/procedure room because there can be no shadowing and the physician requires a light source that they can grab and direct.

The Chair of the Workgroup brought up the issue of two surgical lights being allocated to many of these services. For example 10140 *Incision and drainage of hematoma, seroma or fluid collection* includes both an exam light (EQ168) and a surgical light (EF014). Many of the services that have two lights have not been surveyed since 2003 or not at all. The Chair suggested that although it may not be possible for the Workgroup to determine whether or not a light is needed, it might be appropriate to recommend a screen for code review, using the criteria of two or more surgical lights included in the direct PE inputs. Specialty society staff clarified that in those instances when two lights are in one code you can see by the amount of minutes allocated that one light is for the service itself and the other is for the post-operative visits included in the global. A Workgroup member expressed concern that they do not have a surgical light in their office although it is allocated to services that they provide on a regular basis. Specialty society staff explained that the direct practice expense inputs are based on the dominant provider of the service so even if one specialty can provide the service without the light, it is important to keep in mind that the light may typically be used or in the room for the dominant provider of that service.

The Workgroup then discussed the inverse problem which is that when services requiring a light source are billed with an E/M service the cost of the light is not included for the time spent on the E/M even though the service and the E/M both take place in the same room. AMA staff clarified that although this is true, it is an issue that the Workgroup was not tasked with and the PE Subcommittee cannot address it because it would entail creating E/M codes specific to specialty type which is not feasible.

Ultimately the Workgroup determined that there does not seem to be a significant problem here other than the assumptions that the PE Subcommittee brings to reviewing the codes. **The Workgroup recommends the following action:**

- **The PE Subcommittee should review the E/M standard package.**
- **That as codes are reviewed the PE Subcommittee pays special attention to:**
    - **The resources necessary to provide the service apart from the E/M service, and**
    - **The makeup of the dominant specialty's exam rooms when considering the type of light(s) included in the direct practice expense inputs for the procedure.**
- **Specialties should not include the time of the E/M in the equipment time for lights.**
- **Specialties provide justification for the lights that they are recommending in their written PE summary of recommendation (SoR).**

The PE Subcommittee approved the recommendations of the Workgroup.

CT Guided Needle Biopsy 77012

As part of the PE Subcommittee Report at the April 2017 RUC meeting the Chair of the Subcommittee said the following regarding CPT code 77012 *Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation*, which was reviewed at the April 2017 meeting.

> At the next meeting, the PE Subcommittee will plan to discuss the CT guided biopsy codes and validate the understanding, that the RUC was operating under today, that guidance CPT code 77012 *Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation* is added to the appropriate one amongst 6 existing CT biopsy codes of varying durations of time to get the correct duration of time for whatever is being biopsied. The Subcommittee will make sure that there is no overlap or duplication.

Staff found that the following CPT codes are the top six biopsy codes that CPT code 77012 is billed together with in the nonfacility setting.

- 48102, *Biopsy of pancreas, percutaneous needle*
- 32405, *Biopsy, lung or mediastinum, percutaneous needle*
- 49180, *Biopsy, abdominal or retroperitoneal mass, percutaneous needle*
- 20225, *Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)*
- 32400, *Biopsy, pleura, percutaneous needle*
- 20220, *Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)*

The PE Subcommittee reviewed the analysis during the fine needle aspiration (tab 4) practice expense review, where 77012 is part of the family because it is being bundled with CPT code 10022. The specialty societies requested to affirm the recently review PE inputs from April 2017. The data indicate that although these codes are billed together, most of the codes are rarely done in the nonfacility setting. The only exception is CPT code 32405 which has already been identified by the Relativity Assessment Workgroup (RAW) for bundling of 32405 and 77012 because it is billed together 75% or more overall (facility and nonfacility settings in aggregate).

The PE Subcommittee determined that given the extremely low volume in the nonfacility setting the impact of any potential duplicative practice expense inputs is immaterial and no further action is required of the PE Subcommittee at this time.

Discussion of PE Section of RUC Comment Letter on NPRM

Because of time limitations the discussion of the PE Section of RUC Comment Letter on NPRM was tabled until the January 2018 RUC Meeting.

Practice Expense Recommendations for CPT 2019:

Tab	Title	PE Input Changes
4	Fine Needle Aspiration	Modifications
5	Knee Arthrography Injection	Modifications
6	Breast MRI with Computer-Aided Detection	Modifications
7	Neurostimulator Services	No Change
8	Psychological and Neuropsychological Testing	Modifications
9	Bronchoscopy	Modifications
10	Transcatheter Aortic Valve Replacement	No Change
11	Injection – Eye	Modifications
12	Echo Exam of Eye Thickness	Modifications
13	Coronary Flow Reserve Measurement	No PE Inputs

AMA/Specialty Society RVS Update Committee **Tab 16**
Research Subcommittee
October 6, 2017

Members Present: Margie Andreae, MD (Chair), Gregory Przybylski, MD (Vice Chair), 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, Bradley Marple, MD, Daniel McQuillen, MD, Timothy Tillo, DPM, Christopher Senkowski, MD, Stanley W. Stead, MD, MBA, Robert Zwolak, MD

I. Minutes, June 21, 2017 RSC Conference Call and Subsequent Electronic Review

The Research Subcommittee report from the June 2017 conference call and subsequent electronic review included in Tab 16 of the October 2017 agenda materials was approved without modification.

II. Review of Specialty Requests for the January 2018 RUC meeting

I. Request for Review of Proposed Vignettes and Targeted Samples

a. Electrocorticogram (96X00)

American Academy of Neurology
American Clinical Neurophysiology Society

The Research Subcommittee reviewed the vignette submitted by the specialty societies and approved it as follows:

96X00 Electrocorticogram from an implanted brain neurostimulator pulse generator/transmitter, including recording, with interpretation and report by a physician or qualified health care professional, up to 30 days

Research-Approved Vignette: A 30-year-old woman with medically refractory partial onset seizures occurring several times per month **has been** ~~**is**~~ treated with a surgically implanted intracranial responsive neurostimulator. Stored electrocorticograms (ECoG) ~~**are reviewed to determine whether neurostimulator programming or patient management changes are needed.**~~ **are interpreted.**

96X00 captures a new service that is not currently reportable; the surveying societies requested approval to survey a list of names provided by NeuroPace (manufacturer of the RNS System.) The society also proposed to do a random sampling of members from the American Clinical Neurophysiology Society (ACNS), the National Association of Epilepsy Centers (NAEC), and the American Academy of Neurology (AAN) Epilepsy Section. **The Research Subcommittee approved for the specialty to use the targeted sample described above along with a random sample, with summary data reported separately and together.**

b. Dual-energy X-ray absorptiometry (DXA) (77081)
American College of Radiology

The Research Subcommittee reviewed the vignette submitted by the specialty society and approved it as follows:

77081 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)

Research-Approved Vignette: A 55-year-old female with primary hyperparathyroidism being evaluated for possible treatment presents for bone mineral density evaluation of the distal radius.

MR Elastography (76X01)
American College of Radiology

The Research Subcommittee reviewed the vignette submitted by the specialty society and approved it as follows:

76X01 Magnetic resonance (e.g., vibration) elastography
Research-Approved Vignette: A **55-year-old** ~~**22-year-old**~~ male with a BMI of 38 presents with fatigue. Lab testing shows elevated lipids and ALT. Recent abdominal ultrasonography showed evidence of hepatic steatosis. The patient's qualified health **professional** ~~**provider**~~ is concerned that the patient may have progressed to non-alcoholic steatohepatitis and MR elastography is performed as a non-invasive measure of liver fibrosis.

For the January 2018 meeting, the ACR requested to perform a targeted survey for MR Elastography, CPT code 76X01. The society proposed to reach out to the Society of Abdominal Radiology (SAR) as a potential sample pool and are hoping to coordinate with this society. **The Research Subcommittee approved for the specialty to use a random sample of SAR membership along with a random sample of ACR membership, with summary data reported separately and together.**

Radioactive Tracer (38792)
American College of Radiology

The Research Subcommittee reviewed the vignette submitted by the specialty society and approved it as follows:

38792 Injection procedure; radioactive tracer for identification of sentinel node
Research-approved Vignette: A 55-year-old female with a diagnosis of malignant neoplasm of the breast undergoes injection of a radiotracer for localization of the lymph nodes prior to sentinel node biopsy [reported separately] and local excision [reported separately].

MR-Guided Fine Needle Aspiration (10X11-10X19)
American College of Radiology

For the October 2017 RUC meeting the ACR, along with several other societies, surveyed the Fine Needle Aspiration code family which contained CPT codes 10021, and 10X11-10X19. By the submission deadline, the specialties achieved the minimum number of required surveys for all codes except for 10X18 and 10X19, MR-guided FNA, which have low utilization and were only surveyed by the ACR and the SIR. To date, both of our surveys remain open.

For the January meeting, the ACR requested to perform a targeted survey for MR-guided FNA, CPT codes 10X18-10X19. ACR has reached out to the Society of Abdominal Radiology (SAR) as a potential sample pool and are hoping to coordinate with them. **The Research Subcommittee approved for the specialty to use a random sample of SAR membership along with a random sample of ACR membership, with summary data reported separately and together.**

US Elastography (767X1-767X3)
American College of Radiology

For the January 2018 meeting, the ACR requests to perform a targeted survey for US Elastography, CPT codes 767X1-767X3. The society plans to reach out to both the Society of Radiologists in Ultrasound (SRU) and Society of Abdominal Radiology (SAR) to expand the sample pool for this survey and are hoping to coordinate with these societies. **The Research Subcommittee approved for the specialty to use a random sample of SAR and SRU membership along with a random sample of ACR membership, with summary data reported separately and together.**

Contrast-Enhanced Ultrasound (76X0X, 76X1X)
American College of Radiology

For the January 2018 meeting, the ACR requested to perform a targeted survey for Contrast-Enhanced Ultrasound, CPT codes 76X0X and 76X1X. The society plans to reach out to both the Society of Radiologists in Ultrasound (SRU) and Society of Abdominal Radiology (SAR) to expand the sample pool for this survey and are hoping to coordinate with these societies **The Research Subcommittee approved for the specialty to use a random sample of SAR and SRU membership along with a random sample of ACR membership, with summary data reported separately and together.**

c. Dilation of Urinary Tract (52334, 74485)
American Urological Association

The Research Subcommittee reviewed the vignettes submitted by the specialty society:

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

PROPOSED VIGNETTE: A patient has a large renal stone. A guide wire for percutaneous nephrostomy is placed by the retrograde method for guidance and targeting.

The Research Subcommittee requested for the specialty society to resubmit the vignette for electronic review with the typical age and gender. No other issues were raised regarding the proposed vignette.

74485 Dilation of nephrostomy, ureters, or urethra, radiological supervision and interpretation
PROPOSED VIGNETTE: A patient with a ureteral stricture undergoes dilation of the ureter with imaging. Radiologic supervision and interpretation of images is done during and immediately following dilation.

The Research Subcommittee requested for the specialty society to resubmit the vignette for electronic review with the typical age and gender. The Research Subcommittee noted that the typical patient for this procedure was proposed as ureters as this RS&I code can be performed with different codes, in addition to the 52334. The specialty confirmed that dilation of the ureter is typical.

Transurethral Destruction of Prostate Tissue (538X3, 53850, 53852)
American Urological Association

AUA requested to use a targeted survey and as well as a random survey for CPT codes 538X3, 53850 and 53852. The Society will be requesting names from industry for each of these codes to use for the targeted surveys if approved by this committee. **The Research Subcommittee approved for the specialty to use a targeted sample along with a random sample, with summary data reported separately and together.**

d. Electroretinography (92X71, 92X73); *Targeted Sample Request only*
American Academy of Ophthalmology

For new Electroretinography codes 92X71 and 92X73, AAO requested to use a targeted survey as these services are almost exclusively performed in academic centers with full retina services and large retina practices. They estimated that approximately 500 eye care providers perform these services nationally. They requested approval to us a targeted sample of a US-based member list provided by the International Society for Clinical Electro-physiology of Vision (ISCEV) and large retina facilities (both community and academic). They also request to use vendor lists from three manufacturers. The society did not think a random survey of their members would be appropriate because of the potential for members to confuse this new service with an existing but different service (see below). **The Research Subcommittee approved the specialty request to use a targeted sample from industry lists, all US members of ISCEV and large retina practices.**

A subcommittee member suggested for the societies to consider proposing custom language for the survey distribution email to clarify for the survey respondents that

this service is distinct from another similar service. This was not mandated by the subcommittee; the specialty may submit new request to Research for electronic review of proposed language if they desire. The Subcommittee noted that the survey template should include the CPT introductory language and parentheticals, as is the case for all work surveys.

The Research Subcommittee Vice Chair noted that the Subcommittee does not currently have explicit guidance on when it is appropriate to only use a targeted survey and when it is appropriate to use both a targeted and a random sample together. **The Subcommittee agreed to discuss this general issue at the January 2018 meeting.**

II. Request for Review of Proposed Vignettes

a. Exploration of Artery/Vein (35761)

Society of Vascular Surgery

The Research Subcommittee reviewed the vignette submitted by the specialty society and approved it as follows:

35761 Exploration (not followed by surgical repair), with or without lysis of artery; other vessels
Research-approved Vignette: A **35 year old male** ~~**patient**~~ arrives in the emergency department with active upper ~~**arm**~~ extremity hemorrhage after accidentally running into a ~~**plate**~~ glass window with outstretched arm. **Emergency** ~~**Emergent**~~ exploration of the brachial artery is performed, but no brachial artery injury is present.

b. Biopsy or Excision of Inguinofemoral Node(s) (3853X)

American Congress of Obstetricians and Gynecologists

The Research Subcommittee reviewed the vignette submitted by the specialty society and approved it as follows:

3853X Biopsy or excision of lymph node(s); open, inguinofemoral node(s).
Research-Approved Vignette: A 65 year old has a previously confirmed squamous cell carcinoma of the vulva that is distant (more than 2cm) from the midline. An inguinofemoral lymph node(s) excision is performed. **(Note: Interoperative mapping is reported separately.)**

c. Fibrinolysins Screen (85390)

College of American Pathologists

The Research Subcommittee reviewed the vignette submitted by the specialty society and approved it as follows:

85390 Fibrinolysins or coagulopathy screen, interpretation and report
Research-approved Vignette: A 65 year old **female** presents with symptoms of sepsis**.** ~~**due to peritonitis following a ruptured bowel.**~~ The patient demonstrates diffuse bleeding, **significant thrombocytopenia** ~~**platelet counts of less than 30,000 per**~~

~~milliliter~~, and elevated prothrombin time- international normalized ratio (PT-INR) and activated partial thromboplastin time (PTT). A fibrinolysin screening panel is ordered.

Flow Cytometry (88184-5)
College of American Pathologists

The Research Subcommittee reviewed the vignettes submitted by the specialty society and approved them as follows:

88184 Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker
Research-approved Vignette: A 35-year-old female presents with petechiae and pancytopenia. A peripheral blood smear demonstrates numerous blasts. Flow-cytometry immunophenotyping is performed to assist in the classification of the acute leukemia.

88185 Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (List separately in addition to code for first marker)
Research-approved Vignette: A 35-year-old female presents with petechiae and pancytopenia. A peripheral blood smear demonstrates numerous blasts. Flow-cytometry immunophenotyping is performed to assist in the classification of the acute leukemia.

d. Peripheral Vascular Rehabilitation (93668)
American College of Cardiology
Society of Vascular Surgery

The Research Subcommittee reviewed the vignettes submitted by the specialty societies and approved it as follows:
93668 Peripheral arterial disease (PAD) rehabilitation, per session
Research-approved vignette: 66-year-old male with ischemic claudication has a ~~positive~~ atherosclerosis risk factor profile that includes a high prevalence of diabetes, prior tobacco use, hypertension, and hypercholesterolemia. ~~Suffers co-morbid atherosclerotic syndromes including manifestations of coronary artery disease (transient ischemic attacks or stroke).~~ Patient is referred for supervised exercise therapy to treat symptomatic peripheral artery disease.

III. Request for Review of Proposed Vignettes and RUC Survey Modification

a. Congenital cardiac catheterization dilution studies (93561-2)
American College of Cardiology
The Society for Cardiovascular Angiography and Interventions

The Research Subcommittee reviewed the vignettes submitted by the specialty societies and approved them as follows:

93561 Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization, with cardiac output measurement (separate procedure)
Research-Approved Vignette: A 12-year-old boy with D-Transposition of the great arteries ~~**who**~~ underwent surgical repair in infancy. He now presents with progressive fatigue and dyspnea. He is known to now have an intact atrial and ventricular **septa** ~~**septum**~~ following his previous surgical repair. ~~**Attempts at calculating cardiac index by Fick equation are felt to be erroneous due to the many assumptions (assumed VO2, inability to obtain a direct pulmonary venous saturation due to patch repair of the atrial septum) which lead to a cardiac index that is seemingly inaccurate.**~~ Thermodilution studies are performed during a separately reported cardiac catheterization.

93562 Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output
Research-approved Vignette: A 3-year-old girl with history of prematurity, chronic lung disease, and a previously repaired ventricular septal defect presents to cardiology for evaluation of pulmonary hypertension. She is taken to the cardiac catheterization lab for diagnostic right and left heart catheterization as well as pulmonary vaso-reactivity resting. ~~**The purpose of the repeated thermodilution studies is to accurately assess for changes in the cardiac index resulting from changes in the pulmonary and systemic vascular resistances.**~~ During the separately reported cardiac catheterization, thermodilution studies are performed.

The societies requested RSC guidance on changing the global period for these two services to ZZZ. As this decision is outside of the Subcommittee's purview (the CPT Editorial Panel and CMS would instead need to be involved), AMA staff will assist the specialties with this issue separately.

Pulmonary Wireless Pressor Sensor Services (332X0, 9XXX2)
American College of Cardiology
The Society for Cardiovascular Angiography and Interventions

The Subcommittee requested to use a targeted sample of interventional cardiologists who perform this service. As this list would be derived from ACC and SCAI's memberships, Research Subcommittee approval is not required.

To develop work RVU recommendations for new code 9XXX2, ACC and SCAI requested Research Subcommittee approval to modify the XXX Imaging & Diagnostic survey tool to add a sentence to the instructions for Question 2 reminding respondents that the code is inclusive of all work during the billing period. "**Please keep in mind this code includes ALL interpretation(s), trend analysis, and report(s) undertaken for the weekly review."* The Subcommittee expressed reservation with the language originally proposed thinking it might confuse respondents with the term "weekly". **Instead, the Research Subcommittee approved for the following custom language to be added to the end of the physician time survey question: "*Please note, this service is performed over a 30-day period."**

Separately, the Research Subcommittee requested for AMA RUC staff to notify AMA CPT staff that the descriptor should state "professional" instead of "provider" for QHP.

IV. Request for Applying Recent RUC Recommendation for Deleted Code to New CPT Code

a. Gastrostomy Tube Replacement (43X63-43X64)

American College of Gastroenterology
American Gastroenterological Association
American Society for Gastroenterology
American College of Emergency Physicians

The specialty societies requested that the Research Subcommittee allow the use of April 2017 RUC approved values for CPT code 43760 (*Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance*) for newly number code 43X63 (*Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract*) that was approved at the September 2017 CPT Editorial Panel at the request of the American College of Surgeons. **The Research Subcommittee noted that it <u>does not</u> support the specialty's proposal to use the RUC-approved 43760 values and practice expense for new code number 43X63. The Research Subcommittee agreed that the Specialties must conduct a new RUC survey for this new CPT code as part of the family of the new codes. The RUC will review this service at the January 2018 RUC meeting.**

It was also noted that the budget neutrality for this service will be a comparison to the current value of the service and not the recommendation from the April 2017 meeting.

V. Request for Review of Proposed RSL and Targeted Sample

a. Leadless Pacemaker Procedures (33X05-33X06)

Heart Rhythm Society
American College of Cardiology

The societies requested the Subcommittee's approval to conduct a targeted survey of individuals known to provide leadless pacemaker services in tandem with a random survey. Leadless pacemakers were granted FDA approval in 2016. Few physicians have been trained to conduct the relevant implantation and removal procedures. Only one manufacturer has an FDA-approved device that will use these codes. A second manufacturer is doing clinical trials. They were seeking guidance from the Subcommittee on whether they should pursue targeted surveys lists from both manufacturers or only from the FDA-approved manufacturer. **The Research Subcommittee approved for the specialty to use a targeted sample of the vendor list from the manufacturer that has full FDA approval along with a random sample of their members, with summary data reported separately and together. The Subcommittee does not approve the use of a vendor list from the separate manufacturer with the device still undergoing clinical trials and does not yet have FDA approval.**

The Research Subcommittee also reviewed the specialty's proposed 090-day global reference service list and recommended for the societies to consider adding another 090-day global service with an RVU below the current lowest code. Codes suggested for consideration included 33222, 33233 and 33241.

VI. Request for Review of Proposed Survey Modifications

a. Remote Chronic Care Remote Physiologic Monitoring (994X9)

American College of Cardiology

One Research Subcommittee reviewer noted that they compared this proposal to the survey instrument utilized for chronic care management code 99490 and noted that the template has several similarities which were appropriate. The Subcommittee discussed the proposed survey template changes for new CPT code 994X9 and agreed that the proposed language was appropriate as submitted. **The Research Subcommittee approved the proposed custom survey language without modification as follows:**

Total-service period

Over the course of a calendar month, the practice receives regular reports of physiologic data for a patient. Clinical staff review the results and, utilizing a treatment plan, make adjustments in therapy as necessary under the direction of a physician or qualified health care professional. During the month, there are at least 20 minutes spent on the activities outside of a day of a reported E/M service. During the month, there is at least one interactive contact (eg phone) with the patient or caregiver.

NOTE: Do not include time spent on Evaluation and Management services or other specific chronic care management or monitoring services.

Question 2a: Clinical Staff Time

How much CLINICAL STAFF time (ie RN, LPN, MTA) is required per patient treated for each of the following steps in patient care related to this service? It is important to be as precise as possible. For example, indicate 3 or 6 minutes instead of rounding to 5 minutes or indicate 14 or 17 minutes instead of rounding to 15 minutes. Indicate your CLINICAL STAFF's time for the survey code below. *(Refer to definitions.)*

Total time spent by clinical support staff (ie RN, LPN, medical technician) in a calendar month: _____ minutes

Question 2b: Physician or QHP Time

How much of your own time is required per patient treated for each of the following steps in patient care related to this procedure? It is important to be as precise as possible. For example, indicate 3 or 6 minutes instead of rounding to 5

minutes or indicate 14 or 17 minutes instead of rounding to 15 minutes. Indicate your time for the survey code on the front cover. *(Refer to definitions.)*

Total time spent by you in a calendar month: _____ minutes

VERY IMPORTANT

Question 6

Based on your review of all previous questions, please provide your estimate work RVU (to the hundredth decimal point) for the survey code: [ ]

For example, if the survey code involves the same amount of physician work as the reference service you choose, you would assign the same work RVU. If the survey code involves less work than the reference service you would estimate a work RVU that is less than the work RVU of the reference service and vice versa. This methodology attempts to set the work RVU of the survey service "relative" to the work RVU of comparable and established reference services. Please keep in mind the range of work RVUs in the reference service list when providing your estimate.

Note, for this question, only include the work you perform. DO NOT include the work provided by support staff, such as RNs, LPNs, medical secretaries, receptionists and technicians, as their RVUs and work are measured separately from this survey process.

Please Click Here to View a PDF of the CPT Introductory Language for the New and Revised Chronic Care Remote Physiologic Monitoring CPT Codes

III. Pre and Post Time Packages (continued from April 2017 RSC Meeting)

a. Pre-service Package Definitions

For the October 2017 meeting, building upon the Subcommittees discussion pertaining to potentially renaming the pre-service time packages to better align their titles with their time components, a Subcommittee member has submitted the following proposed changes for the Subcommittee's consideration:

Pre-service Time Package	Current Time Package Name	Proposed New Time Package Name
1	Straightforward Patient/Straightforward Procedure (No anesthesia care)	Local Anesthesia/Straightforward Procedure (If no anesthesia care, deduct 1 minute)
2	Difficult Patient/Straightforward Procedure (No anesthesia care)	Local Anesthesia/Complex Procedure
3	Straightforward Patient/Difficult Procedure	General Anesthesia or Complex Regional Block/ Straightforward Procedure
4	Difficult Patient/Difficult Procedure	General Anesthesia or Complex Regional Block/ Complex Procedure

Several Subcommittee members expressed reservation with eliminating the concept of Straightforward vs. Difficult patient. It was noted that the difference between packages 1 and 2 is the length of the history and exam which does not completely align with the difficulty of the procedure, but instead with how many factors need to be considered as part of the evaluation.

Several Subcommittee members also noted that a concrete definition for straightforward vs. difficult would be challenging.

A Subcommittee member suggested for instructions to be drafted with sample codes which would be appropriate for each package as an example to help societies with proposing the appropriate pre-service time package.

Several Subcommittee members expressed interest in making changes to the current pre-time packages, noting that more packages may be needed for increased granularity. For example, it was noted that there is currently no package for straightforward patient/straight forward procedure with anesthesia care.

The Research Subcommittee agreed that a pre-service and post-service time package workgroup should be formed to discuss this issue further. The Subcommittee will seek interest in participation on this workgroup.

b. Non-facility Post-service Time Packages

At the October 2016 meeting, the Time-Intensity Workgroup observed that there is currently no standard post-time package for office setting. The Workgroup agreed that a series of post-time packages for the office setting should be considered. As the Time-Intensity Workgroup, which previously reported to the Research Subcommittee, has been sunset and its responsibilities have been assigned back to Research, this item was added to the Subcommittee's agenda for consideration. After reviewing the below analysis provided by AMA Staff at the April 2017 meeting, the Subcommittee expressed general interest in developing non-facility post-time packages. The Subcommittee noted they would continue the discussion at the October 2017 RSC meeting.

For the October 2017 meeting, a Subcommittee member had submitted proposed non-facility post-time categories for the Subcommittee's consideration:

10A Local Anesthesia/ Straightforward Procedure
10B Local Anesthesia/ Complex Procedure
10C IV Sedation or Regional Block/Straightforward Procedure
10D IV Sedation or Regional Block/Complex Procedure

Following a brief discussion, **the Research Subcommittee agreed that the pre-service and post-service time package workgroup should be formed to discuss this issue further.**

IV. Survey Instrument (new items)

a. Instructions for when respondent does not agree with vignette

The survey instructions currently do not have prominent instructions stating that survey respondents should value the services based on the provided typical patient. AMA Staff had drafted proposed language for the Subcommittee's consideration (for inclusion on the first page where the typical patient is listed for RUC online survey tool). Following some revisions, the Research Subcommittee approved the new survey instructions as underlined in red below:

IMPORTANT: Please check CPT codes for procedures/services that you have experience performing or are familiar with. You will be surveyed about each code you select.

Note: If you think the vignette patient does not represent your typical patient, please do the following:

1) Complete the survey using the typical patient/vignette described below
AND
2) explain in the following section how your typical patient differs from the typical patient described in this survey

Once you have made your selection(s), please click the "Next" button below to continue.

The Research Subcommittee also requested for AMA Staff to perform an analysis for the January 2018 RUC Meeting regarding how often in the past few years codes had less than 50 percent agreement with the provided vignette.

b. Instructions to not include work for performing Moderate Sedation

With the recent unbundling of Moderate sedation services from all procedures formerly listed in CPT Appendix G, the RUC survey does not yet explicitly emphasize that this work is no longer bundled with surgical services. AMA staff has drafted the following proposed addition to the pre-service period definitions for 000-day, 010-day and 090-day global codes for the Subcommittee's consideration. **The Subcommittee approved the proposed language as follows:**

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 (~~also known as~~ conscious) sedation services (reported with CPT codes 99151-99157).

c. Review of survey instrument warnings on zero intra-service time and work RVUs and data trimming instructions

At the April 2017 RUC meeting, A RUC member raised the point that through the survey process, it is possible to input zero minutes for intra-service time. AMA staff explained current warning instructions from Qualtrics ask the survey respondent to confirm that they wish to indicate zero. The RUC Chair requests that the Research Subcommittee review instructions to societies regarding trimming of entries of zeros and other outlier data, as well as other relevant changes.

The current RUC survey process instructions on data trimming state *"As approved at the January 2013 RUC meeting by the Research Subcommittee, if societies trim data, they will need to disclose that information and provide a rationale. The RUC would review and approve the appropriateness of any specific data trimming on an individual code basis."*

For intra-service time, the response is simply required to be numeric value in Qualtrics. Survey respondents are currently permitted to put zero minutes, though if a respondent does put zero, they are taken to a warning page stating: "You put zero minutes of intra-service time for one or more of the survey codes in the previous question. Hit the "back" button and review your responses, as you may have made a typo or misinterpreted the instructions."

For work RVUs, the current data entry rules in Qualtrics only permit a survey respondent put a work RVU between 0.00 and 120. If they do not do so, they receive an error message stating: "You have exceeded the reasonable amount of work RVUs and/or left a field blank. Please re-review the instructions above and then enter a numerical value to the 2nd decimal point"

The Research Subcommittee recommends for the RUC online survey tool to have a hard stop which prohibits respondents from putting zero minutes of intra-service time or 0.00 work RVUs. These should be accompanied by an appropriate error message noting that a work RVU of 0.01 or intra-service time of 1 minute is the lowest value that is allowed.

The Subcommittee did not recommend any revisions to the current RUC survey data trimming rules.

d. Standard Survey Language Solutions for Time-Based Codes

Following the June Research Subcommittee conference call, a Subcommittee 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.

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 pull together examples of language used in the past and also noted that they would continue discussing this issue at the January 2018 meeting.**

V. 000-day global codes typical billed with E/M Services (new item)

At the April 2017 RUC meeting, during *Other Business,* a RUC member requested that methodological issues related to 000-day global codes typically billed with E/M be referred to the Research Subcommittee. The RUC member had requested for Research to study and examine issues related to the overlap of 000-day global codes with E/M and recommend potential solutions that would improve the RUC's methodology and comfort level with dealing with those issues.

In the CY2017 NPRM, CMS observed that for services administered on the same day as an E/M service, there is some overlap in physician work.

> *Excerpt from CY2017 NPRM "In cases where a service is typically furnished to a beneficiary on the same day as an E/M service, we believe that there is overlap between the two services in some of the activities furnished during the preservice evaluation and postservice time. Our longstanding adjustments have reflected a broad assumption that at least one-third of the work time in both the preservice evaluation and postservice period is duplicative of work furnished during the E/M visit."*

In the Final Rule for CY 2017, CMS had finalized a list of 000-day global services reported with an Evaluation and Management (E/M) service 50 percent of the time or more, on the same day of service, same patient, by the same physician, that have not been reviewed in the last five years with Medicare utilization greater than 20,000. The RUC reviewed these services at the April 2017 meeting.

The RUC has determined to what degree pre-service evaluation and/or post-service time should be reduced to account for overlap with E/M services on a case-by-case basis. AMA staff has created a table which includes existing codes from the past 3 RUC meetings to show how the RUC has handled case-by-case deductions in the recent past.

The Research Subcommittee had a relatively brief discussion on this issue. One Subcommittee member noted their observation that sometimes when pre-service and/or post-service times are reduced to account for overlap with an E/M service, the work RVU is not also reduced to account for this change. That Subcommittee member and others noted that the adjusting of pre-service and post-service minutes does not necessarily warrant a proportional reduction in work RVU and should be handled on a case by case basis. **The Subcommittee agreed they would continue discussing this issue at the January 2018 RUC meeting.**

VI. Other Business

a. Appropriate Summary Data for RUC-approved Extant Data Sources – Informational Only

At the April 2017 Research Subcommittee meeting, as part of its review of TVT Registry for TAVR, the Subcommittee also discussed whether mean or median summary data would be more

appropriate for the Registry summary data. **The Subcommittee requested that the specialties provide to the RUC both the median and mean summary data from the extant database.** The Subcommittee also requested for AMA staff to also seek consultation within the AMA on this question to better inform the RUC. Following up on this discussion, AMA RUC staff met with AMA Director of Economic and Health Policy Research Carol Kane, PhD and Senior Economist Kurt Gillis, PhD. Dr. Kane and Dr. Gillis recommend for specialties to 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.

AMA/Specialty Society RVS Update Committee **Tab 17**
MPC Workgroup
October 5, 2017

Workgroup members in attendance: Doctors Alan Lazaroff (Chair), Gregory Barkley, Jimmy Clark, John Lanza, Alnoor Malick, Bradley Marple, Nader Massarweh, Swati Mehrotra, Julia Pillsbury, Paul Pessis, M. Eugene Sherman, Norman Smith, Ezquiel Silva III, James Waldorf

Review of Specialty Code Recommendations
The MPC Workgroup members reviewed proposals from several specialties for codes to be added or removed from the MPC list. Representatives from the specialty societies attended the meeting to provide clarity and answer questions from workgroup members. The MPC Workgroup members also noted that specialty societies should be encouraged to take full advantage of the MPC review process to both add new services and remove services that are no longer appropriate for the list. Finally, the members reminded the specialty societies of the rule that any specialty with 10% or more of the utilization has the right to comment on the appropriateness of addition or deletion of the code. AMA staff indicated that the appropriate specialties either have already been contacted or will be to ensure that the codes are appropriate. It was also noted that going forward, specialties who recommend adding a code to the MPC list should provide a list that shows how the recommended codes for addition fit in their society's hierarchy of codes. In the end, the MPC Workgroup members agreed to include all specialty recommended codes to the MPC list except CPT codes 36905 and 36906. The MPC Workgroup tabled these two codes for the next MPC Workgroup meeting because they are both included in this year's proposed rule and the final rule RVU outcome for the two tabled codes is still unknown.

The MPC Workgroup recommends that the following CPT codes be added to the MPC list moving forward:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2016 Frequency
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	1.10	000	Jan – 14	953,153
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	3.78	010	Apr –11	283,089
64644	Chemodenervation of one extremity; 5 or more muscles	1.82	000	Jan – 13	29,028
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	5.30	000	Jan – 16	126,950
37253	Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)	1.44	ZZZ	Jan – 15	24,130
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent	2.65	ZZZ	Jan – 16	10,534

	vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)				

The MPC Workgroup recommends that the following CPT codes be deleted from the MPC list moving forward:

Code	Long Descriptor	Work RVU	Global	Most Recent RUC Review	2016 Frequency
11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion	0.81	000	Aug – 05	3,598,177
71010	Radiologic examination, chest; single view, frontal	0.18	XXX	Aug – 05	17,269,035
71020	Radiologic examination, chest, 2 views, frontal and lateral;	0.22	XXX	Aug – 05	11,866,284
74020	Radiologic examination, abdomen; complete, including decubitus and/or erect views	0.27	XXX	Aug – 05	605,551

AMA/Specialty Society RVS Update Committee **Tab 18**
Professional Liability Insurance (PLI) Workgroup Meeting
October 5, 2017

Members Present: Doctors James Blankenship (Chair), Ronald Burd, Kathleen Cain, Stephen Chan, Joseph Cleveland, William Gee, Michael Gerardi, Gwenn Jackson, Walt Larimore, Eileen Moynihan, Daniel Nagle, Stanley Stead, and Doris Tomer, LCSW

I. Follow up to RUC Comment Letter

The Chair summarized the PLI comments from the RUC comment letter on the CY 2018 Proposed Rule. The comment letter focused on the following three areas as discussed on the Workgroup conference call in August:

- Low Volume Services
- Premium Crosswalks
- Cardiology Surgical Risk Factor

a. Low Volume Services

CMS has proposed to implement a long sought RUC recommendation to use service-level overrides based on the expected specialty in order to determine the specialty mix for low volume procedures (fewer than 100 allowed services in the Medicare claims data). Further, CMS proposed to use the list of expected specialty overrides based on the recommendations of the RUC. Accordingly, the list of Expected Specialty Recommendations for Low Volume Codes was updated, approved, and collated into one list as part of the RUC comment letter.

b. Premium Crosswalks

The Workgroup discussed the key points reflected in the comment letter in regard to CMS acquiring sufficient premium data from all fifty states for both MD and non-MD specialties. The Workgroup had recommended that moving forward, CMS should obtain adequate data (eg, from all 50 states for all specialties), rather than cross-walking.

Accordingly, the RUC comment letter states, "The RUC is concerned about the proposed dramatic valuation changes that are not indicative of what is occurring in the PLI premium market. In general, the market has not reflected significant changes in the past several years. CMS should consider delaying implementation of new premium data until the Agency has the opportunity to seek additional data to avoid blending risk factors and cross-walking."

c. Cardiology Surgical Risk Factor

CMS proposed classifying cardiology as a blend rather than split into surgical and non-surgical risk factors as it has been in the past because, according to the contractor report, there was insufficient premium data to justify the split this year. Data was received for 12 states compared to 41 states in the previous year, so it did not reach the established CMS threshold of 35 states to construct a unique risk factor. The Workgroup again expressed concern with data collection efforts.

Accordingly, the RUC comment letter states, "The RUC recommends that cardiology continue to be split into surgical and non-surgical risk factors. We propose a crosswalk to Cardiac Surgery surgical risk factor as an interim solution for CY 2018 while expressing concern with the inadequate data collection."

II. Review of New Issues Addressed by Specialty Society Comments

Input was solicited from the specialties on their PLI comments for the Proposed Rule. Two new issues were identified for the Workgroup's discussion as outlined in the American College of Surgeons comment letter:

- Calculating a National Average PLI Premium for Each Specialty by Work RVU vs. Population Weighting
- PLI Premium Data for Facility Providers

The Workgroup discussed the issue of specialty premium calculation weighting based on population estimates versus RVUs as it has been in the past. Given that the premiums are tied to the type of cases performed and the risk-of-service, using population only and not accounting for surgical versus non-surgical work is a cause for concern. The Acumen report states that, "Beginning CY 2016, CMS incorporated population estimates from the American Community Survey (ACS) as weights for specialty premiums. The ACS estimates replaced the use of total RVU and MP RVUs to weight specialty premiums in the CY 2015 MP RVU Update. This change was implemented following CMS's determination that using RVUs as weights introduced the potential for circularity in the MP RVU calculations." The Workgroup determined that more information is needed for them to make an informed recommendation, and they will ask Acumen to address this issue in detail in January.

The Workgroup agreed that specific data should be collected for facility providers (eg, IDTFs, mobile units, etc) and will articulate that concern in discussions with CMS at the January presentation.

III. PLI Premium Data Collection

The Workgroup was in strong agreement that CMS should be able to obtain premium information for all Medicare physician specialties, and other health care professionals and facility providers, in all states. The Workgroup understands that representatives from Acumen and CMS will discuss data collection efforts at the next RUC meeting. The Workgroup was tasked with developing a list of questions for the presenter(s) to address in January 2018:

1. Describe data collection efforts and obstacles to acquiring data in all fifty states.

2. Address why Acumen was unable to collect data for all specialties, non-physician health care professionals, and facility providers.

3. Discuss in detail the methodology for calculating a national average PLI premium for each specialty by RVUs vs. population weighting.

4. Describe the calculation of PLI GPCIs.

The PLI Workgroup will meet at the January RUC meeting to continue discussion on premium data collection efforts. Workgroup members who have suggestions regarding opportunities related to premium data collection and/or critiques of the CMS methodology, should contact AMA staff prior to this meeting.

AMA/Specialty Society RVS Update Committee **Tab 19**
Relativity Assessment Workgroup
October 5, 2017

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

I. Re-Review of Services – Action Plan Review (15 issues)

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. Fifteen code families were flagged and action plans were submitted for review. **The Workgroup reviewed the following and recommends:**

Issue	CPT Code	Recommendation
Complex Wound Repair	13120	Review in 3 years (October 2020)
	13121	
	13122	
Stab Phlebectomy of Varicose Veins	37765	Survey for April 2018
	37766	
Cystourethroscopy	52214	Maintain and remove from this flag. Any issues that remain are in the commercial side and all appropriate efforts have occurred.
	52224	
	52234	
	52235	
	52240	
Injection of Anesthetic Agent	64415	Maintain and remove from this flag. Utilization appropriate and for 64447 there is an appropriate increase due to the management of chronic pain, knee surgery and aging population.
	64445	
	64447	
Contrast X-Ray of Knee Joint	73580	Review in 3 years (October 2020) and show data for the total joint replacement codes in correlation with this service.
Ultrasound Guidance for Needle Placement	76942	Review action plan for January 2018.
Urinary Cytopathology	88120	Maintain and remove from flag. The utilization is decreasing appropriately.
	88121	
	88365	
	88367	
	88368	
Electro-oculography	92270	Maintain and remove from flag. Utilization appropriately decreased significantly.
Treatment of Swallowing Dysfunction	92526	Review in 3 years (October 2020)
Evaluation of Swallowing Function	92610	Review in 3 years (October 2020). Possible miscoding is currently being investigated.
Audiology Services	92626	Refer to CPT May 2018 and CPT Assistant

Percutaneous Transluminal Coronary Thrombectomy	92973	Maintain and remove from flag. Utilization decreased appropriately.
Laser Treatment – Skin	96920	Review in 2 years (October 2019)
	96921	
	96922	
Debridement	97597	Maintain and remove from flag.
	97598	
Advance Care Planning	99497	Review in 2 years (October 2019)
	99498	

II. New Technology/New Services – Action Plan Review (8 issues)

In September 2005, the RUC began a process of flagging services that represent new technology as the codes were presented to the Committee. Codes were flagged from October 2012-April 2013 with three years of available Medicare claims data (2014, 2015 and preliminary 2016 data).

The RUC agreed that the "New Technology" designation was intended to identify new services or codes whose use was expected to increase over time, such that as the service becomes more common and its use more diffuse, the actual work involved (time and/or intensity) or practice expenses might conceivably change (i.e., what may have seemed hard when originally valued may seem less hard now that it is more common). The RUC affirmed that codes showing a significant increase of utilization over time or dramatically more utilization than initially predicted by the specialty society would, in general, need to be resurveyed by the predominant specialty or specialties.

The Workgroup reviewed action plans submitted by the specialty societies and recommends:

CPT Code	Recommendation
21011-28047	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
66183	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
77293	Review in 3 years (October 2020)
88375	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
93583	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
99487	Review in 3 years (October 2020)
99489	Review in 3 years (October 2020)
99490	Review in 3 years (October 2020)
99495	Refer to Research Subcommittee January 2018 to possibly modify the survey. Survey for April 2018.
99496	Refer to Research Subcommittee January 2018 to possibly modify the survey. Survey for April 2018.
99497	Review in 2 years (October 2019)
99498	Review in 2 years (October 2019)

III. Negative IWPUT – Action Plan Review (22 codes)

A RUC member suggested that the Relativity Assessment Workgroup review services negative intra-service work per unit of time (IWPUT) as a possible screen. AMA Staff gathered 2014 and 2015 Medicare utilization over 1,000 with negative IWPUT. The Workgroup reviewed this list of codes and determined that it should be revised for negative IWPUT with Medicare utilization over 10,000 for all services or over 1,000 for Harvard valued and CMS/Other source codes. Twenty-two services were identified and placed on the level of interest for action plans to review at the October 2017 meeting.

The Workgroup reviewed the action plans submitted by the specialty societies and recommends:

CPT Code	Recommendation
20005	Survey for April 2018
22310	Survey for April 2018
26020	Survey for April 2018
26055	Survey for April 2018
26160	Survey for April 2018
27220	Survey for April 2018
33015	Refer to CPT for deletion. If additional specialty societies do not agree to submit a coding change application for deletion then this service should be surveyed.
33025	Survey for April 2018 (identify any additional codes in this family via LOI process).
35761	Survey for January 2018
38792	Survey for January 2018
40808	Survey for April 2018 (identify any additional codes in this family via LOI process).
46500	Survey for January 2018
76376	Survey for April 2018
76514	Surveyed for Oct 2017
77081	Survey for January 2018
85390	Survey for January 2018
90911	Survey for April 2018
92225	Refer to CPT February 2018/RUC April 2018
92548	Refer to CPT September 2018/RUC January 2019
93561 93562 (f)	Survey for January 2018
95024	Maintain. IWPUT is not for low work RVU codes and a resurvey of work would not result in a change in work RVU from the current value of 0.01
95870	Maintain. This service was recently surveyed, April 2012. At that time the survey supported a higher work RVU however, there was no compelling evidence to support an increase for this service.
96154	Survey for April 2018

IV. Site of Service Anomaly – Action Plan Review (20926)

AMA Staff reviewed services with anomalous sites of service when compared to Medicare utilization data. One service was identified, CPT code 20926, in which the Medicare data from 2013-2016e indicated that it was performed less than 50% of the time in the inpatient setting, yet include inpatient hospital Evaluation and Management services within the global period. The specialty societies submitted an action plan and indicated that they believe the site of service issue is due to miscoding. The CPT manual includes a parenthetical that was added in 2011 that states (For injection(s) of platelet rich plasma, use 0232T) which resulted in some decrease in utilization for a few years, but now the utilization is creeping up again. The specialty societies believe the typical patient related to this code would be treated in a facility setting and that the site of service anomaly, for both the outpatient and the office setting is the result of miscoding. The specialty societies propose to address this miscoding by developing a CPT assistant article and possible introductory language to emphasize correct coding. **The Workgroup recommends that CPT code 20926 be referred to the CPT Editorial Panel for the May 2018 CPT Editorial meeting to add/revise the introductory language and referred to CPT Assistant for education on when to report this service.**

V. Surveyed by One Specialty – Now Performed by a Different Specialty

AMA Staff re-examined services that were surveyed by one specialty and are now performed by a different specialty based on 2016 estimated Medicare utilization over 1,000. Eight codes were identified. **The Relativity Assessment Workgroup recommends CPT code 92548 (which is already identified via the be referred to the Negative IWPUT screen) be referred to the CPT September 2018/RUC January 2019 meeting and action plans for codes 11981, 20225, 62270, 62368, 64590, 97598 to review in greater detail at the January 2018 Relativity Assessment Workgroup meeting. The Workgroup recommends removing CPT code 96127 from this screen as this is a PE only code and is being reviewed at the October 2017 RUC meeting.**

VI. CMS/Other Source – Utilization over 30,000

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 recommends action plans for all 34 services review in greater detail at the January 2018 Relativity Assessment Workgroup meeting (codes 70210, 70220, 70250, 70360, 70480, 72132, 72190, 73000, 73010, 73020, 73701, 74240, 74246, 74250, 74270, 75625, 75726, 75774, 76098, 76604, 77073, 77075, 77077, 88141, 92585, 94200, 95831, G0124, G0279, G0364, G0365, G0396, G0446, G6002).**

VII. Low IWPUT

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 services with an IWPUT of 0.0224 or lower. **The Workgroup determined that it would like to pare down the data to better assess whether this is an appropriate screen. The Workgroup determined that the Workgroup Chair should work with AMA staff to develop additional screening criteria such as services greater than 30,000 in Medicare utilization, over 5 (or perhaps 10 to 15) minutes of intra-service time, specified Medicare allowed charges amount, RUC surveyed more than 5 years ago, etc. The Workgroup will review an abbreviated list in January 2018.**

VIII. Reported Together 75% or More

Maintaining the consistency with previous iterations, AMA staff used the 2016 estimated 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 requests action plans for further review whether a code bundle solution should be developed for these services.**

IX. Other Issues

The Workgroup will work with the PE Subcommittee to brainstorm possible practice expense screens for the identification of potentially misvalued services.

X. 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.

AMA/Specialty Society RVS Update Committee **Tab 20**
Health Care Professionals Advisory Committee Review Board
Thursday, October 5, 2017

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, 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

Doctor Bishop called the meeting to order at 4:00 pm and let the Review Board know that Dr. Nikjeh will be chairing the meeting. Dr. Nikjeh advised the Review Board that although there is not enough time to discuss process issues at this meeting we do have materials distributed by staff that outline the HCPAC process. These materials include the appeals process. All the HCPAC members should familiarize themselves with these policies and procedures.

II. CMS Update

Doctor Edith Hambrick from CMS attended the HCPAC meeting and gave the HCPAC an update on recent activities at the Agency. Despite major changes at Health and Human Services (HHS) there are really no changes at the department level of CMS. There have been a few names floated as possible replacements for the head of HHS, but no definitive information yet. The Agency is still planning to release the final rule on November 1st. If any specialty societies or individuals plan to meet with CMS regarding the final rule please do so as soon as possible.

III. Relative Value Recommendations for CPT 2019

Psychological and Neuropsychological Testing

The American Speech-Language-Hearing Association (96105, 96125) and the American Psychological Association (963X3, 963X4, 963X7-963X9, 96X10, 96X12) surveyed codes identified by the CMS High Expenditure Procedural Codes screen.

CPT Code	Global	Description	HCPAC wRVU Rec	Pre-Time	Intra-Time	Post-Time	IWPUT	Rationale	Add Ref Codes
Psychological/Neuropsychological Testing									
Testing Evaluation Services									
963X3	XXX	Psychological testing evaluation services, first hour	2.50	5	60	5	0.0379	CROSSWALK: **90847**, *Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes* (wRVU = 2.50; time = 5/50/21; IWPUT = 0.0384; RUC April 2012)	90846 (wRVU = 2.40)
963X4	ZZZ	Psychological testing evaluation services, each addl hour	1.90	0	60	0	0.0317	CROSSWALK: **90836,** *Psychotherapy 45 min; when performed with EM* (wRVU = 1.90; time = 0/45/3; IWPUT = 0.0407; RUC April 2012)	88323 (wRVU = 1.83) 95864 (wRVU = 1.99) 92460 (wRVU = 1.76)
Test Administration and Scoring									
963X7	XXX	Psychological or neuropsychological test admin. and scoring by physician or healthcare professional, first 30 min.	0.55	3	30	3	0.0139	CROSSWALK: **97605**; *Negative pressure wound therapy* (wRVU= 0.55; time= 3/20/5; IWPUT = 0.0185; RUC Jan 2014;)	
963X8	ZZZ	Psychological or neuropsychological test admin. and scoring by physician or healthcare professional, each addl 30 min.	0.46	0	30	0	0.0153	CROSSWALK: **96152** *Health & Behav intervention* (wRVU = 0.46; time = 4/15/5; IWPUT = 0.0172; RUC Feb 01)	
963X9	XXX	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method, first 30 minutes	PE Only						
96X10	ZZZ	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes	PE Only						
Automated Test with Result									
96X12	XXX	Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only	PE Only						
Assessment of Aphasia and Cognitive Performance Testing									
96105	XXX	Assessment of aphasia	1.75	4	60	10	0.0240	EXISTING VALUE: maintain current value	92640 (wRVU = 1.76)
96125	XXX	Cognitive performing testing	1.70	4	60	10	0.0230	EXISTING VALUE: maintain current value	

The HCPAC approved the direct practice expense inputs as reviewed and modified by the Practice Expense Subcommittee.

AMA/Specialty Society RVS Update Committee **Tab 21**
Anesthesia Workgroup
October 6, 2017

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

I. Review analysis comparing the physician work component of anesthesia base units to work RVUs

At the April 2017 Anesthesia Workgroup meeting, the Workgroup noted it would continue review and discussion of anesthesia services at the October 2017 meeting. AMA staff, working with ASA, developed an analysis comparing the physician work component of anesthesia base units to work RVUs.

Doctor DiSesa indicated it has been ten years since the last review/validation of anesthesia services and that the objective is to try and link the anesthesia services to physician services in some way so as to assure proper relativity.

AMA staff reviewed the *Review Anesthesia to Surgical Codes* spreadsheet. This list comprises the top 32 anesthesia codes with $20 million or more in 2016e Medicare Allowed Charges, which represent 75% of total 2016e Anesthesia Medicare Allowed charges. The same day surgical code was obtained from same day/same patient top surgical code reported with the anesthesia service from the 2015 Medicare 5% file. Lastly, the 25th percentile, median, and 75th percentile anesthesia time units were obtained from the 2015 Medicare 5% file, MAC claims, AA, QX, QZ modifiers. Using the current formula (published by CMS in the 1994 Federal Register and used by the RUC and ASA) for converting anesthesia values on the same scale as physician work values is as follows: *Anesthesia units* X *(Anesthesia Conversion Factor/Payment Schedule Conversion Factor)* X -0.786 *(Anesthesia work fraction) = RVUs*. For purposes of this examination, we calculated the Surgical Same Day work RVU to compare to the 25th % anesthesia time unit, median anesthesia time unit, and the 75% anesthesia time unit. *Base unit + Anesthesia time unit* X (22.0454/35.8887) X 0.786.

The Workgroup reviewed the most frequently reported 32 anesthesia codes and compared these codes to the top surgical codes with which they are reported. The Workgroup had the following concerns/issues:

- Concern with the range of intensities of surgical codes reported with each anesthesia code. AMA staff will work with ASA staff to compare for all 32 codes the surgical code IWPUT to the Post-Induction Period Procedure Anesthesia (PIPPA) to review the extent of correlation and to determine whether there is a need for more granularity.
- Concern that anesthesia services need to be identified via the potentially misvalued code process. For example, if surgical codes for which the work largely has decreased due to efficiencies or review via the potentially misvalued process, the associated anesthesia code may need to be reviewed as well.

- **The Workgroup determined it must first validate the 2007 methodology to identify a set of anchor codes. AMA staff noted that 8 of the top 32 anesthesia codes have a single top surgical code that is reported at least 50% of the time. 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 goal is to have these data available for review at the January 2018 Anesthesia Workgroup meeting.**

- **AMA staff will gather the top 5 surgical services for each of the top 32 anesthesia codes and display the surgical codes IWPUT compared to the PIPPA of the anesthesia codes for review at the January 2018 Workgroup meeting.**

Approved by the RUC – October 7, 2017

Tab 8 Psychological and Neuropsychological Testing
Facilitation Committee #1

Members: Doctors Michael Bishop (Chair), Dale Blasier, Ronald Burd, David Han, David Hitzeman, Walter Larimore, Alnoor Malick, Gregory Przybylski, Julia Pillsbury and Timothy Tillo, DPM.

96X11 Psychological 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

The Facilitation Committee determined that the issue with this service was that the primary providers of were not surveyed (primary care and nurse practitioners). This service is currently reported with 96103 *Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report* (work RVU = 0.51, 8 minutes pre-service, 8 minutes intra-service and 14 minutes post service time) or 96120 *Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report* (work RVU = 0.51, 8 minutes pre-service, 8 minutes intra-service and 14 minutes post service time). **The Committee recommends an interim value of 0.51 for CPT code 96X11 and 8 minutes pre-service, 8 minutes intra-service and 14 minutes post service time and resurvey the correct individuals for January 2018. The specialty societies should submit a revised vignette to the Research Subcommittee prior to survey.**

963X0 Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour

The Facilitation Committee reviewed the specialty societies' recommendation of 2.60 and determined that the survey data did not support that recommendation, survey 25th percentile was 2.48 work RVUs and median was 3.13 work RVUs. Using magnitude estimation the Facilitation Committee determined that a work RVU of 2.50 crosswalked to 90847 *Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes* (work RVU = 2.50 and 5 minutes pre-service, 50 minutes intra-service and 21 minutes post-service time) was appropriate. Additionally, a work RVU of 2.50 was recommended for codes 963X3 and 963X5 at this meeting. **The RUC recommends a work RVU of 2.50 for CPT code 963X0 and 5 minutes pre-service, 60 minutes intra-service and 5 minutes post-service time.**

963X1 Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)

The Facilitation Committee was concerned about the intensity of this add-on service related to the intensity of the base code. Therefore, the Committee recommends CPT code 963X1 be crosswalked to CPT code 96570 *Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)* (work RVU of 1.10 and 30 minutes intra-service time). **The Committee recommends a work RVU of 1.10 and 30 minutes intra-service time for CPT cod 963X1.**

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