AMA/Specialty Society RVS Update Committee
Renaissance Hotel, Chicago, IL
April 26-29, 2017

Meeting Minutes

I. Welcome and Call to Order

Doctor Peter Smith called the meeting to order on Friday, April 28, 2017 at 8:09 a.m. The following RUC Members were in attendance:

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

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

*Alternate

II. Chair's Report

- Doctor Smith welcomed everyone to the RUC Meeting.

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

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

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

- Doctor Smith welcomed new RUC members:
  - David C. Han, MD (SVS)
  - Alnoor Malick, MD (ACAAI)
  - Dee Adams Nikjeh, PhD, CCC-SLP (HCPAC)

- Doctor Smith welcomed new RUC Alternate members:
  - Timothy Tillo, DPM (HCPAC)
  - Robert M. Zwolak, MD (SVS)

- Doctor Smith welcomed the following Observers:
  - Brian DeBusk, PhD – MedPAC
  - Alice Coombs, MD – MedPAC

- 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 from 100,000 to 999,999 = **50 respondents**
  - Codes with <100,000 Medicare = **30 respondents**
  - Surveys below the established thresholds for services with Medicare claims of 100,000 or greater will be reviewed as interim and specialty societies will need to resurvey for the next meeting.

- Doctor Smith laid out 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 laid out 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 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 remotes 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 reported that the next "Best RUC Reviewer" Award will be presented at the October meeting and will be related to the evaluation of Practice Expense (PE). This award was created to recognize that the value of the meeting proceeding expeditiously and accurately is dependent on the work that is done prior to the meeting. 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:

- Like the CPT Editorial Panel and the AMA House of Delegates, the RUC has begun using a meeting app. It contains the agenda, background information and resources, maps, and list of attendees. In addition, the app will be constantly updated during the meeting to reflect the tab that is currently under discussion. Staff will be assessing its usefulness after this meeting via electronic survey.

IV. Approval of Minutes from January 2017 RUC Meeting

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

V. CPT Editorial Panel Update

Doctor Kathy Krol welcomed the following members of the CPT Editorial Panel:

- Kenneth Brin, MD, Chair
- Kevin Vorenkamp, MD

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

- Follow-up to the RUC on CPT actions for topics sent to CPT based on recommendations of the RAW workgroup. In general, the CPT process is proceeding with all topics RUC has sent to CPT for consideration.
    - Specific update was shared from the February 2017 Panel meeting on 3 topics that have been delayed in the CPT process past the RUC deadline**:**
        - Skin Biopsy - The skin biopsy issue was approved at the February Panel meeting and is being valued at this RUC meeting.
        - Neurostimulator Services - The Panel postponed the Neurostimulator Services application at the February meeting, with the applicants not able to complete and present an application for this meeting. New specialties expressed an interest in participating just before and during the February meeting. CPT Panel reviewers and staff have spent time with the applicants, trying to give them additional support to complete this topic, which is on the June 2017 CPT agenda with a new application being reviewed.
        - Electroretinography -There were six applications on the February Panel agenda from two different applicants, each requesting codes for full field, multifocal, and pattern electroretinography. It is the third time this topic has been on the CPT agenda in the last four CPT meetings. The Panel and applicants did a lot of work on the language during the February meeting, but again there was not consensus on how these codes should be reported, and the topic was again postponed. The Panel made substantial progress and provided additional support to all of the applicants. This topic is on the agenda with new applications for the June 2017 CPT meeting.
    - RUC Issues from January 2017 RUC meeting:
        - The issues RUC sent back to CPT at the January meeting were all discussed at the February CPT meeting, and are in process of resolution.

- Update on CPT Needs for APMs – At the Annual CPT Advisors' meeting in February 2017, a discussion followed a presentation on Alternative Payment Models (APMs) and the resounding message from participants was that CPT urgently needs to begin looking at coding for APMs. AMA responded that it is researching what is necessary to accomplish this. Doctor Brin provided his preliminary thoughts about what is needed and next steps to develop APMs to the Emerging CPT/RUC Issues Workgroup on April 27, 2017. He proposed a fly-in meeting of stakeholders and feedback on that process is solicited.

- MPCW Fly-In meeting – The Molecular Pathology Coding Workgroup had a fly-in meeting on April 4, 2017 to address coding strategies for broad panel genomic sequencing procedures. An example of this type of test is the application in Tab 23 on the February 2017 agenda, which was postponed and is on the June Panel agenda. It was a productive meeting that engaged stakeholders from the payer, laboratory, and physician communities. (While this is not a RUC-related issue, it was noted as a CPT activity.)

- DMPAG – Digital Medicine Payment Advisory Group:
    - CPT Panel convened the Telehealth Services Workgroup.
    - While the Workgroup addressed some coding issues, it became apparent that the issues related to the proliferation of digital technologies into clinical practice were larger in scope than just coding.
    - AMA convened the DMPAG to address the broader scope.
    - The Advisory Group was appointed by AMA. Fourteen members include Panel and RUC members, clinicians from large health systems that are very engaged in the use of these

technologies, representatives of companies providing technologies, and an industry association representative. Supported by staff from all areas of AMA.
  - The Advisory Group will convene three face-to-face meetings in 2017.
  - The Advisory Group is considering multiple issues, primarily related to coding for remote patient services.
  - As the Advisory Group makes progress, AMA will find opportunities to provide updates and gain input from Advisors and the House of Medicine.

- The next CPT Editorial Panel meeting will take place June 1-3, 2017 in Boston. The Panel will consider roughly 60 agenda items.

- The submission deadline for code change applications for the September 2017 meeting is June 13, 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):

- Introduced staff from CMS attending this meeting:
  - Ryan Howe, PhD - Director
  - Tourette Jackson - Analyst
  - Karen Nakano, MD - CMS Medical Officer
  - Emily Yoder - Analyst

- Announced leadership/management under the new Administration:
  - Doctor Tom Price, HHS Secretary
  - Ms. Seema Verma, MPH, CMS Administrator

- The Notice of Proposed Rulemaking (NPRM) for the Medicare Physicians' Payment Schedule will be released on time. Please come in and talk to CMS about any issues regarding codes or policy.

VII. Contractor Medical Director Update (Informational)

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

- Two contract areas are being re-bid: Jurisdictions J (AL, GA, TN) and F (includes 10 western states). They are still waiting for the contract to be awarded for Jurisdiction J, while the RFP is out for Jurisdiction F and proposals are due soon.

- Under CMS' contracting reform, instead of having one multi-function contractor per state, there are now multiple single-function contractors. The different types of contractors for reviewing claims were described.

- Two codes on the RUC agenda raised Doctor Haley's interest: 64450 and G0166. These codes experienced substantial increases driven by only a half-dozen providers in several states. Doctor Smith clarified that when issues regarding coding and utilization irregularities are encountered, the RUC will submit a letter to CMS specifying what occurred.

VIII. Washington Update (Informational)

Sharon McIlrath, Assistant Director Federal Affairs, AMA, provided the RUC with the following information regarding the AMA's advocacy efforts:

- Regulatory relief is one of the primary goals of the new Administration. Rules of the road:
  - *"To the maximum extent permitted by law"* Department and Agency heads should "waive, defer, grant exemptions from, or delay" any ACA provision that "would impose a fiscal burden."
  - Any regulation not yet in effect is frozen for 60-90 days unless it has been approved by a Trump appointee, has a statutory deadline or is emergency/ urgent.
  - For every new regulation, two must be repealed. Net cost of new and repealed can't exceed zero. Per Administrative Procedures Act, repeal requires notice and comment period.
  - Every agency must create a Regulatory Reform Task Force to identify regulations that reduce jobs, are outdated, unnecessary or inconsistent, or have costs that outweigh benefits. A progress report is due late May.

- AMA Two Track Approach:
  - MACRA (QPP)
    - Two State/Specialty Work Groups: one addressing MIPS, another on APMs
    - 32 recommendations shared with HHS Secretary/staff, CMS Administrator/staff, and Federation
    - Also working on legislation
  - Non-MACRA
    - Separate Workgroup
    - List under development covers Medicare FFS & MA; PQRS, MU, VBM Penalties; Prior Authorization; Documentation/Certification; EHR; Program Integrity

- AMA Advocacy:
  - Our Quality Payment Program (QPP) Goals
    - More gradual transition
    - Maximize success; limit penalties
    - More APM alternatives for physicians
  - Merit-based Incentive Payment System (MIPS) Wish List Highlights. Legislation is likely needed to make these happen.
    - Extend 2-year performance threshold "special rule"
    - Gradually ramp up "pick your pace" requirements
    - Delay implementation of cost category
  - Other Proposed MIPS Improvements
    - Quality: 3 measures; outcome not required; no claims-based population measures
    - Meaningful Use (MU)/Advancing Care Information (ACI): 90 day reporting; keep existing EHRs; eliminate pass-fail
    - Improvement Activities: Increase Category Weight; keep reporting simple; stability
  - Alternative Payment Models (APMs) Proposals
    - Maintain Nominal Risk Threshold of 8% of revenues
    - Expand Opportunities to participate in APMs, including physician-focused APMs
    - AMA wants data and technical help for interested specialties

- Regulatory Relief: Items Under Discussion
    - PQRS, VM, MU Penalties: Sign-on letter asked CMS to take a number of steps to hold most physicians harmless from 2018 penalties. Discussed with top CMS and HHS officials. Changes rules retroactively so will be challenging.
    - Preauthorization: Standardize forms/transactions; Based on publically available & current clinical guideline; Prohibited for generic, standard and inexpensive drugs & for chronic/ongoing conditions. Restricted to "outlier" providers.
    - Social Security Number Removal from Medicare cards: To be phased in starting April 1, 2018. AMA wants CMS to issue a formal regulation; create a look-up data base; conduct adequate outreach/education for physicians and patients.
    - Documentation/Certification: Standardize forms & requirements; target problem providers; eliminate recertification for chronic/ongoing conditions.
    - Appropriate Use Criteria: Delay start date; reduce, simplify and phase in requirements.
    - EHR: Make certified venders disclose prices and available options. Implement data blocking prohibition from 21st Century Cures law. Refocus certification to reflect real-world needs of physicians.
    - Physician Office-Based Labs: 2014 law requires labs to report prices they charge private payers for use in a new clinical lab fee schedule. Reporting burden and lower payments for lab tests are anticipated. AMA is working with the coalition to find solution.
    - In-office Drug Compounding: Exempt physician offices and/or sterile drug products from FDA's draft "Insanitary Conditions" guidance.
    - Medicare Advantage Audits: Require health plans to allow at least 90 days to respond, support electronic submission & compensate physicians.
    - Program Integrity: Require reviewers to use uniform approach and apply coverage and payment policies consistently. Eliminate duplicate reviews. Use properly adjusted predictive analysis to focus on claims most at risk for improper payments. Repeal RAC contingency fee structure; Require RACs to have physician audits reviewed by a physician of same specialty and to reimburse physicians who win an appeal for cost of complying with RUC requests. Address concerns with "Two Midnights" policy.

IX. Medicare Spending and Utilization Growth for 2016 (Informational)

Dr. Kurt Gillis, AMA Principal Economist, provided an update on Medicare Physician Payment Schedule - Spending and Utilization Growth for 2016.

- A presentation was given to review the analysis of Medicare Physician/Supplier Procedure Summary files (PSPS).
    - Estimates are based on claims for 2016 processed through December 31, 2016 (>92% complete).
    - Spending changes broken down into changes in pay, utilization and site of service.
    - Medicare Physician Fee Schedule services are provided to fee-for-service enrollees. Does not include Medicare Advantage utilization.
    - Approximately 34 million Part B fee-for-service enrollees in 2016.
    - Spending accounts for a little over 25% of total Part B spending and approximately 11% of total Medicare spending.

- Results for 2016 – Overall, spending and utilization growth are up sharply from recent years.
    - Medicare physician spending increased 4.0% due to:
        - Increase in fee-for-service enrollment (1.2%)
        - Increase in utilization per enrollee (3.4%)
        - Decrease in MFS pay (-0.8%)

- Imaging
  - Spending is up 4%
  - First increase in spending for imaging since 2008
  - 3% increase in utilization per enrollee
  - Utilization growth is up for all major imaging categories
- Evaluation and Management (E/M)
  - 3% increase in spending
  - 3% increase in utilization per enrollee
  - -1% pay change
  - Specific categories with growth in utilization:
    - Wellness visits – new in 2011 (17% growth)
    - Specialist/Other – Transitional Care Management (TCM) new in 2013 (16% growth)
- Procedures
  - 4% increase in spending
  - 4% increase in utilization per enrollee
  - 10% growth in utilization for *Physical Therapy*
  - Major pay reductions for some categories
    - 43% cut for *Eye Procedures/Treatment of Retinal Lesions* (CPT 67228)
    - 14% cut for *Colonoscopy* (e.g., CPT 45380)
- Tests
  - 7% increase in spending
  - 5% increase in utilization per enrollee
  - 12% growth in utilization for *EKG Monitoring* (CPT 93229)

- Reason utilization growth may be overstated for 2016
  - We estimate 2016 spending based on completeness of 2015 claims. Completeness for 2015 may have been low due to ICD-10 implementation.
    - Implemented 4th quarter of 2015
    - May have slowed submission and/or processing of claims
  - However, it is unlikely that this accounts for all of the increase in utilization growth
  - More uncertainty in this year's estimates than usual
  - These estimates are revised in the fall when final data is received.

X. Relative Value Recommendations for *CPT 2018/ CPT 2019:*

Anesthesia for Intestinal Endoscopic Procedures (Tab 4)
Marc Leib, MD, JD (ASA); Richard Rosenquist, MD (ASA); Neal Cohen, MD, MPH, MS (ASA)
Facilitation Committee #1

In the Final Rule for 2016, CMS stated that the anesthesia procedure codes 00740 *Anesthesia for procedure on gastrointestinal tract using an endoscope* and 00810 *Anesthesia for procedure on lower intestine using an endoscope* are used for anesthesia furnished in conjunction with lower GI procedures. In reviewing Medicare claims data, CMS noted that a separate anesthesia service is now reported more than 50 percent of the time when several types of colonoscopy procedures are reported. Given the significant change in the relative frequency with which anesthesia codes are reported with colonoscopy services, CMS believes the base units of the anesthesia services should be reexamined. Therefore, CMS identified CPT codes 00740 and 00810 as potentially misvalued.

The RUC reviewed CPT codes 00740 and 00810 in January 2016 and recommended:

1. An interim base unit of 5 for codes 00740 and 00810 and notes the comparison to the RUC recommended values for moderate sedation, 99156 and 99157, results in a work RVU equivalent that is only slightly higher than moderate sedation service of the same number of minutes.
2. Referral to the Research Subcommittee for review of the vignettes and to develop a method on how to review the survey data to value these services. The RUC recommended that the specialty societies revise the vignette for the typical patient receiving anesthesia for an EGD for 00740 and for a patient receiving anesthesia for a colonoscopy (45378) for 00810.
3. Resurvey 00740 and 00810 for the April 2016 RUC meeting.

In April 2016, an Ad Hoc Anesthesia Workgroup was formed to discuss the issues surrounding these services. The specialty society requested and the Workgroup agreed that CPT codes 00740 and 00810 are too broad in the range of endoscopic procedures covered under each code and should be referred to the CPT Editorial Panel September 2016 meeting to request a new family of anesthesia codes to describe anesthesia for GI endoscopic procedures. The revised codes will specifically identify those patients undergoing both upper and lower gastrointestinal endoscopic procedures. The RUC recommended CPT codes 00740 and 00810 be referred to CPT to better define these services. The Anesthesia Workgroup also recommended an educational presentation be provided to the RUC on the existing survey and valuation process for anesthesia services since it has not been validated or used for a survey since 2007, including a specific example of how the data from a survey are used to value an anesthesia service.

In September 2016, the CPT Editorial Panel deleted two codes 00740 and 00810 and created two new codes for upper, two new codes for lower and one new code for upper and lower endoscopic procedures.

In January 2017, ASA provided an overview of the anesthesia payment system. The three main points discussed were that payment for anesthesia services are based on a different relative system, time is not a factor in establishing base unit value and payments for anesthesia services use a different formula.

Payments for anesthesia services are based on a different relative system.
The rank order of anesthesia codes is independent of the intra-service times for the anesthesia procedures (or the underlying surgical procedures). Base units range from a low of 3 units to a high of 30 base units with the exception of three add-on codes. Noting that anesthesia base and time units include a combination of work, practice expense and professional liability. For 2017, the percentage of the anesthesia units allocated to physician work is 78.6%

Time is not a factor in establishing base unit value.
The base unit value reflects three major components of the anesthesia service: (1) the intensity and complexity of the intra-service anesthesia care (but not the length of time of that care); (2) the amount of pre-anesthesia service work (pre-anesthesia evaluation and preparation of equipment and medications); and (3) the amount of post-anesthesia service. Hence, two anesthesia CPT codes can have the same or similar base unit values but very different intra-service anesthesia times. The similarity of base unit values indicates that the two codes have similar intra-service intensity/complexity, pre-anesthesia work, and post-anesthesia work. Differences in intra-service anesthesia times are accounted for by reporting the actual time for each procedure, not through differences in base unit values. Similarly, two anesthesia CPT codes may have very different base unit values but similar intra-services times.

Payments for anesthesia services use a different formula.
Anesthesia services are valued based on the base unit value and time. For each anesthesia claim, time is separately calculated and is submitted in actual minutes. CMS converts reported minutes into time units when determining payment. Per CMS, 15 minutes equal 1 time unit. To determine the total number of time units, the reported number of minutes is divided by 15 and taken out to

one decimal place. Although CMS uses a 15-minute time unit, CMS does not pay in 15-minute increments, but pays by the minute (divides minutes by 15 to determine the number of units to 1 decimal place). [Anesthesia Base Units + Time Units] x Anesthesia Conversion Factor. The 2017 Anesthesia Conversion Factor is $22.0454.

In September 2016 the CPT Editorial Panel created five new codes for upper and lower endoscopic procedures and deleted two codes 00740 and 00810. In January 2017, the RUC noted that 00811 will be reported 1,205,000 times for Medicare patients and therefore did not meet the threshold of 75 surveys and 00812 will be reported 515,000 and therefore did not meet the threshold of 50 surveys. The recommend values for these services were interim and the specialty society resurveyed for the April 2017 RUC meeting.

00811 ***Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified***
The RUC reviewed the survey results from 114 anesthesiologists and determined that the survey 25th percentile base unit of 4 appropriately accounts for the work required to administer anesthesia for these services. This new code represents about 70% of the Medicare utilization of the old 00810 service. The survey respondents indicated that the intensity and complexity measures for 00811 are equal or slightly more than those for the top two key reference services 00910 *Anesthesia for transurethral procedures (including urethrocystoscopy); not otherwise specified* (base unit = 3) and 00914 *Anesthesia for transurethral procedures (including urethrocystoscopy); transurethral resection of prostate* (base unit = 5) which supports the base unit recommendation. The RUC noted that the overall intensity for the lower GI anesthesia services is less than the upper GI services 00731 and 00732. Therefore, the survey 25th percentile and median base unit of 4 is more appropriate than the median of 5 base units. **The RUC recommends a base unit of 4 for CPT code 00811.**

00812 ***Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy***
The RUC reviewed the survey results from 97 anesthesiologists and determined that the survey 25th percentile base unit of 3 appropriately accounts for the work required to administer anesthesia for these services. This new code represents about 30% of the Medicare utilization of the old 00810 service. The survey respondents indicated that the intensity and complexity measures for 00812 are identical to slightly less intense than those for the top two key reference services 00910 *Anesthesia for transurethral procedures (including urethrocystoscopy); not otherwise specified* (base unit = 3) and 00914 *Anesthesia for transurethral procedures (including urethrocystoscopy); transurethral resection of prostate* (base unit = 5), which supports the base unit recommendation. The majority of respondents chose key reference service 00910 and the RUC determined that the work for 00812 is more closely related the top key reference service. Based on the RUC reviewer comments, screening colonoscopies typically may be less intense and take less time, 25 minutes, than the diagnostic or procedural colonoscopy, therefore 3 base units is appropriate. The RUC agreed that this service should be valued lower than the anesthesia for upper GI services CPT codes 00731, 00732 and for diagnostic colonoscopy 00811, thus is valued appropriately. **The RUC recommends a base unit of 3 for CPT code 00812.**

The RUC affirmed its January 2017 recommendations for 00731, 00732 and 00813 without modification.

Practice Expense
In January 2017, the specialty society requested the standard 8 minutes of colorectal service time as is consistent for all anesthesia codes. The RUC recommends the direct practice expense inputs as submitted by the specialty society.

Work Neutrality
The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the 2018 Medicare conversion factor.

Skin Biopsy (Tab 5)
Howard Rogers, MD (AAD); Mark Kaufmann, MD (AAD); Daniel Siegel, MD, MS (AAD)
Facilitation Committee #2

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 (E/M) services and services reviewed since CY 2010. CPT codes 11100 and 11101 were identified via this screen. Prior to the January 2016 RUC meeting, the specialty society notified the RUC that their survey data displayed a bimodal distribution of responses with more outliers than usual. The specialty explained that the code descriptions do not distinguish between different types of biopsies and thus they would like to bring the biopsy of skin lesion codes back to the CPT Editorial Panel in May 2016 for refinement of the codes. The RUC recommended referring CPT codes 11100 and 11101 to the CPT Editorial Panel. In February 2017, the CPT Editorial Panel deleted two codes and created 6 codes for primary and additional biopsy based on the thickness of the sample and the technique utilized.

11102 Tangential biopsy of skin, (eg, shave, scoop, saucerize, curette); single lesion
The RUC reviewed the survey results from 101 dermatologists and determined that the survey respondents overestimated the work required to perform these services relative to other skin biopsy codes and services in the Medicare Physician Payment Schedule. Based on preliminary comments from the RUC and the reduction in intra-service time, the specialty society reduced their original recommendations. The specialty society recommended a direct work RVU crosswalk to 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66 and 5 minutes intra-service time, 21 minutes total time). The specialty society decreased the survey evaluation time by 2 minutes to account for any overlap as this service will typically be performed with an E/M. The RUC recommends 3 minutes evaluation time, 2 minutes positioning time, 2 minutes scrub/dress/wait time, 6 minutes intra-service time and 5 minutes immediate post-service time. The RUC referenced similar services 20600 *Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance* (work RVU = 0.66 and 21 minutes total time), 92511 Nasopharyngoscopy with endoscope (separate procedure) (work RVU = 0.61and 17 minutes total time) and 11300 *Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less* (work RVU = 0.60 and 21 minutes total time). **The RUC recommends a work RVU of 0.66 for CPT code 11102.**

11103 Tangential biopsy of skin, (eg, shave, scoop, saucerize, curette); each separate/additional lesion (List separately in addition to code for primary procedure)
The RUC reviewed the survey results from 101 dermatologists and determined that the survey respondents overestimated the work required to perform these services relative to other skin biopsy codes and services in the Medicare Physician Payment Schedule. Based on preliminary comments from the RUC and the reduction in intra-service time, the specialty society reduced their original recommendations. The specialty society recommends a direct work RVU crosswalk to 11732 *Avulsion of nail plate, partial or complete, simple; each additional nail plate (List separately in addition to code for primary procedure)* (work RVU = 0.38 and 8 minutes intra-service time). The specialty indicated that 11103 is not just a larger or contiguous procedure but is a second procedure at a different site or side. Thus, the survey respondents may have indicated more time for the add-on code intra-service because there would be some additional preparation and re-positioning. However, since the add-on codes typically do not have additional pre or post-time, the standard survey instrument used did not ask that information. The specialty society

decreased the survey intra-service time by 1 minute to be the same as the base code 11102. The RUC recommends 6 minutes of intra-service time. The RUC noted that it is appropriate that this add-on is not exactly half of the base code because there is not much duplication of services as this is performed on a separate site than the base code and there is additional physician work to transition to a different site.

The RUC noted that this service requires 4 minutes less than the deleted code 11101 (work RVU = 0.41 and 10 minutes intra-service time), thus the recommended lower work RVU for 11103 is appropriate to account for this decrease in time. The RUC referenced similar services 15272 *Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 0.33 and 10 minutes intra-service time) and 15276 *Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 0.50 and 10 minutes intra-service time) to support the recommendation. **The RUC recommends a work RVU of 0.38 for CPT code 11103.**

11104 Punch biopsy of skin, (including simple closure when performed); single lesion
The RUC reviewed the survey results from 101 dermatologists and determined that the survey respondents overestimated the work required to perform these services relative to other skin biopsy codes and services in the Medicare Physician Payment Schedule. Based on preliminary comments from the RUC and the reduction in intra-service time, the specialty society reduced their original recommendations. The specialty society recommended a direct work RVU crosswalk to 69220 *Debridement, mastoidectomy cavity, simple (eg, routine cleaning)* (work RVU = 0.83 and 10 minutes of intra-service time), as these services require the same intra-service time and require the same physician work to perform. The RUC noted that the punch biopsy is deeper and there is more bleeding than the tangential biopsy.

The RUC indicated a concern whether this service will be reported with an Evaluation and Management (E/M) on the same day as it was typical with the previous deleted code. The specialty society recommended decreasing the pre-evaluation by 2 minutes to account for any possible overlap with an E/M. The RUC also noted that the scrub, dress and wait time is 1 more minute for the punch biopsy compared to the tangential biopsy (11102) to account for the typical patient having deeply invasive carcinoma that is sclerotic, therefore additional anesthesia care is necessary for more injections. The RUC recommends 3 minutes pre-evaluation time, 2 minutes positioning and 3 minutes scrub, dress and wait time, 10 minutes intra-service time and 5 minutes immediate post-service time.

The RUC compared 11104 to the key reference service 12011 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less* (work RVU = 1.07 and 12 minutes intra-service time), which the survey respondents indicated that the intensity to complete 11104 was 57% identical and 33% more. **The RUC recommends a work RVU of 0.83 for CPT code 11104.**

11105 Punch biopsy of skin, (including simple closure when performed); each separate/additional lesion (List separately in addition to code for primary procedure)
The RUC reviewed the survey results from 101 dermatologists and determined that the survey respondents overestimated the work required to perform these services relative to other skin biopsy codes and services in the Medicare Physician Payment Schedule. Based on preliminary comments from the RUC, the specialty society reduced their original recommendations. The specialty society recommends a direct work RVU crosswalk to 92134 *Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina* (work RVU = 0.45 and 10 minutes of intra-service time) as these services require

the same intra-service time and require the same physician work to perform. The specialty indicated that 11105 is not just a larger or contiguous procedure but is a second procedure at a different site or side. The RUC recommends 10 minutes of intra-service time. The RUC noted that it is appropriate that this add-on is not exactly half of the base code because there is not much duplication of services as this is performed on a separate site than the base code and there is some additional work to transition to a different site.

The RUC referenced key reference service code 11045 *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 0.50 and 15 minutes intra-service time) and noted that the surveyed code requires less physician time and work and is appropriately valued lower. **The RUC recommends a work RVU of 0.45 for CPT code 11105.**

11106 Incisional biopsy of skin (eg, wedge), (including simple closure when performed); single lesion
The RUC reviewed the survey results from 101 dermatologists and determined that the survey respondents overestimated the work required to perform these services relative to other skin biopsy codes and services in the Medicare Physician Payment Schedule. Based on preliminary comments from the RUC, the specialty society reduced their original recommendations. The specialty society recommended a direct work RVU crosswalk to 11042 *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less* (work RVU = 1.01 and 15 minutes of intra-service time) as these services require the same intra-service time and require the same physician work to perform.

The specialty society indicated that this service will never be reported with an E/M on the same day as this service will be a separate appointment. The RUC agreed that 11106 requires 1 more minute of positioning than 11102 and 11104 to have the patient lie down and access the lower extremity. The RUC recommends 6 minutes pre-evaluation time, 3 minutes positioning and 3 minutes scrub, dress and wait time, 15 minutes intra-service time and 6 minutes immediate post-service time.

For additional support the RUC referenced MPC code 12002 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm* (work RVU = 1.14 and 15 minutes intra-service time) and similar service 46614 *Anoscopy; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)* (work RVU = 1.00 and 15 minutes intra-service time). **The RUC recommends a work RVU of 1.01 for CPT code 11106.**

11107 Incisional biopsy of skin (eg, wedge), (including simple closure when performed); each separate/additional lesion (List separately in addition to code for primary procedure)
The RUC reviewed the survey results from 101 dermatologists and determined that the survey respondents overestimated the work required to perform these services relative to other skin biopsy codes and services in the Medicare Physician Payment Schedule. Based on preliminary comments from the RUC, the specialty society reduced their original recommendations. The specialty society recommended a direct work RVU crosswalk to 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 and 15 minutes of intra-service time as these services require the same intra-service time and require the same physician work to perform. The specialty indicated that 11107 is not just a larger or contiguous procedure but is a second procedure at a different site or side. The RUC recommends 15 minutes of intra-service time. The RUC noted that it is appropriate that this add-on is not exactly half the value of the base code because there is not much duplication of services as this is performed on a separate site than the base code and there is some additional work to transition to a different site.

The RUC referenced similar service 11045 *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 0.50 and 15 minutes intra-service time) and noted that these services require similar physician work and time to perform. **The RUC recommends a work RVU of 0.54 for CPT code 11107.**

Practice Expense
The PE Subcommittee made some initial modifications and the RUC reviewed the direct practice expenses and made the following additional modifications:

- Removed any inputs associated with an Evaluation and Management service for 11102 and 11104
- Adjusted the assist physician time to 2/3 for 11102 and 11103
- Removed any inputs related to cautery for 11102 and 11103
- Confirmed that a sterile environment for all six services was justified

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.

Structural Allograft (Tab 6)
John Heiner, MD (AAOS) and William Creevy, MD, MS (AAOS)

In February 2017, the CPT Editorial Panel created three new add-on codes to describe allografts. These three new add-on codes were originally accepted by the Panel at the September/ October 2016 RUC meeting, but deferred until CPT 2019 pending specialty submission of add-on code designation and terminology. The codes will be designated as add-on codes and revised to more accurately describe the structural allograft procedures they represent.

20932 ***Allograft, includes templating, cutting, placement and internal fixation when performed; osteoarticular, including articular surface and contiguous bone***
The RUC reviewed the survey results from 49 physicians and agreed with the following physician time component: intra-service time of 140 minutes. The RUC reviewed the recommended work RVU of 13.01 which is the survey 25th percentile and agreed that this value appropriately accounts for the physician work involved. To justify the work RVU of 13.01, the RUC referenced CPT code 22843 *Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments* (work RVU= 13.44, intra-service time of 120 minutes) and noted that both services have similar intra-services and total times and therefore should be valued similarly. The RUC also reviewed CPT code 22844 *Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments* (work RVU= 16.42, intra-service time of 150 minutes) and noted that both services have similar intra-service and total times, further supporting a work RVU at the 25th percentile of 13.01 for the survey code. **The RUC recommends a work RVU of 13.01 for CPT code 20932.**

20933 ***Allograft, includes templating, cutting, placement and internal fixation when performed; hemicortical intercalary, partial (ie, hemicylindrical)***
The RUC reviewed the survey results from 49 physicians and agreed with the following physician time component: intra-service time of 130 minutes. The RUC reviewed the recommended work RVU of 11.94 which is the survey 25th percentile and agreed that this value appropriately accounts for the physician work involved. To justify the work RVU of 11.94, the RUC referenced CPT code 22842 *Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments* (work RVU= 12.56, intra-service time of 105 minutes) and noted that both services have similar intra-service times, total

times, and involve a similar amount of physician work and therefore should be valued similarly. The RUC also reviewed CPT code 22843 *Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments* (work RVU= 13.44, intra-service time of 120 minutes) and noted that both services have similar intra-service and total times, further supporting a work RVU of 11.94 for the survey code. **The RUC recommends a work RVU of 11.94 for CPT code 20933.**

20934 ***Allograft, includes templating, cutting, placement and internal fixation when performed; intercalary, complete (ie, cylindrical)***
The RUC reviewed the survey results from 49 physicians and agreed with the following physician time component: intra-service time of 135 minutes. The RUC reviewed the recommended work RVU of 13.00 which is the survey 25th percentile and agreed that this value appropriately accounts for the physician work involved. To justify the work RVU of 13.00, the RUC referenced CPT code 22842 *Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments* (work RVU= 12.56, intra-service time of 105 minutes) and noted that both services have similar intra-service times, total times, and involve a similar amount of physician work and therefore should be valued similarly. The RUC also reviewed CPT code 22844 *Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments* (work RVU= 16.42, intra-service time of 150 minutes) and noted that both services have similar intra-service and total times, further supporting a work RVU of 13.00 for the survey code. **The RUC recommends a work RVU of 13.00 for CPT code 20934.**

Practice Expense
There are no direct practice expense inputs for CPT codes 20932- 20934. These services are facility-only and do not require any clinical staff pre-service time.

Cardiac Event Recorder Procedures (Tab 7)
Richard Wright, MD (ACC); Mark Schoenfeld, MD (HRS); Thad Waites, MD (ACC); David Slotwiner, MD (HRS)

In February 2017, the CPT Editorial Panel created two new codes replacing cardiac event recorder codes to reflect new technology. The Panel also conducted editorial revisions to six codes to clarify *physiologic* monitor and *subcutaneous* cardiac rhythm monitor systems.

33285 ***Insertion, subcutaneous cardiac rhythm monitor, including programming***
The RUC reviewed the survey results from 66 physicians and agreed with the following physician time component: pre-service time of 20 minutes, intra-service time of 10 minutes, and post-service time of 10 minutes. The RUC reviewed the survey 25th percentile work RVU of 1.81 and determined that the survey respondents somewhat overestimated the work required to perform this service. Based on preliminary comments from the RUC, the specialty societies reduced their original recommendations. The specialty societies recommended a direct work RVU crosswalk to CPT code 52000 *Cystourethroscopy (separate procedure)* (work RVU= 1.53, pre-service time of 20 minutes, intra-service time of 10 minutes, and post-time of 10 minutes). The RUC agreed that this value appropriately accounts for the physician work involved, noting that both services have identical work RVUs, intra-service and post-service times, and therefore should be valued similarly. The RUC also reviewed CPT code 62322 *Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance* (work RVU= 1.55, pre-service time of 18 minutes, intra-service time of 11 minutes, and post-service time of 10 minutes) and noted that both services have very similar intra-service times, identical post-service times, and involve a similar amount of physician work, further supporting a work RVU below the 25th percentile of 1.53 for the survey code. The survey code, a 000 global period code, replaces the

deleted 090 global period CPT code 33282. **The RUC recommends a work RVU of 1.53 for CPT code 33285.**

33286 ***Removal, subcutaneous cardiac rhythm monitor***
The RUC reviewed the survey results from 66 physicians and agreed with the following physician time component: pre-service time of 20 minutes, intra-service time of 15 minutes, and post-service time of 10 minutes. The RUC reviewed the recommended work RVU of 1.50 which is at the 25th percentile and agreed that this value appropriately accounts for the physician work involved. To justify the work RVU of 1.50, the RUC referenced CPT code 57452 *Colposcopy of the cervix including upper/adjacent vagina;* (work RVU= 1.50, pre-service time of 15 minutes, intra-service time of 15 minutes, and post-time of 10 minutes) and noted that both services have identical work RVUs, intra-service, and post-service times, and therefore should be valued similarly. The RUC also reviewed CPT code 52000 *Cystourethroscopy (separate procedure)* (work RVU= 1.53, pre-service time of 20 minutes, intra-service time of 10 minutes, and post-time of 10 minutes) and noted that both services have similar intra-service times, identical post-service times and involve a similar amount of physician work, further supporting a work RVU at the 25th percentile of 1.50 for the survey code. The survey code has a slightly higher intra-service time and a slightly lower work value compared to 33285 because more intense physician work is required to insert the device than to remove the device from a patient. The survey code, a 000 global period code, replaces the deleted 090 global period CPT code 33284. **The RUC recommends a work RVU of 1.50 for CPT code 33286.**

Affirmation of RUC Recommendations
The RUC affirmed the recent RUC recommendations for CPT codes 93285, 93290, 93291, 93297, 93298, and 93299 previously submitted after review in this coding cycle. The relativity within the family remains correct.

Practice Expense
The PE Subcommittee reviewed the direct practice expense inputs and made the following minor changes: moved clinical staff time for provide pre-service education/obtain consent from pre-service to service period and removed supply items: shave prep tray (SA067) and heparin (SH039). The PE Subcommittee noted that the device used for this service is a high-cost supply and reiterated the RUC's recommendation that high-cost supplies be separately reimbursable through J-codes. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

New Technology/New Services
CPT codes 33285 and 33286 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.

Continuous Glucose Monitoring (PE Only) (Tab 8)
John A. Seibel, MD (AACE); Mary Newman, MD (ACP); Allan R. Glass, MD (ES)
Facilitation Committee #3

In April 2013, CPT code 95251 was identified through the High Volume Growth screen and the RUC recommended surveying 95251 and 95250 for January 2014. In May 2014, the CPT Editorial Panel created two Category I codes to report continuous glucose monitoring (CGM) via patient managed "real time" monitoring device and revised two Category I codes to report continuous glucose monitoring via provider managed "retrospective" monitoring device. At the September 2014 RUC meeting, the specialty requested withdrawal of CPT codes 9525X1 and 9525X2 in order to take these codes back to CPT to restructure and better define the timeframe described. The specialty society communicated with the CPT Editorial Panel to rescind codes 9525X1 and 9525X2 at the October 2014 CPT meeting to allow the specialties to submit a new coding change proposal. The RUC recommended referral to the CPT Editorial Panel. However,

the most recent specialty society proposed revisions were not approved by CPT and the specialty societies indicated there is new information to present to the Relativity Assessment Workgroup. The specialty societies requested that the Workgroup review its action plan at the April 2016 meeting. In April 2016, the specialty societies indicated that the growth of these services has steadied in the most recent five years and should be removed from the screen. The Workgroup noted that the 2013 Workgroup recommendation was to survey these services based on the high growth in the years examined and these services have not been reviewed in over ten years. CPT codes 95250 and 95251 were surveyed for October 2016.

In October 2016, at the Practice Expense Subcommittee, there was extensive discussion around the issue of what codes are appropriate to report when the patient owns the equipment versus when the practice owns the equipment. The specialties clarified that CPT code 95250 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording,* since it is a PE-only code, should not be reported when the equipment is owned by the patient. In this scenario, only CPT code 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report* would be reported. The RUC agreed with the Subcommittee that it is important that either education or a CPT parenthetical be created to clarify the appropriate reporting of these services. The RUC recommended this service be referred to the CPT Editorial Panel Executive Committee to provide a solution to ensure correct coding occurs. In February 2017 the CPT Editorial Panel revised CPT codes 95250 and 95251 and created a new code to differentiate between physician-owned and patient-owned equipment.

95250 ***Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording***
The RUC reviewed the direct practice expense inputs for CPT code 95250 and discussed that these inputs had been reviewed and approved by the PE Subcommittee at the October 2016 RUC meeting. The Subcommittee agreed with the specialty that there had been no change since that time and the inputs remained appropriate. **The RUC affirmed the direct practice expense inputs for CPT code 95250 as reviewed and approved by the PE Subcommittee in October 2016.**

95249 ***Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training and printout of recording***
The RUC reviewed the direct practice expense inputs for new PE-only code 95249 and agreed with the specialty that the service is the same as CPT code 95250, except that the physician staff does not remove and clean the patient's equipment. The RUC discussed that CPT code 95250 was based on a survey conducted by the specialty society when the code was reviewed in October 2016 and at that time the PE Subcommittee approved 47 minutes for training on the device and 25 minutes for downloading and analyzing the data. The RUC discussed the following points:

- The CGM device includes one durable medical equipment (DME) item, the data receiver, and two supply items, the sensor and transmitter. The expected useful life of the CGM device is about 3 years.
- Code 95249 includes two patient visits to the provider office. During the first visit the staff performs extensive patient education, as indicated on the PE SoR. During the subsequent visit, the staff performs significant data manipulation, as also indicated on the PE SoR. **The RUC recommends referral to the CPT Editorial Panel to add introductory language indicating that when data are collected outside the provider office, as when the patient uses a phone app, code 95249 cannot be billed.**

- The proposed time for each visit is based on time-and-motion studies performed by the society, which recorded actual service times for 41 patients who were treated by 5 providers.
- **The RUC recommends referral to the CPT Editorial Panel to add introductory language indicating that 95249 is to be billed only once during the entire period that the patient owns the data receiver. The code cannot be billed for any subsequent use of the CGM device by the patient or physician. Code 95249 cannot be billed when the patient receives a new sensor or transmitter.**

  The RUC agreed to accept the specialty society's original proposal to crosswalk the PE inputs for CPT code 95249 to the recommended inputs for CPT code 95250 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording* (work RVU=0.00), which were submitted to CMS following the October 2016 RUC meeting with the removal of 5 of clinical staff time to *Remove continuous glucose monitoring sensor* and 5 minutes to *Perform procedure/service in post-service period---NOT directly related to physician work time,* (previously listed as clinical activity, *download data*) because the clinical staff would not be cleaning the patient-owned equipment during the post-service period when they downloading and analyze the patient data, as they would in CPT code 95250. The specialties will provide a letter to the CPT Editorial Panel outlining the recommended language for guidelines as indicated above to be added as an editorial change to CPT code 95249. **Additionally, the RUC recommends that the specialty work with the AMA to develop a CPT Assistant article to clarify appropriate use of the new CPT code 95249, specifically that the code should only be reported when instructing the patient on use of a new data receiver and cannot be reported when data is collected outside of the provider office. The RUC recommends the PE inputs as originally submitted by the specialty society and reviewed and approved by the PE Subcommittee with further modifications by the RUC.**

  The RUC affirmed its October 2016 recommendations for 95250 and 95251 without modification.

<u>Chronic Care Management Services (Tab 9)</u>
John Agens, MD,(AGS); Jennifer Aloff, MD, (AAFP); Kevin Kerber, MD (AAN); Mary Newman MD, (ACP)
Facilitation Committee #3

In February 2017, the CPT Editorial Panel created a new code to describe at least 30 minutes of chronic care management services performed personally by the physician or qualified health care professional over one calendar month. This service is different than existing chronic care management services 99490 *Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month…*(work RVU = 0.61) and 99487 *Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month* (work RVU = 1.00) which are performed by clinical staff under the supervision of a physician. The patient acuity criteria for all these services are the same but the physician work is different and more intense for 99491. CPT code 99491 cannot be reported with 99490 or 99487 and must capture all the work for the month.

The RUC reviewed the survey results from 153 physicians for CPT code 99491 and determined that the survey 25th percentile of 1.45 work RVUs appropriately accounts for the work required to

perform this service. The RUC recommends 30 minutes of intra-service time for 99491. The RUC compared the surveyed code to the top key reference service 99214 (work RVU = 1.50, 25 minutes intra-service time and 40 minutes total time) and determined that the physician work and time for 99491 is slightly less as this is a non face-to-face service. For additional support, the RUC referenced similar service 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU= 1.42 and 29 minutes total time). **The RUC recommends a work RVU of 1.45 for CPT code 99491.**

Practice Expense
There is a single clinical staff time input for this service, 15 minutes to *Perform procedure/service---NOT directly related to physician work time* and no supplies or equipment. The 15 minutes of time is distributed throughout the month and the clinical staff will typically perform the following tasks during this time:

- Relaying/communicating patient messages,
- Communication with patient and/or pharmacy for prescription refills, prior authorizations or clarifications (assisting physician with paperwork for DME may be included here, or separately)
- Coordination with outside agencies or other providers (i.e. Obtaining referral forms, tracking down documentation of care received outside the primary care office or tracking down results on tests ordered by provider other that the PCP)

An observer from CMS questioned why the clinical labor staff time is half that of the physician time. The specialty societies indicated that the clinical staff services would include patient maintenance activities such as answering questions, refilling prescriptions and calling home care agencies, that would extend beyond any activities included in other Evaluation and Management services. An additional concern that the description of clinical labor staff work may overlap with the physician work was addressed during the review. The specialty societies indicated that it is possible that in rare cases the requirements for 99490 (20 minutes clinical staff time) and 99491 (30 minutes of physician time) could both be met. However, this would not be the typical case and this situation would only arise if both the physician time and the clinical staff were tracked and documented. If both are tracked and documented then the physician would have the choice as to which code to report. **The RUC recommends that the specialties work with the AMA to develop a CPT Assistant article to clarify the proper reporting of code 99491 versus 99490. The RUC recommends the direct practice expense inputs without modification as submitted by the specialty societies and approved by the Practice Expense Subcommittee.**

New Technology/New Services
This service 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.

<u>Injection Tendon Origin/Insertion (Tab 10)</u>
Matthew Grierson, MD (AAPMR); Brooke Bisbee, DPM (APMA); Lloyd Smith, DPM (APMA); Ann Miller-Breslow, MD (ASSH); William Creevy, MD (AAOS); John Heiner, MD (AAOS); Fredrica Smith, MD (ACRh); Peter Mangone, MD (AOFAS)

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. CPT code 20551 was identified on this list.

The RUC reviewed the survey results from 249 podiatrists, rheumatologists, physiatrists, orthopaedic surgeons, hand surgeons and foot and ankle surgeons and determined that it was appropriate to maintain the current work RVU of 0.75, which also represents both the survey

median and 25th percentile. The specialty societies recommended pre-time package 6, but reduced the package evaluation time from 17 minutes to 5 minutes to account for overlap in time with and E/M service that is typically reported on the same day. The RUC carefully examined potential overlap with an E/M service and recommends 5 minutes evaluation time, 1 minute positioning time, 5 minutes scrub/dress/wait time, 5 minutes of intra-service time, and 5 minutes of post-service time. The five minutes of evaluation time includes time to obtain consent after discussion of possible complications and also includes time to prepare for the procedure which includes confirming availability of necessary supplies and instruments and preparation of syringes; one with local anesthetic and one with mixed anesthetic and steroid. The one minute for positioning includes both positioning the patient for the injection and confirming the injection site. The five minutes for scrub/dress/wait time accounts for prepping the injection site, injecting the local anesthetic and waiting for anesthetic effect.

The RUC compared CPT code 20551 to the top two key reference service codes 20550 *Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")* (work RVU = 0.75) and 20605 *Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance* (work RVU = 0.68) and noted that the recommended total pre-service time of 11 minutes is consistent with the pre-service time in the key reference service codes both of which include a reduction in time to account for an E/M service billed concurrently. Key reference code 20550 represents the same overall work while the second key reference code 20605 involves somewhat less physician work. This is supported by the intensity/complexity measures from providers familiar with both services that indicated 20551 is more complex/intense than 20605. Further, the recommended value maintains the accepted intensity/complexity rank order and relativity for code 20551 with many other injection procedures requiring 5 minutes of intra-service time. For additional support, the RUC compared the survey code to multi-specialty point of comparison CPT codes 67820 *Correction of trichiasis; epilation, by forceps only* (work RVU = 0.71) and 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU = 0.84). Finally, the RUC also compared code 20551 with 12 other recently reviewed and similar codes that have 5 minutes of intra-time and determined that a work RVU of 0.75 is appropriate relative to these other services. The RUC determined that the key reference codes and comparable MPC codes support maintaining the current work value for the survey code.

The RUC agreed with the consensus of the specialty societies that the physician work for this service has not changed since 2002 and recommends that the work RVU be maintained as supported by the current survey 25th and median work RVU. **The RUC recommends a work RVU of 0.75 for CPT code 20551.**

In addition, the RUC observed that there are inconsistencies in the Medicare Claims Processing Manual (Manual) related to reporting an E/M service on the same day as a minor procedure. While acknowledging the CMS staff citation from the manual, Chapter 12, Section 40.1, paragraph B, regarding reporting an E/M visit with a 000-day global code and the expectation that all of the focused evaluation work is included in the global period, the presenters noted that in two other sections of the same Manual chapter, the guidance provided is different. Specifically, Section 40.1 paragraph C and Section 40.2 paragraph A (#8) of the Manual confirm that it is permissible to report an E/M code on the same day as a minor surgical procedure when a significant, separately identifiable service is also performed. It is appropriate to append modifier 25 to the E/M code in instances where a significant, separately identifiable evaluation and management service is performed by same physician on the day of a procedure. The RUC also noted this Section of the Manual corresponds to CPT Modifier 25 instructions which state: "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service

above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported."

Further, the specialty societies identified potential misreporting of CPT code 20551. For CMS consideration, the Medicare Provider Utilization data indicates that 15 nurse practitioners and physician assistants out of over 1700 providers represented 21% of the total 2014 utilization. In addition, these 15 providers typically reported CPT code 20551 in units of 4-5 per day/session. **The RUC requests that CMS investigate the potential misreporting of CPT code 20551.**

Practice Expense
The Practice Expense Subcommittee reduced the time to *Prepare room, equipment and supplies* (CA013) from 3 minutes to the standard of 2 minutes. The PE Subcommittee discussed the potential for overlap with the evaluation and management service with the time for preparing the room, supplies and equipment. It was determined that this time addresses the preparation of the supplies related directly to the injection itself including logging injectables (eg, name, lot, expiration date) into the medical record and does not overlap with preparing the room for an E/M visit. CMS staff questioned whether the patients present with pain only and tried to discern any overlap with E/M. The specialties explained that it is typical to first examine the patient to determine where the pain is coming from and to determine if an injection or another procedure is medically necessary. Often times, the initial treatment is conservative medical management. In addition, the PE Subcommittee discussed the potential for overlap with E/M with the time for clean room/equipment. It was determined that the cleaning time for this code addresses the cleaning of supplies related directly to the injection itself, including sharps disposal and logging injectables back into storage, and was appropriate.

At the RUC meeting, there was discussion that the exam light should be removed. The light was erroneously left in by the Subcommittee with the assumption that it was part of the standard office E/M. The RUC agreed to removal of the exam light. The RUC recommends the direct practice expense inputs as approved with modification by the PE Subcommittee and an additional amendment by the RUC.

Application of Long Arm Splint (Tab 11)
Anne Miller, MD (ASSH); William Creevy, MD (AAOS); John Heiner, MD (AAOS); Ethan Booker, MD (ACEP); Jordan Celeste, MD (ACEP)

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. CPT code 29105 was identified on this list.

The RUC reviewed the survey results from 157 emergency medicine physicians, orthopaedic surgeons and hand surgeons and determined that it was appropriate to recommend a work RVU of 0.80 which is the survey median and less than the current work value. The specialty societies recommended pre-time package 1, but reduced the package evaluation time from 13 minutes to 5 minutes to account for overlap in time because this service is typically reported with an E/M on the same day. The scrub/dress/ wait time was reduced by 5 minutes to 1 minute for donning protective clothing for the procedure which involves water and plaster. The specialty recommended post-time package 7a, but reduced the time from 18 minutes to 5 minutes to be consistent with the survey median time. This reflects a reduction of 4 minutes from the current Harvard post-service time. The RUC carefully examined potential overlap with an E/M and recommends 5 minutes evaluation time, 1 minute positioning time, 1 minute scrub/dress/wait

time for a total of 7 minutes pre-service time, 20 minutes intra-service time, and 5 minutes of post-service time.

The RUC compared CPT code 29105 to the top two key reference service codes 29075 *Application, cast; elbow to finger (short arm)* (work RVU = 0.77) and 29405 *Application of short leg cast (below knee to toes);* (work RVU = 0.80) and noted that the recommended total pre-service time of 7 minutes is consistent with the pre-service time in both key reference service codes and represents the same overall work as in 29405. Further, the recommended post-service time of 5 minutes is consistent with the post-service time for both key reference service codes. The recommended value is also supported by the intensity/complexity measures which indicated that 29105 is more complex/intense than both key reference service codes. For additional support, the RUC referenced MPC codes 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66) and 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU = 0.84) and agreed that these codes appropriately bracket 29105. **The RUC recommends a work RVU of 0.80 for CPT code 29105.**

In addition, the RUC observed that there are inconsistencies in the Medicare Claims Processing Manual (Manual) related to reporting an E/M service on the same day as a minor procedure. While acknowledging the CMS staff citation from the manual, Chapter 12, Section 40.1, paragraph B, regarding reporting an E/M visit with a 000-day global code and the expectation that all of the focused evaluation work is included in the global period, the presenters noted that in two other sections of the same Manual chapter, the guidance provided is different. Specifically, Section 40.1 paragraph C and Section 40.2 paragraph A (#8) of the Manual confirm that it is permissible to report an E/M code on the same day as a minor surgical procedure when a significant, separately identifiable service is also performed. It is appropriate to append modifier 25 to the E/M code in instances where a significant, separately identifiable evaluation and management service is performed by same physician on the day of a procedure. The RUC also noted this Section of the Manual corresponds to CPT Modifier 25 instructions which state: "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported."

Practice Expense

The Practice Expense Subcommittee had an extensive discussion about clinical staff time being potentially duplicative of physician work, but agreed with the society that two people are required to perform this procedure. The PE Subcommittee also discussed the potential for overlap with an E/M service. The specialty societies indicated that when a patient is first seen for an injury, an E/M is appropriate since evaluation of the patient will include more than a focused exam of the extremity. The patient's neurological status will be evaluated and the patient will be sent for x-rays. Once the x-rays are reviewed and it is determined that splinting is appropriate (which may not always be the case), the splinting procedure is reviewed with the patient, consent is obtained and the physician verifies all supplies and equipment is available, positions the patient, and dons protective clothing. The PE Subcommittee agreed that this additional work did not overlap with the E/M service. The only modification was a change from supply item *gown, patient* (SB026) to *gown, staff, impervious* (SB027) since a patient gown is just tissue paper without arm covering and would not protect the physician during the splinting procedure. The RUC recommends the direct practice expense inputs with one modification as reviewed and approved by the PE 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.

Percutaneous Change of G-tube (Tab 12)
R. Bruce Cameron, MD (ACG); Dawn Francis, MD (AGA); Seth Gross, MD (ASGE); Ethan Booker, MD (ACEP); Jordan Celeste, MD (ACEP); Charles Mabry, MD (ACS); Nader Massarweh, MD (ACS)
Facilitation Committee #1

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. CPT code 43760 was identified on this list.

43760 ***Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance***
The RUC reviewed the survey results from 295 emergency medicine physicians, gastroenterologists and general surgeons. The specialties presented the combined survey summary data for all specialties that surveyed and also presented the survey summary data separated out for each specialty. After reviewing the data, the RUC noted that the current survey data was bimodal with ED physicians reporting less time than GI and GS physicians. The RUC determined that because ED physicians were the dominant Medicare provider (37%), the work RVU for 43760 would need to be reflective of the work and time for ED physicians. However, the RUC also noted that because the data was bimodal, it may be appropriate to consider changes in the CPT descriptors to better differentiate physician work.

The specialty societies recommended pre-time package 1, but reduced the package evaluation time from 13 minutes to 5 minutes to account for overlap in time with an E/M reported on the same day. The scrub, dress, wait time and post-service time were also reduced, to be consistent with the survey median time. The RUC carefully examined potential overlap with an E/M service and agreed with the following physician time component: 5 minutes of pre-service evaluation time, 1 minute of pre-service positioning time, 3 minutes of pre-service scrub, dress, wait time, 7 minutes of intra-service time, and 5 minutes of post-service time.

The specialties recommended maintaining the current work RVU of 0.90 which was also the survey 25th percentile work RVU, however, the RUC determined 0.90 somewhat overestimated the work. The RUC noted that the previous survey did not include the dominant provider (ED physicians) whose time and work estimates in the current survey were lower than the GI and GS physicians. To identify an appropriate valuation, the RUC reviewed CPT code 20550 *Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")* (work RVU = 0.75, pre-service evaluation time of 5 minutes, pre-service positioning time of 1 minute, pre-service scrub, dress, wait time of 5 minutes, intra-service time of 5 minutes, and immediate post-service time of 5 minutes). The RUC noted that although code 20550 requires less intra-service time, the total time is the same for both services. The RUC also agreed that both services would require similar total physician work and should be valued similarly. Therefore, the RUC recommends a direct work RVU crosswalk from code 20550 to 43760. For additional support, the RUC also reviewed MPC codes 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66, pre-service time of 11 minutes, intra-service time of 5 minutes, post-service time of 5 minutes, and total time of 21 minutes) and 45300 *Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU= 0.80, pre-service time of 7 minutes, intra-service time of 10 minutes, post-service time of 10 minutes, and total time of 27 minutes) and determined these MPC codes appropriately bracket a work RVU of 0.75 for 7 minutes of intra-service time. **The RUC recommends a work RVU of 0.75 for CPT code 43760.**

In addition, the RUC observed that there are inconsistencies in the Medicare Claims Processing Manual (Manual) related to reporting an E/M service on the same day as a minor procedure. While acknowledging the CMS staff citation from the manual, Chapter 12, Section 40.1, paragraph B, regarding reporting an E/M visit with a 000-day global code and the expectation that all of the focused evaluation work is included in the global period, the presenters noted that in two other sections of the same Manual chapter, the guidance provided is different. Specifically, Section 40.1 paragraph C and Section 40.2 paragraph A (#8) of the Manual confirm that it is permissible to report an E/M code on the same day as a minor surgical procedure when a significant, separately identifiable service is also performed. It is appropriate to append modifier 25 to the E/M code in instances where a significant, separately identifiable evaluation and management service is performed by same physician on the day of a procedure. The RUC also noted this Section of the Manual corresponds to CPT Modifier 25 instructions which state: "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.

Practice Expense
The PE Subcommittee discussed that although this service is typically reported with an E/M service globally, this is only true for the facility setting. When this service is performed in a non-facility setting, an E/M service is only reported 6 percent of the time. Therefore, although adjustments were made to physician time to account for overlap of E/M time independent of place of service, there should be no adjustments to clinical staff time in the non-facility setting. The RUC reviewed the direct practice expense details for the non-facility setting and made the following modifications to supply items:

- Remove two SB001 *caps, surgical*;
- Remove one SB019 *drape-towel, sterile 18in x 26in*;
- Reduce two pairs to one SB024 *gloves, sterile;*
- Reduce two to one SB027 *gown, staff, impervious*;
- Reduce two to one SB034 *mask, surgical, with face shield;*
- Reduce two to one SB039 *shoe covers, surgical*

The RUC recommends the direct practice expense inputs as 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.

<u>Diagnostic Proctosigmoidoscopy - Rigid (Tab 13)</u>
Guy Orangio, MD, FACS (ASCRS); Charles Mabry, MD, FACS (ACS); Nader Massarweh, MD (ACS); Don Selzer, MD, FACS (SAGES); Ketan Sheth, MD, FACS (SAGES)

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. CPT code 45300 was identified via this screen.

45300 ***Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)***
The RUC reviewed the survey results from 96 general surgeons and colon and rectal surgeons and determined that it was appropriate to maintain the current work RVU of 0.80, which also represents the survey 25th percentile. The specialty societies recommended pre-time package 5, but reduced the package evaluation time from 7 minutes to 3 minutes to account for overlap in time because this service is typically reported with an E/M on the same day. The RUC carefully examined potential overlap with an E/M service and agreed with the following physician time component: 3 minutes pre-service evaluation time, 5 minutes pre-service positioning time, 2 minutes pre-service scrub, dress, wait time, 10 minutes of intra-service time, and 10 minutes of post-service time. The three minutes of evaluation time includes time to obtain consent after discussion of possible complications and preparing for the procedure which includes confirming availability of necessary supplies and instruments. The five minutes for positioning includes positioning the patient prone and effacing the buttocks. The two minutes for scrub, dress, wait time accounts for donning protective clothing and applying topical anesthesia.

To justify the work RVU of 0.80, the RUC referenced the key reference code 45330 *Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)* (work RVU= 0.84, pre-service time of 21 minutes, intra-service time of 10 minutes, and post-time of 10 minutes) and noted that both services involve a similar amount of physician work, have identical intra-service times, and therefore should be valued similarly. The RUC also reviewed MPC codes 51705 *Change of cystostomy tube; simple* (work RVU= 0.90, pre-service time of 12 minutes, intra-service time of 10 minutes, and post-service time of 10 minutes) and 20553 *Injection(s); single or multiple trigger point(s), 3 or more muscles* (work RVU= 0.75, pre-service time of 12 minutes, intra-service time of 10 minutes, and post-service time of 5 minutes) and noted that both services involve a similar amount of physician work and appropriately bracket a work RVU of 0.80 for the survey code. Lastly, the RUC reviewed a series of other diagnostic endoscopy procedures and agreed that a work RVU of 0.80 appropriately ranks 45300 relative to these services. **The RUC recommends a work RVU of 0.80 for CPT code 45300.**

In addition, the RUC observed that there are inconsistencies in the Medicare Claims Processing Manual (Manual) related to reporting an E/M service on the same day as a minor procedure. While acknowledging the CMS staff citation from the manual, Chapter 12, Section 40.1, paragraph B, regarding reporting an E/M visit with a 000-day global code and the expectation that all of the focused evaluation work is included in the global period, the presenters noted that in two other sections of the same Manual chapter, the guidance provided is different. Specifically, Section 40.1 paragraph C and Section 40.2 paragraph A (#8) of the Manual confirm that it is permissible to report an E/M code on the same day as a minor surgical procedure when a significant, separately identifiable service is also performed. It is appropriate to append modifier 25 to the E/M code in instances where a significant, separately identifiable evaluation and management service is performed by same physician on the day of a procedure. The RUC also noted this Section of the Manual corresponds to CPT Modifier 25 instructions which state: "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.

Practice Expense
The Practice Expense Subcommittee verified that there is no overlap in the direct practice expense inputs with an E/M service that is typically reported on the same day. The Subcommittee removed 3 minutes of pre-service time in the non-facility setting for c*omplete pre-procedure phone calls and prescription* (CA005) since a pre-service phone call is included in an E/M service. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Removal of Intraperitoneal Catheter (Tab 14)
Charles Mabry, MD, FACS (ACS); Nader Massarweh, MD, FACS (ACS); Matthew Sideman, MD, FACS (SVS); Francesco Aiello, MD, FACS (SVS)

In October 2016, CPT code 49422 was identified as a site of service anomaly because Medicare data from 2012-2014 indicated that it was performed less than 50% of the time in the inpatient setting, yet included inpatient hospital Evaluation and Management services within the global period. The RUC determined that this service would be placed on the next level of interest form to survey for April 2017. Prior to survey, the specialty societies requested that the service be changed from a 010 day global to a 000 day global. As a rationale, the specialties indicated that code 49422 may be performed due to: catheter site infection; fractured/blocked catheter; or discontinued need for catheter. Based on a review of billed-with data, 49422 is reported alone almost 60% of the time and billed with creation of an A-V fistula or renal transplantation less than 12% of the time. Therefore, removal is most typically required for infection. Patients with an IP catheter-related infection that does not respond to oral antibiotic treatment will have the catheter removed and will be placed on different oral or IV antibiotics after removal. Depending on severity of the infection and response to post-removal antibiotics, the patient may be discharged within 24 hours or may be hospitalized for several days. This dichotomy is evident with the almost equal 2015 Medicare site-of-service split for inpatient (47%) and outpatient (47%) claims. If the patient undergoes catheter removal, antibiotic treatment, and is released the next day, it is most likely that the patient will follow-up with the nephrologist. In these cases, the patient may not return to the surgeon's office for suture removal. On the other hand, if a patient undergoes catheter removal and is unresponsive or slow to respond to antibiotic treatment, the patient will likely be admitted to the hospital for several days and the infection site will be monitored by the surgeon, as necessary, to determine if additional procedures/surgery is necessary. CMS agreed with this rationale and reassigned the global period to 000-day. The specialty society surveyed this service as a 000-day global period.

49422 ***Removal of tunneled intraperitoneal catheter***
The RUC reviewed the survey results from 37 general and vascular surgeons and determined that the survey 25th percentile work RVU of 4.00 appropriately accounted for the work required to perform this service. The RUC recommends 33 minutes of pre-service evaluation time, 3 minutes of pre-service positioning, 10 minutes of pre-service scrub/dress/wait, 45 minutes intra-service time and 20 minutes post-service time. The specialty societies argued that the survey respondents indicated that the physician work, time and intensity was identical to the top key reference code 49421 *Insertion of tunneled intraperitoneal catheter for dialysis, open* (work RVU = 4.21 and 45 minutes intra-service time). The RUC thoroughly discussed the intensity and work required to perform the removal of intraperitoneal catheter compared to the insertion. The specialty societies indicated that the active peritonitis, necessity of nasogastric tube, scarred fascia and risk of entering the peritoneum and bowel to safely dissect and remove the double cuff catheter contribute to a higher intensity than the insertion and that the removal code has always been valued higher than the insertion code for these reasons. However, the RUC disagreed and noted that it is generally straightforward to free the catheter from the adhesions and it is not more intense or difficult than the insertion.

The RUC compared the surveyed code to CPT codes 49406 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous* (work RVU = 4.00 and 40 minutes intra-service time) and 50432 *Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation* (work RVU = 4.00 and 48 minutes intra-service time) and determined these services require the same physician work to perform. **The RUC recommends a work RVU of 4.00 for CPT code 49422.**

Practice Expense
The Practice Expense Subcommittee modified the direct practice expense inputs by reducing the pre-service clinical staff time to the standard for minimal use of clinical staff, and reducing *conduct patient communication*s (CA037) to one rather than two phone calls at 3 minutes. The RUC approved the direct practice expense inputs with modifications as reviewed and approved by the PE Subcommittee.

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

Vaginal Treatments (Tab 15)
George Hill, MD (ACOG); Jon Hathaway, MD, PhD (ACOG); Mitch Schuster, MD (ACOG)

In the Final Rule for 2017, CMS finalized the list of 000-day global services reported with an E/M 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. CPT codes 57150 and 57160 were identified as part of this screen.

57150 ***Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease***
The RUC reviewed the survey results from 131 gynecologists and recommends a work RVU of 0.50 which is supported by a direct work RVU crosswalk to 2nd key reference code CPT code 51701 *Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)* (work RVU = 0.50, 5 minutes intra-service time and 24 minutes total time) and falls below both the survey 25th percentile and the current work value. To further support a work RVU of 0.50, the RUC crosswalked the survey code to CPT code 17250 *Chemical cauterization of granulation tissue (proud flesh, sinus or fistula* (work RVU = 0.50, 5 minutes intra-service time and 17 minutes total time) and noted that the survey code has the same intra-service time and nearly identical total time and intensity. The RUC noted that the recommended decrease in work is reflective of the decrease in intra-service time. For additional support, the RUC also referenced top key reference CPT code 51700 *Bladder irrigation, simple, lavage and/or instillation* (work RVU = 0.60) and MPC code 51702 *Insertion of temporary indwelling bladder catheter; simple (eg, Foley)* (work RVU = 0.50).

The RUC examined the pre-service times for potential overlap with E/M and recommends 6 minutes evaluation time, 3 minutes positioning time, 1 minute scrub/dress/wait time, 5 minutes intra-service time, and 3 minutes of immediate post-service time. The RUC agrees with the direct crosswalk recommendation of 0.50 work RVUs and believes that it appropriately ranks this procedure within the obstetrics/gynecology family. **The RUC recommends a work RVU of 0.50 for CPT code 57150.**

57160 ***Fitting and insertion of pessary or other intravaginal support device***
The RUC reviewed the survey results from 228 gynecologists and determined that it was appropriate to maintain the current work RVU of 0.89, below the survey 25th percentile. The RUC discussed the time recommendations to ensure they accounted for potential overlap with E/M and removed 1 minute of scrub/dress/wait which is not typical for this service. The RUC recommends 7 minutes evaluation time, 3 minutes positioning time, 15 minutes intra-service time, and 9 minutes of immediate post-service time. The survey respondents indicated an increase from 5 to 9 minutes of immediate post-service time. The specialty society indicated and the RUC agreed that the increase in post-service time is due to a greater push towards more conservative care with more thorough evaluation and fitting of multiple pessaries if necessary.

For additional support, the RUC compared the survey code to MPC codes 67820 *Correction of trichiasis; epilation, by forceps only* (work RVU = 0.71) and 11042 *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less* (work RVU = 1.01) and noted that the survey code fits appropriately within the obstetrics/gynecology family. **The RUC recommends a work RVU of 0.89 for CPT code 57160.**

In addition, the RUC observed that there are inconsistencies in the Medicare Claims Processing Manual (Manual) related to reporting an E/M service on the same day as a minor procedure. While acknowledging the CMS staff citation from the manual, Chapter 12, Section 40.1, paragraph B, regarding reporting an E/M visit with a 000-day global code and the expectation that all of the focused evaluation work is included in the global period, the presenters noted that in two other sections of the same Manual chapter, the guidance provided is different. Specifically, Section 40.1 paragraph C and Section 40.2 paragraph A (#8) of the Manual confirm that it is permissible to report an E/M code on the same day as a minor surgical procedure when a significant, separately identifiable service is also performed. It is appropriate to append modifier 25 to the E/M code in instances where a significant, separately identifiable evaluation and management service is performed by same physician on the day of a procedure. The RUC also noted this Section of the Manual corresponds to CPT Modifier 25 instructions which state: "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported."

Practice Expense
The specialty society explained that they are asking for additional supply items over the current inputs because there appears to be a database error and needed supplies for the service are missing from when this service was last reviewed in 2005. The specialty explained that the vignette for 57150 only describes the application of medicament, but for the typical patient the physician does both the irrigation and the application of medicament. The PE Subcommittee discussed that the supplies have to reflect the vignette used in the survey and that the specialty has the option of revising the vignette and resurveying or taking the code to the CPT Editorial Panel and revising the descriptor or possibly dividing out the code into two codes. For CPT code 57150, the PE Subcommittee eliminated the following supplies based on the description of the service and the vignette:

- SB027 gown, staff, impervious
- SB034 mask, surgical, with face shield
- SB039 shoe covers, surgical
- SD029 catheter, red rubber

And added the following supply:

- SB006 drape, non-sterile, sheet 40in x 60in

The PE Subcommittee did not modify CPT code 57160. 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 will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Biopsy of Uterus Lining (Tab 16)
George Hill, MD (ACOG); Jon Hathaway, MD, PhD (ACOG); Mitch Schuster, MD (ACOG); Mark Shahin, MD (ACOG)
Facilitation Committee #2

In the Final Rule for 2017, CMS finalized the list of 000-day global services reported with an E/M 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. CPT code 58100 was identified on this list and 58110 was surveyed as part of the family.

58100 ***Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)***
The RUC reviewed the survey results from 94 obstetricians and gynecologists and determined that the survey 25th percentile work RVU of 1.21 accurately reflected the physician work necessary for this service. The pre-service time for scrub/dress/wait was eliminated and the RUC noted that the one minute needed to apply the topical anesthesia is appropriately performed during the intra-service period. This practice of including the topical anesthesia in the intra-service time period is different than most other services but is not unusual for gynecological procedures and is also standard practice in some otolaryngology services. The specialty society decreased the surveyed pre-service evaluation to account for any overlap with the associated E/M service and CPT code 58100. The RUC recommends following times: 7 minutes evaluation time, 3 minutes positioning time, 10 minutes intra-service time, and 5 minutes post-service time.

The RUC compared CPT code 58100 to the top two key reference service codes 57456 *Colposcopy of the cervix including upper/adjacent vagina; with endocervical curettage* (work RVU = 1.85) and 56821 *Colposcopy of the vulva; with biopsy(s)* (work RVU = 2.05) and noted that the survey code had less total time and inappropriately high intensity at the median value; therefore, the RUC recommends the 25th percentile value. **The RUC recommends a work RVU of 1.21 for CPT code 58100.**

58110 ***Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 91 obstetricians and gynecologists and determined that it was appropriate to maintain the current work RVU of 0.77 for add-on code 58110. The RUC reviewed the existing work RVU of 0.77 which is below the 25th percentile and agreed that this value appropriately accounts for the physician work involved. The RUC compared CPT code 58110 to key reference service CPT code 76802 (work RVU = 0.83 and 10 minutes intra-service time) and noted that both require similar physician work and time to complete. The RUC recommends maintaining the current value with the survey intra-service time of 12 minutes **The RUC recommends a work RVU of 0.77 for CPT code 58110.**

In addition, the RUC observed that there are inconsistencies in the Medicare Claims Processing Manual (Manual) related to reporting an E/M service on the same day as a minor procedure.

While acknowledging the CMS staff citation from the manual, Chapter 12, Section 40.1, paragraph B, regarding reporting an E/M visit with a 000-day global code and the expectation that all of the focused evaluation work is included in the global period, the presenters noted that in two other sections of the same Manual chapter, the guidance provided is different. Specifically, Section 40.1 paragraph C and Section 40.2 paragraph A (#8) of the Manual confirm that it is permissible to report an E/M code on the same day as a minor surgical procedure when a significant, separately identifiable service is also performed. It is appropriate to append modifier 25 to the E/M code in instances where a significant, separately identifiable evaluation and management service is performed by same physician on the day of a procedure. The RUC also noted this Section of the Manual corresponds to CPT Modifier 25 instructions which state: "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported."

Practice Expense:
The RUC recommends the practice expenses without modification as submitted by the specialty society and approved by the PE 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.

Injection - Greater Occipital Nerve (Tab 17)
Brooke Bisbee, DPM (APMA); Lloyd Smith, DPM (AAOS); William Creevy, MD (AAOS); John Heiner, MD (AAOS); Peter Mangone, MD (AOFAS)

In the Final Rule for 2017, CMS finalized the list of 000-day global services reported with an E/M 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. CPT code 64405 was identified on this list.

The RUC reviewed the survey results from 175 physicians from four different specialties and determined that it was appropriate to maintain the current work RVU of 0.94, which also represents the survey 25th percentile. The specialty societies recommended pre-time package 5, but reduced the package evaluation time by one minute to account for overlap because this service is typically reported with an E/M on the same day. The post-service time was reduced by 5 minutes in accordance with the survey results. The RUC carefully examined potential overlap with E/M services included in CPT 64405 and further reduced the pre-service evaluation time by 1 minute to 5 minutes. In addition, the RUC reduced the positioning time by 2 minutes and removed the 3 minutes of pre-service time for scrub/dress/wait because local anesthetic is not typical prior to this procedure but is included in the injection itself. The RUC recommends 5 minutes evaluation time, 1 minute positioning time, 5 minutes of intra-service time, and 5 minutes of immediate post-service time.

The RUC compared the survey code to the top two key reference services 20526 *Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel* (work RVU = 0.94) and 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66) and noted that the current work RVU of the survey code is appropriately equal to carpal tunnel and higher than the other injections. The 2nd key reference code 20526 represents identical overall work and total time. For additional support, the RUC compared the survey code to several multi-specialty point of comparison CPT codes: 67820 *Correction of trichiasis; epilation, by forceps only* (work

RVU = 0.71), 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU = 0.84), 51720 *Bladder instillation of anticarcinogenic agent (including retention time)* (work RVU = 0.87) and 20527 *Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)* (work RVU = 1.00), and agreed that the survey 25th percentile of 0.94 places survey code 64405 in proper rank order. The RUC determined that the key reference services and comparable MPC codes support maintaining the current value for the survey code.

The RUC further agreed with the consensus of the specialty societies that the physician work for this service has not fundamentally changed since it was last reviewed in 2010 as part of the 4th Five-Year Review and recommends that the work RVU be maintained at the 25th percentile in accordance with the most recent survey. **The RUC recommends a work RVU of 0.94 for CPT code 64405.**

In addition, the RUC observed that there are inconsistencies in the Medicare Claims Processing Manual (Manual) related to reporting an E/M service on the same day as a minor procedure. While acknowledging the CMS staff citation from the manual, Chapter 12, Section 40.1, paragraph B, regarding reporting an E/M visit with a 000-day global code and the expectation that all of the focused evaluation work is included in the global period, the presenters noted that in two other sections of the same Manual chapter, the guidance provided is different. Specifically, Section 40.1 paragraph C and Section 40.2 paragraph A (#8) of the Manual confirm that it is permissible to report an E/M code on the same day as a minor surgical procedure when a significant, separately identifiable service is also performed. It is appropriate to append modifier 25 to the E/M code in instances where a significant, separately identifiable evaluation and management service is performed by same physician on the day of a procedure. The RUC also noted this Section of the Manual corresponds to CPT Modifier 25 instructions which state: "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported."

Practice Expense
The Practice Expense Subcommittee eliminated any clinical staff time and supplies that overlap with an evaluation and management service as the code is reported with an E/M more than 50% of the time. Additionally the RUC removed the exam light (EQ168) as it would not typically be used for this service and would not be in a standard room used for evaluation and management. The RUC recommends the direct practice expense inputs with modifications as reviewed and approved by the PE Subcommittee.

Injection – Digital Nerves (Tab 18)
Brooke Bisbee, DPM (APMA); Lloyd Smith, DPM (AAOS); William Creevy, MD (AAOS); John Heiner, MD (AAOS); Peter Mangone, MD (AOFAS)

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. CPT code 64455 was identified on this list.

64455 ***Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)***
The RUC reviewed the survey results from 205 orthopaedic surgeons, foot and ankle surgeons and podiatrists and determined that the current value of 0.75, which was also the survey 25th

percentile and median, appropriately accounts for the work required to perform this service. The specialty societies recommended pre-time package 6, but reduced the package evaluation time from 17 minutes to 5 minutes to account for overlap in time with an E/M reported on the same day. The RUC carefully examined potential overlap with E/M services included in CPT code 64455 and recommends 5 minutes evaluation time, 1 minute positioning time, 5 minutes scrub/dress/wait time, 5 minutes of intra-service time and 5 minutes of post-service time. The five minutes of evaluation time includes time to obtain consent after discussion of possible complications and preparing for the procedure which includes confirming availability of necessary supplies and instruments and preparation of syringes; one with local anesthetic and one with mixed anesthetic and steroid. The one minute for positioning includes both positioning the patient for the injection and confirming the injection site. The five minutes for scrub/dress/wait time accounts for prepping the injection site, injecting the local anesthetic and waiting for anesthetic effect.

The RUC compared CPT code 64455 to the top two key reference services 64450 *Injection, anesthetic agent; other peripheral nerve or branch* (work RVU = 0.75) and 20550 *Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")* (work RVU = 0.75) and agreed that all three injections would require the same physician work and time justifying maintaining the current value. For additional support the RUC referenced MPC codes 67820 *Correction of trichiasis; epilation, by forceps only* (work RVU = 0.71) and 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU = 0.84). **The RUC recommends a work RVU of 0.75 for CPT code 64455.**

In addition, the RUC observed that there are inconsistencies in the Medicare Claims Processing Manual (Manual) related to reporting an E/M service on the same day as a minor procedure. While acknowledging the CMS staff citation from the manual, Chapter 12, Section 40.1, paragraph B, regarding reporting an E/M visit with a 000-day global code and the expectation that all of the focused evaluation work is included in the global period, the presenters noted that in two other sections of the same Manual chapter, the guidance provided is different. Specifically, Section 40.1 paragraph C and Section 40.2 paragraph A (#8) of the Manual confirm that it is permissible to report an E/M code on the same day as a minor surgical procedure when a significant, separately identifiable service is also performed. It is appropriate to append modifier 25 to the E/M code in instances where a significant, separately identifiable evaluation and management service is performed by same physician on the day of a procedure. The RUC also noted this Section of the Manual corresponds to CPT Modifier 25 instructions which state: "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported."

Practice Expense

The Practice Expense Subcommittee reduced the time to *Prepare room, equipment and supplies* (CA013) from 3 minutes to the standard of 2 minutes. The PE Subcommittee discussed the potential for overlap with the evaluation and management service with the time for preparing the room, supplies and equipment. It was determined that this time addresses the preparation of the supplies related directly to the injection itself including logging injectables (eg, name, lot, expiration date) into the medical record and does not overlap with preparing the room for an E/M visit. CMS staff questioned whether the patients present with pain only and tried to discern any overlap with E/M. The specialties explained that it is typical to first examine the patient to determine where the pain is coming from and to determine if an injection or another procedure is medically necessary. Often times, the initial treatment is conservative medical management. In addition, the PE Subcommittee discussed the potential for overlap with E/M with the time for

clean room/equipment. It was determined that the cleaning time for this code addresses the cleaning of supplies related directly to the injection itself, including sharps disposal and logging injectables back into storage, and was appropriate. Additionally the RUC removed the *exam light* (EQ168) as it would not typically be used for this service and would not be in a standard room used for evaluation and management. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Removal of Foreign Body - Eye (Tab 19)
David B. Glasser, MD (AAO) and Charlie Fitzpatrick, OD (AOA)

In the Final Rule for 2017, CMS finalized the list of 000-day global services reported with an E/M 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. CPT codes 65205 and 65210 were identified as part of this screen.

65205 ***Removal of foreign body, external eye; conjunctival superficial***
The RUC reviewed the survey results from 47 ophthalmologists and optometrists and determined that it was appropriate to recommend a work RVU of 0.49, which is less than both the survey 25th percentile and the current work value. The specialty societies decreased the survey pre-service evaluation time from 7 minutes to 3 minutes to account for any overlap in work between the associated E/M service and CPT code 65205. The RUC recommends 3 minutes pre-service evaluation time, 1 minute pre-service scrub/dress/wait time, 3 minutes intra-service time and 4 minutes of immediate post-service time.

The RUC noted that the physician work required to perform CPT code 65205 and the procedure itself has not fundamentally changed. However, the survey respondents indicated that the intra-servie time is two minutes less, decreasing from 5 minutes to 3 minutes. Since the survey 25th percentile work RVU is higher than the current work RVU, the RUC recommends a direct crosswalk to the second top key reference service 68200 *Subconjunctival injection* (work RVU = 0.49 and 11 minutes total time). CPT codes 65205 and 68200 both require the same total time to perform and the survey respondents indicated that the overall intensity and complexity of these services is identical (67%). The RUC also compared the survey code to the top key reference service 65222 *Removal of foreign body, external eye, corneal, with slit lamp* (work RVU = 0.84 and 15 minutes total time) and noted that 65222 requires more physician work and time to complete and is appropriately valued higher. Additionally, the survey respondents indicated that the survey code is overall similar or slightly less intense. **The RUC recommends a work RVU of 0.49 for CPT code 65205.**

65210 ***Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating***
The RUC reviewed the survey results from 39 ophthalmologists and optometrists and determined that the survey 25th percentile work value of 0.75 accurately reflects the physician work necessary for this service. The specialty societies decreased the survey pre-service evaluation time and immediate post-service time to account for any overlap in work between the associated E/M service and CPT code 65210. The RUC recommends the following times: 3 minutes pre-service evaluation time, 1 minute pre-service scrub/dress/wait time, 5 minutes intra-service time and 4 minutes immediate post-service time.
The RUC noted that CPT code 65210 had never been surveyed and was based on Harvard time which contributed to the median survey intra-service time of 5 minutes being less than half of the current value of 13 minutes. The RUC agreed with the consensus of the specialty societies that the procedure has not fundamentally changed and recommends a work RVU at the 25th percentile in accordance with the recent survey.

The RUC compared CPT code 65210 to the top key reference service code 65222 *Removal of foreign body, external eye; corneal, with slit lamp* (work RVU = 0.84) and noted that the intensity and complexity measures for the survey code were similar to those for the key reference service code. For additional support, the RUC referenced MPC codes 20553 *Injection(s); single or multiple trigger point(s), 3 or more muscles* (work RVU = 0.75) and 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66) and similar service CPT code 64450 *Injection, anesthetic agent; other peripheral nerve or branch* (work RVU = 0.75). **The RUC recommends a work RVU of 0.75 for CPT code 65210.**

In addition, the RUC observed that there are inconsistencies in the Medicare Claims Processing Manual (Manual) related to reporting an E/M service on the same day as a minor procedure. While acknowledging the CMS staff citation from the manual, Chapter 12, Section 40.1, paragraph B, regarding reporting an E/M visit with a 000-day global code and the expectation that all of the focused evaluation work is included in the global period, the presenters noted that in two other sections of the same Manual chapter, the guidance provided is different. Specifically, Section 40.1 paragraph C and Section 40.2 paragraph A (#8) of the Manual confirm that it is permissible to report an E/M code on the same day as a minor surgical procedure when a significant, separately identifiable service is also performed. It is appropriate to append modifier 25 to the E/M code in instances where a significant, separately identifiable evaluation and management service is performed by same physician on the day of a procedure. The RUC also noted this Section of the Manual corresponds to CPT Modifier 25 instructions which state: "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported."

Practice Expense:
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 will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

X-Ray Spine (Tab 20)
Kurt Schoppe, MD (ACR); Daniel Wessell, MD (ACR); John Heiner, MD (AAOS); William Creevy, MD (AAOS); Gregory N. Nicola, MD (ASN); Melissa Chen, MD (ASN)

In October 2016, the Relativity Assessment Workgroup expanded the CMS/Other Source codes screen, lowering the Medicare utilization threshold from 250,000 to 100,000 based on 2015 Medicare utilization data. CPT codes 72020 and 72072 were captured on this screen. The family was expanded to include CPT codes 72040, 72050, 72052, 72070, 72074, 72080, 72100, 72110, 72114, and 72120. The Workgroup recommended the specialty societies survey these services for April 2017, with a strong recommendation that the Research Subcommittee consider the specialty societies' request to allow direct crosswalks to similar services for physician work and time.

In February, the Research Subcommittee approved for the specialties to utilize a crosswalk methodology to make physician work and physician time recommendations in lieu of conducting a RUC survey. The Research Subcommittee had reviewed the recommendation made by the specialty societies to crosswalk times and values for these identified codes to other codes performed by the specialty societies. On the Research Subcommittee conference call, the

specialty societies explained that when determining an appropriate crosswalk, they tried to find RUC reviewed codes that were similar in service and time, performed on similar anatomical site, required similar number of views and required similar patient positions. The Research Subcommittee agreed that the methodology employed by the specialty was appropriate for these services, noting past precedent of the Research Subcommittee approving a similar request for X-ray codes in 2010. As part of its discussion, the Subcommittee noted that it would not recommend for the specialty to propose using lower work RVU crosswalks to justify maintaining the value of higher work RVU codes.

72020 ***Radiologic examination, spine, single view, specify level***
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared the code under review to CPT code 73551 *Radiologic examination, femur; 1 view* (work RVU of 0.16, pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minutes) and noted that both services should be valued similarly as both studies have identical intra-service and total times. In addition, both services are single view examinations typically obtained to check alignment post reduction or for surgical planning. The RUC agreed that the current work RVU for 72020 of 0.15 should be maintained. **The RUC recommends a work RVU of 0.15 for CPT code 72020.**

72040 ***Radiologic examination, spine, cervical; 2 or 3 views***
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared the code under review to CPT code 71100 *Radiologic examination, ribs, unilateral; 2 views* (work RVU of 0.22, pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minutes) and noted that both services should be valued similarly as both services have similar intra-service and total times, while studies of the spine are typically more intense to perform. In addition, both exams are multi-view examinations, typically 2 views, of complex anatomic regions. Therefore, the RUC recommends a direct work RVU crosswalk from code 71100 to 72040. **The RUC recommends a work RVU of 0.22 for CPT code 72040.**

72050 ***Radiologic examination, spine, cervical; 4 or 5 views***
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 5 minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared the code under review to CPT code 72082 *Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); 2 or 3 views* (work RVU of 0.31, pre-service time of 1 minute, intra-service time of 6 minutes and post-service time of 1 minute) and noted that both services should be valued similarly as both services have similar intra-service and total times. In addition, both studies are multi-view examinations of complex anatomic regions. CPT code 72082 typically involves anteroposterior (AP) and lateral views of the thoracic and lumbar spine obtained on 4 images. Two images are stitched together to form the AP view and the other two stitched together to form the lateral view. CPT code 72050 typically consists of AP, lateral and bilateral oblique views of the cervical spine. Therefore, the RUC recommends a direct work

RVU crosswalk from code 72082 to 72050. **The RUC recommends a work RVU of 0.31 for CPT code 72050.**

72052 ***Radiologic examination, spine, cervical; 6 or more views***
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 5 minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared the code under review to CPT code 72083 *Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); 4 or 5 views* (work RVU of 0.35, pre-service time of 1 minute, intra-service time of 7 minutes and post-service time of 1 minute) and noted that both services should be valued similarly as, although the reference code includes slightly more intra-service time, the code under review is a somewhat more intense service to perform. In addition, both studies are multi-view examinations of complex anatomic regions. CPT code 72083 typically involves anteroposterior (AP), lateral and bending views of the thoracic and lumbar spine obtained on multiple images. Pairs of images are stitched together to form the AP, lateral and bending views. CPT code 72052 typically consists of AP, lateral, bilateral oblique, flexion and extension views of the cervical spine. Therefore, the RUC recommends a direct work RVU crosswalk from code 72083 to 72052. **The RUC recommends a work RVU of 0.35 for CPT code 72052.**

72070 ***Radiologic examination, spine; thoracic, 2 views***
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared the code under review to CPT code 71100 *Radiologic examination, ribs, unilateral; 2 views* (work RVU of 0.22, pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute) and noted that both services should be valued similarly as both services have similar intra-service and total times. In addition, both exams are 2 views and cover the same anatomic region, with one focused on the 12 thoracic vertebral bodies and the other the 12 thoracic ribs. Therefore, the RUC recommends a direct work RVU crosswalk from code 71100 to 72070. **The RUC recommends a work RVU of 0.22 for CPT code 72070.**

72072 Radiologic examination, spine; thoracic, 3 views
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared the code under review to CPT code 71100 *Radiologic examination, ribs, unilateral; 2 views* (work RVU of 0.22, pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute) and noted that both services should be valued similarly as both services have identical intra-service and total times. In addition, both studies cover the same anatomic region, with one focused on the 12 thoracic vertebral bodies and the other the 12 thoracic ribs. Therefore, the RUC recommends a direct work RVU crosswalk from code 71100 to 72072. **The RUC recommends a work RVU of 0.22 for CPT code 72072.**

72074 ***Radiologic examination, spine; thoracic, minimum of 4 views***
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared the code under review to CPT code 71100 *Radiologic examination, ribs, unilateral; 2 views* (work RVU of 0.22, pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute) and noted that both services should be valued similarly as both services have identical intra-service and total times. In addition, both studies cover the same anatomic region, with one focused on the 12 thoracic vertebral bodies and the other the 12 thoracic ribs. Therefore, the RUC recommends a direct work RVU crosswalk from code 71100 to 72074. **The RUC recommends a work RVU of 0.22 for CPT code 72074.**

72080 ***Radiologic examination, spine; thoracolumbar junction, minimum of 2 views***
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared the code under review to CPT code 71100 *Radiologic examination, ribs, unilateral; 2 views* (work RVU of 0.22, pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute) and noted that both services should be valued similarly as both services have identical intra-service and total times. In addition, both exams are 2 views and cover the similar anatomic regions, with one focused on the thoracic region and the other the lower thoracic and upper lumbar region. Therefore, the RUC recommends a direct work RVU crosswalk from code 71100 to 72080. **The RUC recommends a work RVU of 0.22 for CPT code 72080.**

72100 ***Radiologic examination, spine, lumbosacral; 2 or 3 views***
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared the code under review to CPT code 71100 *Radiologic examination, ribs, unilateral; 2 views* (work RVU of 0.22, pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute) and noted that both services should be valued similarly as both services have similar intra-service and total times, while studies of the spine are typically more intense to perform. In addition, both exams have similar numbers of views and cover similar anatomic regions, with one focused on the thoracic region and the other the lower thoracic and upper lumbar region. Therefore, the RUC recommends a direct work RVU crosswalk from code 71100 to 72100. **The RUC recommends a work RVU of 0.22 for CPT code 72100.**

72110 ***Radiologic examination, spine, lumbosacral; minimum of 4 views***
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 5 minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared the code under review to CPT code 72082 *Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and*

sacral spine if performed (eg, scoliosis evaluation); 2 or 3 views (work RVU of 0.31, pre-service time of 1 minute, intra-service time of 6 minutes and post-service time of 1 minute) and noted that both services should be valued similarly as both services have similar intra-service and total times. In addition, both studies are multi-view examinations of complex anatomic regions. CPT code 72082 typically involves anteroposterior (AP) and lateral views of the thoracic and lumbar spine obtained on 4 images. Two images are stitched together to form the AP view and the other two stitched together to form the lateral view. CPT code 72110 typically consists of AP, lateral and bilateral oblique views of the lumbosacral spine. Therefore, the RUC recommends a direct work RVU crosswalk from code 72082 to 72110. **The RUC recommends a work RVU of 0.31 for CPT code 72110.**

72114 ***Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views***
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 5 minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared the code under review to CPT code 72082 *Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); 2 or 3 views* (work RVU of 0.31, pre-service time of 1 minute, intra-service time of 6 minutes and post-service time of 1 minute) and noted that both services should be valued similarly as both services have similar intra-service and total times. In addition, both exams are multi-view examinations of complex anatomic regions. CPT code 72082 typically involves anteroposterior (AP) and lateral views of the thoracic and lumbar spine obtained on 4 images. Two images are stitched together to form the AP view and the other two stitched together to form the lateral view. CPT code 72114 typically consists of AP, lateral, bilateral oblique and bending views of the lumbosacral spine. Therefore, the RUC recommends a direct work RVU crosswalk from code 72082 to 72114. **The RUC recommends a work RVU of 0.31 for CPT code 72114.**

72120 ***Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views***
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared the code under review to CPT code 71100 *Radiologic examination, ribs, unilateral; 2 views* (work RVU of 0.22, pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute) and noted that both services should be valued similarly as both services have similar intra-service and total times, while studies of the spine are typically more intense to perform. In addition, both exams have similar numbers of views and cover similar anatomic regions, with one focused on the thoracic region and the other the lower thoracic and upper lumbar region. Therefore, the RUC recommends a direct work RVU crosswalk from code 71100 to 72120. **The RUC recommends a work RVU of 0.22 for CPT code 72120.**

Practice Expense
The RUC recommends the direct practice expense inputs as submitted by the specialty societies and reviewed and approved 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.

X-Ray Sacrum (Tab 21)
Kurt Shoppe, MD (ACR); Daniel Wessell, MD (ACR); John Heiner, MD (AAOS); William Creevy, MD (AAOS)

In October 2016, the Relativity Assessment Workgroup expanded the CMS/Other Source codes screen, lowering the Medicare utilization threshold from 250,000 to 100,000 based on 2015 Medicare utilization data. CPT code 72220 *Radiologic examination, sacrum and coccyx, minimum of 2 views* was captured on this screen. The family was expanded to include CPT codes 72200 *Radiologic examination, sacroiliac joints; less than 3 views* and 72202 *Radiologic examination, sacroiliac joints; 3 or more views*. The Workgroup recommended the specialty societies survey these services for April 2017, with a strong recommendation that the Research Subcommittee consider the specialty societies request to allow direct crosswalks to similar services for physician work and time.

In February, the Research Subcommittee approved for the specialties to utilize a crosswalk methodology to make physician work and physician time recommendations in lieu of conducting a RUC survey. The Research Subcommittee had reviewed the recommendation made by the specialty societies to crosswalk times and values for these identified codes to other codes performed by the specialty societies. On the Research Subcommittee conference call, the specialty societies explained that when determining an appropriate crosswalk, they tried to find RUC reviewed codes that were similar in service and time, performed on similar anatomical site, required similar number of views and required similar patient positions. The Research Subcommittee agreed that the methodology employed by the specialty was appropriate for these services, noting past precedent of the Research Subcommittee approving a similar request for X-ray codes in 2010. As part of its discussion, the Subcommittee noted that it would not recommend for the specialty to propose using lower work RVU crosswalks to justify maintaining the value of higher work RVU codes.

72200 ***Radiologic examination, sacroiliac joints; less than 3 views***
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared the code under review to CPT code 73610 *Radiologic examination, ankle; complete, minimum of 3 views* (work RVU of 0.17, pre-service time of 1 minute, intra-service time of 3 minutes, post-service time of 1 minute) and noted that both services should be valued similarly as both studies have identical intra-service and total times. In addition, CPT code72200 describes a less than 3 view examination of the sacroiliac joints, which typically would include an anteroposterior (AP) view of both sacroiliac joints and an oblique view of the symptomatic joint. The evaluation of both sacroiliac joints on the AP and one joint on the oblique view is similar to the evaluation of a unilateral ankle joint on 3 views for CPT code 73610. Therefore, the RUC recommends a direct work RVU crosswalk from code 73610 to 72200. **The RUC recommends a work RVU of 0.17 for CPT code 72200.**

72202 ***Radiologic examination, sacroiliac joints; 3 or more views***
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared the code under review to CPT code 73562 *Radiologic examination, knee; 3 views* (work RVU of 0.18, pre-service time of 1 minute,

intra-service time of 4 minutes, post-service time of 1 minute) and noted that both services should be valued similarly as both studies have identical intra-service and total times. In addition, CPT code 72202 describes a minimum 3 view examination of both sacroiliac articulations, which is similar to the 3 view knee examination and CPT code 73562, evaluates both the patellofemoral and tibiofemoral articulations. Therefore, the RUC recommends a direct work RVU crosswalk from code 73562 to 72202. **The RUC recommends a work RVU of 0.18 for CPT code 72202.**

72220 ***Radiologic examination, sacrum and coccyx, minimum of 2 views***
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared the code under review to CPT code 73630 *Radiologic examination, foot; complete, minimum of 3 views* (work RVU of 0.17, pre-service time of 1 minute, intra-service time of 3 minutes, post-service time of 1 minute) and noted that both services should be valued similarly as both studies have identical intra-service and total times. In addition, 72220 describes a minimum 2 view radiologic examinations of the 5 sacral segments and 4 coccygeal segments, which is typically performed as a 3 view study similar to the typical 3 view examination of the foot. Therefore, the RUC recommends a direct work RVU crosswalk from code 73630 to 72220. **The RUC recommends a work RVU of 0.17 for CPT code 72220.**

Practice Expense
The RUC recommends the direct practice expense inputs as submitted by the specialty societies and reviewed and approved 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.

X-Ray Elbow /Forearm (Tab 22)
Kurt Shoppe, MD (ACR); Daniel Wessell, MD (ACR); John Heiner, MD (AAOS); William Creevy, MD (AAOS); Anne Miller-Breslow, MD (ASSH)

In October 2016, the Relativity Assessment Workgroup expanded the CMS/Other Source codes screen, lowering the Medicare utilization threshold from 250,000 to 100,000 based on 2015 Medicare utilization data. CPT codes 73070 *Radiologic examination, elbow; 2 views* and 73090 *Radiologic examination; forearm, 2 views* were captured on this screen. The family was expanded to include CPT code 73080 *Radiologic examination, elbow; complete, minimum of 3 views*. The Workgroup recommended the specialty societies survey these services for April 2017, with a strong recommendation that the Research Subcommittee consider the specialty societies request to allow direct crosswalks to similar services for physician work and time.

In February, the Research Subcommittee approved for the specialties to utilize a crosswalk methodology to make physician work and physician time recommendations in lieu of conducting a RUC survey. The Research Subcommittee had reviewed the recommendation made by the specialty societies to crosswalk times and values for these identified codes to other codes performed by the specialty societies. On the Research Subcommittee conference call, the specialty societies explained that when determining an appropriate crosswalk, they tried to find RUC reviewed codes that were similar in service and time, performed on a similar anatomical site, required similar number of views and required similar patient positioning. The Research Subcommittee agreed that the methodology employed by the specialty was appropriate for these services, noting past precedent of the Research Subcommittee approving a similar request for X-

ray codes in 2010. As part of its discussion, the Subcommittee noted that it would not recommend for the specialty to propose using lower work RVU crosswalks to justify maintaining the value of higher work RVU codes.

73070 ***Radiologic examination, elbow; 2 views***
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared CPT code 73070 to CPT code 73600 *Radiologic examination, ankle; 2 views* (work RVU of 0.16, pre-service time of 1 minute, intra-service time of 3 minutes, post-service time of 1 minute) and noted that both services should be valued similarly as both studies were similar in physician work and time, include the articulation of two bones, require a similar number of views and require similar patient positioning. The RUC agreed that the current work RVU for 73070 of 0.15 should be maintained. **The RUC recommends a work RVU of 0.15 for CPT code 73070.**

73080 ***Radiologic examination, elbow; complete, minimum of 3 views***
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared CPT code 73080 to CPT code 73610 *Radiologic examination, ankle; complete, minimum of 3 views* (work RVU of 0.17, pre-service time of 1 minute, intra-service time of 3 minutes, post-service time of 1 minute) were similar in physician work and time, include the articulation of three bones (i.e. the humerus, radius and ulna in the elbow and the tibia, fibula and talus in the ankle), require a similar number of views and require similar patient positioning. Therefore, the RUC recommends a direct work RVU crosswalk from code 73610 to 73080. **The RUC recommends a work RVU of 0.17 for CPT code 73080.**

73090 ***Radiologic examination; forearm, 2 views***
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared CPT code 73090 to CPT code 73590 *Radiologic examination; tibia and fibula, 2 views* (work RVU of 0.15, pre-service time of 1 minute, intra-service time of 3 minutes, post-service time of 1 minute) and noted that both services should be valued similarly as both studies were similar in physician work and time, include examination of corresponding anatomic regions in the upper and lower extremity, require a similar number of views and require similar patient positioning. Therefore, the RUC recommends a direct work RVU crosswalk from code 73590 to 73090. **The RUC recommends a work RVU of 0.16 for CPT code 73090.**

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

X-Ray Heel (Tab 23)
Kurt Shoppe, MD (ACR); Daniel Wessell, MD (ACR); John Heiner, MD (AAOS); William Creevy, MD (AAOS); Brook Bisbee, DPM (APMA); Lloyd Smith, DPM (APMA); Peter Mangone, MD (AOFAS)

In October 2016, the Relativity Assessment Workgroup expanded the CMS/Other Source codes screen, lowering the Medicare utilization threshold from 250,000 to 100,000 based on 2015 Medicare utilization data. The Workgroup recommended the specialty societies survey these services for April 2017, with a strong recommendation that the Research Subcommittee consider the specialty societies request to allow direct crosswalks to similar services for physician work and time.

In February, the Research Subcommittee approved for the specialties to utilize a crosswalk methodology to make physician work and physician time recommendations in lieu of conducting a RUC survey. The Research Subcommittee had reviewed the recommendation made by the specialty societies to crosswalk times and values for these identified codes to other codes performed by the specialty societies. On the Research Subcommittee conference call, the specialty societies explained that when determining an appropriate crosswalk, they tried to find RUC reviewed codes that were similar in service and time, performed on a similar anatomical site, required similar number of views and required similar patient positioning. The Research Subcommittee agreed that the methodology employed by the specialty was appropriate for these services, noting past precedent of the Research Subcommittee approving a similar request for X-ray codes in 2010. As part of its discussion, the Subcommittee noted that it would not recommend for the specialty to propose using lower work RVU crosswalks to justify maintaining the value of higher work RVU codes.

73650 ***Radiologic examination; calcaneus, minimum of 2 views***
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared CPT code 73650 to CPT code 73600 *Radiologic examination, ankle; 2 views* (work RVU of 0.16, pre-service time of 1 minute, intra-service time of 3 minutes, post-service time of 1 minute) and noted that both services should be valued similarly as both studies have identical intra-service and total times. In addition, CPT codes 73650 and 73600 describe minimum 2 views, require similar positioning and include 2 view radiologic examinations of similar anatomic regions, the hind foot and ankle, respectively. Therefore, the RUC recommends a direct work RVU crosswalk from code 73600 to 73650. **The RUC recommends a work RVU of 0.16 for CPT code 73650.**

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

X-Ray Toe (Tab 24)
Kurt Shoppe, MD (ACR); Daniel Wessell, MD (ACR); John Heiner, MD (AAOS); William Creevy, MD (AAOS); Brook Bisbee, DPM (APMA); Lloyd Smith, DPM (APMA); Peter Mangone, MD (AOFAS)

In October 2016, the Relativity Assessment Workgroup expanded the CMS/Other Source codes screen, lowering the Medicare utilization threshold from 250,000 to 100,000 based on 2015 Medicare utilization data. The Workgroup recommended the specialty societies survey these services for April 2017, with a strong recommendation that the Research Subcommittee consider

the specialty societies request to allow direct crosswalks to similar services for physician work and time.

In February, the Research Subcommittee approved for the specialties to utilize a crosswalk methodology to make physician work and physician time recommendations in lieu of conducting a RUC survey. The Research Subcommittee had reviewed the recommendation made by the specialty societies to crosswalk times and values for these identified codes to other codes performed by the specialty societies. On the Research Subcommittee conference call, the specialty societies explained that when determining an appropriate crosswalk, they tried to find RUC reviewed codes that were similar in service and time, performed on a similar anatomical site, required similar number of views and required similar patient positioning. The Research Subcommittee agreed that the methodology employed by the specialty was appropriate for these services, noting past precedent of the Research Subcommittee approving a similar request for X-ray codes in 2010. As part of its discussion, the Subcommittee noted that it would not recommend for the specialty to propose using lower work RVU crosswalks to justify maintaining the value of higher work RVU codes.

73660 ***Radiologic examination; toe(s), minimum of 2 views***
The RUC reviewed the description of pre-service, intra-service and post-service work, expert panel recommendations and similar X-ray services which were recently RUC-reviewed and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

To determine an appropriate work RVU, the RUC compared CPT code 73660 to CPT code 73600 *Radiologic examination, ankle; 2 views* (work RVU of 0.16, pre-service time of 1 minute, intra-service time of 3 minutes, post-service time of 1 minute) and noted that both studies have identical intra-service and total times and require two views, however the reference code service is more complex to perform and therefore the work RVU for 73660 should be less than 73600. The RUC also noted that in April 2016 they recommended maintaining the work RVU of 0.13 for CPT code 73140 *Radiologic examination, finger(s), minimum of 2 views*. Although CMS has not published its determination for CPT code 73140 at this time, this code is another appropriate reference for 73660. The RUC agreed that the current work RVU for 73660 of 0.13 should be maintained. **The RUC recommends a work RVU of 0.13 for CPT code 73660.**

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

X-Ray Esophagus (Tab 25)
Kurt A. Schoppe, MD (ACR) and Daniel Wessell, MD (ACR)

In October 2016, the Relativity Assessment Workgroup expanded the CMS/Other Source codes screen, lowering the Medicare utilization threshold from 250,000 to 100,000 based on 2015 Medicare utilization data; CPT code 74220 was identified by this screen and 74210 and 74230 were identified as part of the same family of services. The Workgroup recommended the specialty societies survey these services for April 2017.

Compelling Evidence
The specialty society presented compelling evidence for codes 74210 and 74220. The society noted that the prior methodology for valuing these codes is unknown and considered flawed, as the source is CMS/Other. As the RUC has noted previously during review of other services, codes with the CMS/Other designation were never surveyed by the RUC or any other stakeholder; their physician time and work were assigned by CMS in rulemaking over 20 years ago using an unknown methodology. The specialty society also noted that an increase in value for these codes is justified

by the survey data, comparisons with the key reference services, and to maintain relativity within the family and other x-ray examinations of the digestive system. The RUC accepted that there is compelling evidence that CPT codes 74210 and 74220 were originally valued using a flawed methodology.

74210 ***Radiologic examination; pharynx and/or cervical esophagus***
The RUC reviewed the survey results from 50 radiologists and agreed with following physician time components: pre-service time of 3 minutes, intra-service time of 10 minutes and post-service time of 2 minute, resulting in a total of 15 minutes.

The RUC reviewed the survey 25th percentile work RVU of 0.59and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.59, the RUC compared the survey code to MPC code 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVU = 0.50, intra-service time of 10 minutes, total time of 13 minutes) and noted that both services have identical intra-service time, whereas the survey code involves more total time, justifying a somewhat higher valuation. To further support a work RVU of 0.59, the RUC compared the survey code to MPC code 76830 *Ultrasound, transvaginal* (work RVU =0.69, intra-service time of 10 minutes, total time of 23 minutes) and noted that both services have identical intra-service time, whereas CPT code 76830 involves somewhat more total time. The RUC agreed that the proposed valuation is appropriately bracketed by both MPC codes. **The RUC recommends a work RVU of 0.59 for CPT code 74210.**

74220 ***Radiologic examination; esophagus***
The RUC reviewed the survey results from 50 radiologists and agreed with following physician time components: pre-service time of 3 minutes, intra-service time of 10 minutes and post-service time of 2 minutes, resulting in a total of 15 minutes.

The RUC reviewed the survey 25th percentile work RVU of 0.67 and agreed that this value appropriately accounts for the physician work involved. The specialty noted and the RUC agreed that although both 74220 and 74210 take a similar amount of time to perform, 74220 is a more intense service to perform, indicating a somewhat higher work RVU is warranted. To justify a work RVU of 0.67, the RUC compared the survey code to MPC code 99282 *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 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 presenting problem(s) are of low to moderate severity* (work RVU = 0.88, intra-service time of 10 minutes, total time of 18 minutes) and noted that both services have identical intra-service time, whereas the reference code involves somewhat more total time, justifying a somewhat lower valuation for the survey code. To further support a work RVU of 0.67, the RUC compared the survey code to MPC code 76830 *Ultrasound, transvaginal* (work RVU of 0.69, intra-service time of 10 minutes, total time of 23 minutes) and noted that both services have identical intra-service time, whereas the survey code is a more intense service to perform. **The RUC recommends a work RVU of 0.67 for CPT code 74220.**

74230 ***Swallowing function, with cineradiography/videoradiography***
The RUC reviewed the survey results from 50 radiologists and agreed with following physician time components: pre-service time of 2 minutes, intra-service time of 10 minutes and post-service time of 3 minutes, resulting in a total of 15 minutes. During the post-service period, the specialty

explained and the RUC agreed that it is typical for the radiologist to discuss the study with the speech therapist, justifying a post-service time of 3 minutes.

The RUC reviewed the current work RVU of 0.53 recommended by the specialties and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.53, the RUC compared the survey code to MPC code 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVU =0.50, intra-service time of 10 minutes, total time of 13 minutes) and noted that both services have identical intra-service time, whereas the survey code involves more total time, justifying a somewhat higher valuation. To further support a work RVU of 0.53, the RUC compared the survey code to MPC code 76830 *Ultrasound, transvaginal* (work RVU = 0.69, intra-service time of 10 minutes, total time of 23 minutes) and noted that both services have identical intra-service time, whereas 76830 involves somewhat more total time. The RUC agreed that the proposed valuation of 0.53 is appropriately bracketed by both MPC codes. **The RUC recommends a work RVU of 0.53 for CPT code 74230.**

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

X-Ray Urinary Tract (Tab 26)
Kurt A. Schoppe, MD (ACR) and Daniel Wessell, MD (ACR)

In October 2016, the Relativity Assessment Workgroup expanded the CMS/Other Source codes screen, lowering the Medicare utilization threshold from 250,000 to 100,000 based on 2015 Medicare utilization data; CPT code 74420 was identified by this screen. The Workgroup recommended the specialty societies survey this service for April 2017.

Compelling Evidence
The specialty societies presented compelling evidence for code 74420. The societies noted that the prior methodology for valuing these codes is unknown and considered flawed, as the source is CMS/Other. As the RUC has noted previously during review of other services, codes with the CMS/Other designation were never surveyed by the RUC or any other stakeholder; their physician time and work were assigned by CMS in rulemaking over 20 years ago using an unknown methodology. The specialty societies also noted that an increase in value for these codes is justified by the survey data, comparisons with the KRS codes, and to maintain relativity with other imaging services. The RUC accepted that there is compelling evidence that 74420 was originally valued using a flawed methodology.

74420 *Urography, retrograde, with or without KUB*
The urology survey respondents from the state of New York were voluntarily removed by the specialties when they were made aware that a non-specialty sponsored email was sent to urologists in the state of New York pertaining to this survey. Therefore, the survey results exclude any urology respondents from the state of New York.

The RUC reviewed the survey results from 219 urologists and radiologists and agreed with following physician time components: pre-service time of 5 minutes, intra-service time of 15 minutes and post-service time of 5 minutes. It was noted that unlike many other imaging services, since the physician is the one performing the fluoroscopy and evaluating the patient during the intra-service portion of the procedure, dictation happens during the post-service period for this code.

The RUC reviewed the survey 25th percentile work RVU of 0.52 and agreed that this value appropriately accounts for the physician work involved in performing this service. To justify a work RVU of 0.52, the RUC compared the survey code to MPC code 93224 *External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional* (work RVU of 0.52, intra-service time of 15 minutes, total time of 24 minutes) and noted that both services have identical intra-service time, similar total times and involve a similar amount of physician work. To further support a work RVU of 0.52, the RUC compared the survey code to top key reference code 74400 *Urography (pyelography), intravenous, with or without KUB, with or without tomography* (work RVU of 0.49, intra-service time of 15 minutes, total time of 25 minutes) and noted that both services have identical intra-service and total times, whereas 79% of the survey respondents that selected 74400 as their key reference service indicated that the survey code is overall a more intense and complex service to perform, supporting that a somewhat higher value for the survey code is warranted. **The RUC recommends a work RVU of 0.52 for CPT code 74420.**

Practice Expense
The Practice Expense Subcommittee agreed that there was compelling evidence that this service was previously misvalued as there are currently no direct practice expense inputs for this service in the non-facility setting, even though the Medicare claims data demonstrate that this service is on occasion performed in the office setting by urologists. The Practice Expense Subcommittee reduced the clinical staff time relative to the original proposal to reflect the way this is typical performed in a urology office, by reducing the time to zero for the following clinical activities:

- *Review patient clinical extant information and questionnaire*
- *Provide education/obtain consent*
- *Prepare room, equipment and supplies*
- *Prepare, set-up and start IV, initial positioning and monitoring of patient*

The Practice Expense Subcommittee also removed all IV supplies which did not reflect the typical patient in the office setting. The specialties noted and the Practice Expense Subcommittee agreed that the typical office does have a lead lined radiology room. The RUC reviewed and approved the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Fluoroscopy (Tab 27)
Kurt A. Schoppe, MD (ACR); Daniel Wessell, MD (ACR); Thomas Turk, MD (AUA); James Dupree, MD (AUA)

In October 2016, the Relativity Assessment Workgroup expanded the CMS/Other Source codes screen, lowering the Medicare utilization threshold from 250,000 to 100,000 based on 2015 Medicare utilization data; CPT code 76000 was identified by this screen and 76001 was included as part of the same family of services. The Workgroup recommended the specialty societies survey these services for April 2017.

Compelling Evidence
The specialty societies presented compelling evidence for code 76000. The societies noted that the prior methodology for valuing these codes is unknown and considered flawed, as the source is CMS/Other. As the RUC has noted previously during review of other services, codes with the CMS/Other designation were never surveyed by the RUC or any other stakeholder; their physician time and work were assigned by CMS in rulemaking over 20 years ago using an unknown methodology. The specialty societies also noted that an increase in value for these codes is justified by the survey data, comparisons with the key reference services, and to maintain relativity with

other imaging services. The RUC accepted that there is compelling evidence that 76000 was originally valued using a flawed methodology.

76000 ***Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time, other than 71023 or 71034 (eg, cardiac fluoroscopy)***
The RUC reviewed the survey results from 85 podiatrists and radiologists and agreed with following physician time components: pre-service time of 5 minutes, intra-service time of 10 minutes and post-service time of 5 minutes. It was noted that unlike many other imaging services, since the physician is the one performing the fluoroscopy and evaluating the patient during the intra-service portion of the procedure, dictation happens during the post-service period for this code.

The RUC noted that orthopedic surgery was given the opportunity to participate in the RUC survey process and actively chose not to participate in the valuation of this service.

The RUC observed that the majority of 76000-TC Medicare claims for this service were billed by a single mobile unit provider in California and the top 5 diagnostic codes for these TC claims all pertain to disorders of the back and spine. It appears that this is being done for pain physicians doing spine injections; it was noted that fluoroscopy is bundled into these underlying services. The RUC recommends that CMS should investigate the use of this service. Also, with the recent bundling of fluoroscopy into many different procedures, the RUC anticipates the volume for 76000 to greatly decrease going forward.

The RUC reviewed the survey 25th percentile work RVU of 0.30 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.30, the RUC compared the survey code to MPC code 92568 *Acoustic reflex testing, threshold* (work RVU = 0.29, intra-service time of 8 minutes, total time of 10 minutes) and noted that with more intra-service and total time, a value of at least 0.30 work RVUs is supported for the survey code. To further support a work RVU of 0.30, the RUC compared the survey code to MPC code 92081 *Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)* (work RVU of 0.30, intra-service time of 7 minutes, total time of 10 minutes) and noted that the survey code has more intra-service and total time. **The RUC recommends a work RVU of 0.30 for CPT code 76000.**

76001 ***Fluoroscopy, physician or other qualified health care professional time more than 1 hour, assisting a nonradiologic physician or other qualified health care professional (eg, nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)***
The specialty noted and the RUC confirmed that the volume has decreased in the past decade as more supervision and interpretation services have been bundled into the underlying procedure codes. The CPT code descriptor language includes several services for which imaging guidance has been bundled (i.e. endoscopy). Additionally, the CPT code descriptor describes a physician spending greater than one hour of professional service time helping another physician. It was the consensus at the RUC and from the presenting societies that this practice is rare, if not obsolete. The specialty societies stated that they intended to request deletion of code 76001 due to very low volume. The presenting specialties noted they suspect that when it is used, it is likely used to describe a service other than that intended by the code. **The RUC refers CPT code 76001 to the CPT Editorial Panel for deletion.**

Practice Expense
The Practice Expense Subcommittee discussed that previously this code has intra-service time in the service period for the clinical staff to *Perform procedure/service---NOT directly related to physician work tim*e (CA021), however the clinical staff time should actually be designated as clinical activity *Assist physician or other qualified healthcare professional---directly related to*

physician work time (100% of physician intra-service time) (CA018). This change results in the clinical staff intra-service time being reduced from 23 minutes to 10 minutes in order to match the physician intra-service time. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee for CPT code 76000.

Ultrasound Exam - Scrotum (Tab 28)
Kurt A. Schoppe, MD (ACR); Daniel Wessell, MD, MPH (ACR); Thomas Turk, MD (AUA); James Dupree, MD (AUA)

In October 2016, the Relativity Assessment Workgroup expanded the CMS/Other Source codes screen, lowering the Medicare utilization threshold from 250,000 to 100,000 based on 2015 Medicare utilization data. CPT code 76870 was identified via this screen for review.

76870 ***Ultrasound, scrotum and contents***
The RUC noted that the urology survey respondents from the state of New York were voluntarily removed by the specialties when they were made aware that a non-specialty sponsored email was sent to urologists in the state of New York pertaining to this survey. Therefore, the survey results exclude any urology respondents from the state of New York.

The RUC reviewed the survey results from 125 physicians and agreed with the following physician time component: pre-service time of 5 minutes, intra-service time of 12 minutes, and post-service time of 5 minutes, resulting in a total of 22 minutes. The RUC reviewed the existing work RVU of 0.64 which is below the 25th percentile RVU of 0.67, and agreed that this value appropriately accounts for the physician work involved. To justify the work RVU of 0.64, the RUC referenced CPT code 76830 *Ultrasound, transvaginal* (work RVU=0.69, pre-service time of 5 minutes, intra-service time of 10 minutes, and post-service time of 8 minutes) and noted that both services have identical pre-service times, similar intra-services times, total times, and involve a similar amount of physician work and therefore should be valued similarly. The RUC also reviewed CPT code 76872 *Ultrasound, transrectal;* (work RVU=0.69, pre-service time of 10 minutes, intra-service time of 15 minutes, and a post-service time of 10 minutes) and noted that both services have similar intra-service times and that CPT code 76872 has identical to somewhat more overall complexity/ intensity, further supporting a work RVU of 0.64 for the survey code. **The RUC recommends a work RVU of 0.64 for CPT code 76870.**

Practice Expense
The RUC reviewed the direct practice expenses and removed clinical staff time to *Confirm availability of prior images/studies* (CA006) and *Review patient clinical extant information and questionnaire* (CA007) because the patient population in the office setting is unlikely to have previous, relevant images. The PE Subcommittee also removed the ultrasound probe condom (SB005). The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

CT Scan for Needle Biopsy (Tab 29)
Kurt A. Schoppe, MD (ACR); Daniel Wessell, MD (ACR); Michael Hall, MD (SIR)

In October 2016, the Relativity Assessment Workgroup expanded the CMS/Other Source codes screen, lowering the Medicare utilization threshold from 250,000 to 100,000 based on 2015 Medicare utilization data. CPT code 77012 was identified via this screen for review.

Compelling Evidence
The specialty society presented compelling evidence for CPT code 77012. The society noted that the prior methodology for valuing these codes is unknown and considered flawed, as the source is CMS/Other. As the RUC has noted previously during review of other services, codes with the CMS/Other designation were never surveyed by the RUC or any other stakeholder; their physician

time and work were assigned by CMS in rulemaking over 20 years ago using an unknown methodology. The specialty society also noted that an increase in value for this code is justified by the survey data and comparisons with the key reference services. The RUC accepted that there is compelling evidence that CPT code 77012 was originally valued using a flawed methodology.

77012 ***Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation***
The RUC reviewed the survey results from 93 physicians and agreed with the following physician time component: pre-service evaluation time of 15 minutes, intra-service time of 35 minutes, and post-service time of 5 minutes. The RUC reviewed the recommended work RVU of 1.50, which is the 25th percentile and agreed that this value appropriately accounts for the physician work involved. To justify the work RVU of 1.50, the RUC referenced MPC code 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family* (work RVU= 1.50, pre-service time of 5 minutes, intra-service time of 25 minutes, and post-time of 10 minutes, total of 40 minutes) and noted that both services require similar physician work and time to perform and therefore should be valued similarly. The RUC also reviewed CPT code 95861 *Needle electromyography; 2 extremities with or without related paraspinal areas* (work RVU= 1.54, pre-service time of 10 minutes, intra-service time of 29 minutes, and post-service time of 10 minutes) and noted that both services have similar work RVUs, intra-service, and post times, further supporting a work RVU at the 25th percentile of 1.50 for the survey code. **The RUC recommends a work RVU of 1.50 for CPT code 77012.**

Practice Expense
The RUC reviewed the direct practice expenses and made no amendments. The RUC recommends the direct practice expense inputs as reviewed by the Practice Expense Subcommittee.

Blood Smear Interpretation (Tab 30)
Jerry W. Hussong, MD, DDS, FCAP (CAP); Roger E. McLendon, MD, FACP (CAP); Jonathan L. Myles, MD, FCAP (CAP)

In October 2016, the Relativity Assessment Workgroup expanded the CMS/Other Source codes screen, lowering the Medicare utilization threshold from 250,000 to 100,000 based on 2015 Medicare utilization data. The Workgroup recommended the specialty society survey this service for April 2017.

85060 ***Blood smear, peripheral, interpretation by physician with written report***
The RUC reviewed the survey results from 95 pathologists and determined that it was appropriate to maintain the current work RVU of 0.45, below the survey 25th percentile. The RUC recommends 12 minutes intra-service time. The RUC compared the surveyed code to the reference service 88388 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)* (work RVU = 0.45, intra-service time of 12 minutes) and noted that both services involve an identical amount of physician work and have identical intra-service times and should be valued the same. For additional support, the RUC compared the surveyed code to CPT code 88314 *Special stain including interpretation and report; histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)* (Work RVU = 0.45, intra-service time of 13 minutes) and noted that

both codes require similar time to perform, justifying the identical work RVUs. **The RUC recommends a work RVU of 0.45 for CPT code 85060.**

Practice Expense
For CPT 85060 the RUC recommends no direct practice expense inputs in the facility or non-facility settings at this time.

Bone Marrow Interpretation (Tab 31)
Jerry W. Hussong, MD, DDS, FCAP (CAP); Roger E. McLendon, MD, FACP (CAP); Jonathan L. Myles, MD, FCAP (CAP)

In October 2016, the Relativity Assessment Workgroup expanded the CMS/Other Source codes screen, lowering the Medicare utilization threshold from 250,000 to 100,000 based on 2015 Medicare utilization data. The Workgroup recommended the specialty society survey these services for April 2017.

Compelling Evidence
The specialty society presented compelling evidence that incorrect assumptions were made in the previous valuation of the service. They explained that a flawed crosswalk assumption was used in the previous evaluation by CMS. CPT code 85097 is a CMS/Other code, in which the physician work and time was not derived from a survey but assigned by CMS over 20 years ago, presumptively by a gap-filling crosswalk. The RUC accepted the specialty's compelling evidence argument.

85097 ***Bone marrow, smear interpretation***
The RUC reviewed the survey results from 77 pathologists and determined that the specialty recommended work RVU of 1.00, below the survey 25th percentile and a direct crosswalk to CPT code 88121 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology* (work RVU = 1.00, intra-service time of 25 minutes), appropriately accounts for the physician work in this service. The RUC recommends no pre-service time, 25 minutes intra-service time and no post-service time for this code. The RUC agreed with the specialty that survey respondents overestimated the physician work of a bone marrow interpretation. The RUC also agreed with the specialty that considering the total work, time, intensity, and complexity of the patient case, the current existing work RVU of 0.94 was too low for the physician work involved. The RUC noted that 75 percent of the survey respondents selected reference services with a greater work value than the current work value of 0.94. The specialty explained it was not appropriate to recommend the survey 25th percentile work value of 1.15 because it would create a rank order anomaly. A RUC member asked the reason that this service has twice the time of 85060 *Blood smear, peripheral, interpretation by physician with written report,* also reviewed at this meeting, which has similar work descriptions. The specialty explained that in a peripheral blood smear, typically, the physician does not have the approximately 12 precursor cells to review, whereas in an aspirate from the bone marrow, the physician is examining all the precursor cells. Additionally, for CPT code 85097 there are more cell types to look at as well as more slides, usually 4, whereas with 85060 you are typically only looking at one slide. The RUC compared the surveyed code to key reference service CPT code 88173 *Cytopathology, evaluation of fine needle aspirate; interpretation and report* (work RVU = 1.39, intra-service time of 25 minutes), which has the same intra-service time, but has pre- and post-service time, justfiying the higher work value. Additionally, the RUC compared the surveyed code to 78266 *Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days,* (work RVU = 1.08, total time of 36 minutes), which has more total time then the surveyed code justifying the higher work value. **The RUC recommends a work RVU of 1.00 for CPT code 85097.**

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

Home Sleep Apnea Testing (Tab 32)
Dennis Hwang, MD (AASM); Fariha Abbasi-Feinberg, MD (AASM); Kevin Kerber, MD (AAN); Kevin L. Kovitz, MD (CHEST); Katina Nicolacakis, MD (ATS); Omar Hussain, MD (ATS)

CPT codes 95800, 95801 and 95806 were flagged for CPT 2011 and reviewed at the October 2014 Relativity Assessment Workgroup meeting. Due to rapid growth in service volume, the RUC recommended that these services be review after two more years of Medicare utilization data (2014 and 2015 data). In October 2016, the RUC recommended that these services be resurveyed for physician work and practice expense for April 2017.

95800 Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time
The RUC reviewed the survey results from 179 physicians and determined that the survey's 25th percentile and work RVU of 1.00 appropriately accounts for the work required to perform this service. The primary difference between sleep study 95800 compared to 95801 is that 95800 includes sleep time assessment. The specialty society noted and the RUC agreed that the intra-service time decreased by 5 minutes due to improved efficiency by the sleep specialists. Physicians are now more familiar with home sleep apnea testing and the new survey time and work RVUs are more reflective of this family of services. Therefore, the RUC is recommending a lower work RVU than the current. The RUC recommends 6 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time.

The RUC compared the surveyed code to the top key reference code 95805 *Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness* (work RVU = 1.20 and 20 minutes intra-service time) and noted that the surveyed code requires slightly less physician work and time and the median survey response indicated the overall intensity and complexity was identical between these two services, therefore, the surveyed code is valued appropriately less. The RUC also referenced similar service 95907 *Nerve conduction studies; 1-2 studies* (work RVU = 1.00 and 15 minutes intra-service time), which requires the same physician work and time to perform. **The RUC recommends a work RVU of 1.00 for CPT code 95800.**

95801 Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)
The RUC reviewed the survey results from 141 physicians and determined that the survey's 25th percentile and work RVU of 1.00, which is also the current value, appropriately accounts for the work required to perform this service. The primary difference between this service and 95800 is that 95801 does not include sleep time assessment nor respiratory effort assessment. The RUC recommends 6 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time. The RUC noted that the physician work and time is the same as 95800.

The RUC compared the surveyed code to MPC code 95805 *Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness* (work RVU = 1.20 and 20 minutes intra-service time) and noted that the surveyed code requires less physician time and work to perform and is appropriately valued lower. The RUC also referenced similar service 95907 *Nerve conduction studies; 1-2 studies* (work RVU = 1.00 and 15 minutes intra-service time), which requires the same physician work and time to perform. **The RUC recommends a work RVU of 1.00 for CPT code 95801.** The specialty society noted that 95801 is very low

volume and they believe it is obsolete and intend on discussing with CPT for possible deletion of this service.

95806 Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)
The RUC reviewed the survey results from 324 physicians and determined that the survey respondents may have overestimated the work RVU. The specialty societies indicated and the RUC recommends a direct crosswalk to similar service 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08 and 15 minutes intra-service time), which appropriately accounts for the work required to perform this service. The respondents indicated that the intra-service time is 15 minutes which is a 10 minute decrease from the current time. The specialties indicated that this service was new the last time it was surveyed and is currently being re-reviewed via identification of the new technology/new services list. The specialty societies indicated that the existing times are likely an overestimate due to the lack of experience providing these then new services in April 2010. Physicians are now more familiar with home sleep apnea testing and the new survey times are more reflective of this family of services. The RUC also noted that the two previous work RVU recommendations for this service were not accepted by CMS and subsequently decreased; however, the survey times were accepted. Thus, an incorrect correlation is suggested when comparing physician work RVU and times between the 2010 survey data to the current survey data and recommended work RVU.

The RUC recommends 6 minutes of pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time. The specialty societies noted and the RUC agreed that CPT code 95806 is more intense and complex than 95800 and 95801 because the inclusion of respiratory effort assessment. Respiratory effort is evaluated to differentiate obstructive versus central respiratory events. Specifically, data from respiratory belts are evaluated for degree of effort, paradoxical breathing, and cardiac oscillations, throughout entire recording period which results in greater intensity and requires more physician work to monitor. Thus, the RUC supported a slightly higher work RVU for 95806 compared to 95800 and 95801.

For additional support, the RUC compared the surveyed code to similar service 93283 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead transvenous implantable defibrillator system* (work RVU = 1.15 and 15 minutes intra-service time) and 72125 *Computed tomography, cervical spine; without contrast material* (work RVU = 1.07 and 15 minutes intra-service time). **The RUC recommends a work RVU of 1.08 for CPT code 95806.**

Practice Expense
The RUC recommends the direct practice expense recommendations as submitted by the specialty societies without modification.

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.

External Counterpulsation (Tab 33)
Richard Wright, MD (ACC) and Thad Waites, MD (ACC)

In October 2016, the Relativity Assessment Workgroup expanded the CMS/Other Source codes screen, lowering the Medicare utilization threshold from 250,000 to 100,000 based on 2015 Medicare utilization data. CPT code G0166 was identified via this screen for review.

G0166 ***External counterpulsation, per treatment session***
The RUC recommends a work RVU of 0.00 for CPT code G0166 because the RUC does not believe that there is physician work involved in this service. After discussion regarding the specialty society's difficult time in reaching adequate survey respondents since there are less than 200 physicians reporting this service in the United States, the specialty society and the RUC concluded that this service is Practice Expense only. **The RUC recommends no physician work for CPT code G0166.**

Practice Expense
The Practice Expense Subcommittee discussed the equipment required for G0166, EQ012 *EECP, external counterpulsation system,* which was originally priced by CMS at $150,000 and is utilized for 60 minutes. This equipment, and the nurse time to monitor the treatment, reflects the cost of this treatment. CMS should review the latest pricing of this device. Other medical supplies were eliminated because the patient is fully clothed. It was noted that the patient returns for a total of 35 treatments and is, therefore, equipped to dress appropriately for the treatment. The PE Subcommittee agreed to delete the following supplies: razor, patient gown, and the multi-specialty pack. The PE Subcommittee also agreed to reduce the alcohol swab-pad to one. The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.

Wound Closure by Adhesive (Tab 34)
Ethan Booker, MD (ACEP); Jordan Celeste, MD (ACEP); Jennifer Aloff, MD (AAFP) PE only

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. CMS identified G0168 via this screen.

The RUC reviewed the survey results from 125 emergency medicine physicians and determined that the current work RVU of 0.45 appropriately accounts for the work required to perform this service. The specialty society presented compelling evidence that this service has a flawed methodology in its initial CMS/Other source data and does not have survey data from the dominant specialties for physician work, time or review of direct practice expense inputs. In 2000, CMS cross-walked G0168 to 99212 *Office or other outpatient visit for the evaluation and management of an established patient* for physician work and time. The RUC determined compelling evidence was met; however, the current valuation is appropriate.

The RUC recommends 5 minutes evaluation time, 1 minute positioning time, 5 minutes intra-service time and 3 minutes immediate post-service time. The specialty societies noted and the RUC agreed that this service is typically reported with an E/M and the survey respondents were clear that the E/M of the patient for the event leading to the injury, other possible injuries, co-morbid conditions and tetanus status are separate and the service descriptor accurately describes the work of this service alone. The RUC compared the surveyed code to the top two key reference services 12011 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less* (work RVU = 1.07 and 12 minutes intra-service time) and 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU = 0.84 and 10 minutes intra-service time) and determined that the physician work and time for the surveyed code is lower. For additional support to maintain the work RVU, the RUC referenced MPC code 51702 *Insertion of temporary indwelling bladder catheter; simple (eg, Foley)* (work RVU = 0.50 and 5 minutes intra-service time). **The RUC recommends a work RVU of 0.45 for code G0168.**

Practice Expense
The Practice Expense Subcommittee modified the direct practice expense inputs by removing clinical staff time to *providing education/obtain consent* (CA011) and deleted an unnecessary *exam light* (EQ168). The specialty societies and Subcommittee changes reduces the clinical staff time by 50%. The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.

Removal of Impacted Cerumen (Tab 35)
R. Peter Manes, MD (AAO-HNS) and Jay Shah, MD (AAO-HNS)

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. Code G0268 was identified for review.

G0268 was created by CMS to track how often removal of cerumen was performed on the same date as audiologic function testing. The specialty society did not survey G0268 since this service mirrors CPT code 69210 *Removal impacted cerumen requiring instrumentation, unilateral* (work RVU = 0.61). The specialty societies indicated and the RUC agreed that code 69210 and G0268 represent the same physician work. CPT code 69210 was recently RUC reviewed in January 2013 and the evaluation time was reduced to account for this service typically being performed with an E/M. The RUC noted that 69210 is for one ear, however CMS rejected the RUC's lower work RVU recommendation and maintained the previous bilateral work RVU. Additionally, CMS does not allow a bilateral indicator for 69210. Therefore, the two services are reported the same for Medicare purposes. The RUC recommends a direct crosswalk of G0268 to CPT code 69210 and recommends 3 minutes evaluation, 2 minutes positioning, 10 minutes intra-service time and 2 minutes immediate post-service time. **The RUC recommends a work RVU of 0.61 for G0268.**

Vignette
The RUC recommends that the same vignette for 69210 be added to the RUC database for G0268:

> A 69-year-old male presents with a recent worsening of hearing in the left ear over a several-day period. He is found to have a cerumen impaction filling the entire external auditory canal. The physician physically removes the cerumen from the canal with instrumentation and magnification.

Practice Expense
The Practice Expense Subcommittee deleted *exam light* (EQ168) because the otoscope has a light. The PE Subcommittee discussed that the specialty recommended reducing the amount of *specula tip, otoscope* (SM025) from the current for G0268 because as is reflected in 69210 the same speculum is used in both ears for the same patient. Therefore there is no duplication in direct practice expense if reported bilaterally. The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.

XI. Practice Expense Subcommittee (Tab 36)

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

- **Obtain Consent Clinical Activity Time Standard for MR and CT Services**

Upon review it was verified that the Practice Expense Subcommittee has been very consistent with the amount of clinical staff time allocated for clinical activity, *provide pre-service*

education/obtain consent, for MR codes with and without contrast. There is more variability in the allocation of staff time for CT codes, but it is within a narrow range. The Subcommittee determined that for CT codes it was appropriate to continue to determine obtain consent time on an ad hoc basis. The Subcommittee then engaged in a broad discussion about the work of obtaining consent and whether it is performed by the physician or the clinical staff and is there any overlap there. Another PE Subcommittee member added that when the physician obtains consent it is a discussion about the service, but the clinical staff have to conduct their own distinct work to help the patient complete the paperwork required to obtain consent and it is not duplicate work. The Subcommittee agreed that the question has been asked frequently enough that a Workgroup should be assigned to explore the issue. The Workgroup will be chaired by Doctor Gregory Barkley.

- **AAO-HNS Practice Expense Requests**

  The Practice Expense Subcommittee reviewed two requests made by The American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS).

  (1) A new clinical activity for applying local/topical anesthesia. The PE Subcommittee determined that the existing clinical activity for applying anesthesia and sedation is sufficient and that the existing PE Summary of Recommendation (SoR) could be used appropriately to provide additional information about what is being anesthetized topically or locally.
  (2) A specialty specific package of equipment to be used for post-procedure monitoring. The PE Subcommittee did not feel that this package was warranted.

- **Exam Light Workgroup**

  The use of exam lights is a common discussion at the PE Subcommittee meetings. This issue came up frequently throughout this meeting and in past meetings as well. The Subcommittee determined that it was appropriate to convene a workgroup to do a systematic examination of what the PE Subcommittee has been doing with exam lights. The Workgroup will be chaired by Tom Weida.

- **CT Guided Biopsy**

  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.

  The RUC approved the Practice Expense Subcommittee Report.

XII. Research Subcommittee (Tab 37)

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

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

- **Proposed Extant Database, RSL, Custom Survey Instrument and Survey Methodology for transcatheter aortic valve replacement (TAVR)**

  The Society of Thoracic Surgeons (STS), American College of Cardiology (ACC) and the Society for Cardiovascular Angiography and Interventions (SCAI) proposed several items pertaining to transcatheter aortic valve replacement (TAVR) codes 33361-33366 for Research Subcommittee approval. The TAVR codes were flagged for review by the RAW based on the new technology screen and are scheduled for review at the October 2017 RUC meeting. The presenters for STS, ACC and SCAI requested for the Research Subcommittee to consider the following items:

  - Request to approve the STS/ACC TVT Registry for use as an Extant Database
  - If the Registry is approved as an Extant Database, also approve the use of the STS/CTS Alternate Five Year Review Methodology that was used in the 2005 Five-Year-Review with modifications to the intensity data collection relative to the TAVR codes that are up for review. Per the established criterion also applied to the STS database, if the specialties find that the database does not meet the 95th/5% criterion (95th percentile confidence interval with a +/-5% variability) the database data will not be used to value the codes and will not be revealed.
  - The specialty societies also requested for the Research Subcommittee to provide guidance on the RUC's intentions regarding the use of the RUC survey in conjunction with the database data valued services and a clear delineation of how each data set will be used in determining the value of the services.
  - Review of a Reference Service List which would be used both for RUC survey for work RVUs/physician time as well as for a direct intensity survey methodology
  - Survey instrument – the original survey used for the TAVR codes was set up as a joint survey with the cardiac surgeon and the interventional cardiologist sitting down together to complete the survey. Because of coding and coverage requirements, the societies again recommend a joint survey in this style and will work with AMA staff to develop an updated survey instrument using Qualtrics, if possible.
  - The societies are still waiting for data from the TVT-R and will plan to develop revised vignettes based on that data and will submit to the Research Subcommittee for review on the Research Subcommittee Call after the June CPT meeting.

  As detailed in the letter submitted as part of this request, the specialties noted and the Subcommittee agreed that the TVT registry meets all of the RUC's extant database requirements. The presenters noted that the database includes all US patients which have had TAVR. They also explained that payment for performing TAVR is contingent on participating in the registry, ensuring that 100% participation would continue.

  As part of the discussion, the Subcommittee noted that, at the October 2016 RUC meeting, the Time and Intensity Workgroup recommended and the RUC approved that "*If a specialty has a RUC-approved source of extant physician time data, then that specialty can use this methodology as supporting evidence for their RUC recommendation, though they would still be required to conduct a RUC survey*." The Subcommittee noted that the specialties series of requests complied with this guidance from the Workgroup.

  The specialties also proposed that they would provide summary data from the Registry based on the most recent 3 years of data available each time they presented a TAVR service to the RUC. A Subcommittee member questioned whether older data would be representative for a service that is still evolving. The presenters concurred, noting that data that was older than 5 years from the database should not be considered for review. More recently, the patient population TAVR has

trended towards a patient population that is relatively younger and less complex than TAVR procedures performed more than 5 years ago.

The Research Subcommittee recommended for the RUC to approve the TVT Registry as a database that meets the RUC's extant database criteria.

The Subcommittee also discussed whether mean or median summary data would be more appropriate for the Registry summary data. **The Research Subcommittee requests 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 on what summary data is most appropriate for datasets of different sizes (ie small sample size, large sample size, total population).**

The Subcommittee also discussed the proposed survey methodology and approved the survey instruments as submitted with the understanding that certain questions would be updated to reflect the latest survey language. The Subcommittee approved use of the modified survey methodology using a joint survey similar to the 2012 TAVR survey. Specialty staff would work with AMA staff to conduct this survey using Qualtrics.

The Subcommittee also approved the concurrent use of a direct intensity survey, noting that both the intensity survey and the work survey instruments would use the same reference service list codes.

The Research Subcommittee also reviewed the proposed reference service list and recommended for the societies to remove any codes last reviewed by the RUC before 2010 and also to remove codes 34812 and 34833, as their global period will be changing to ZZZ.

The Subcommittee also approved for the specialties to use the STS/CTS Alternate Five Year Review Methodology that was used in the 2005 Five-Year Review with modifications to the intensity data collection as support for the survey data collected under the RUC survey process. The Subcommittee agreed with the specialties that a Rausch analysis would not be needed.

- **RUC Survey Intensity and Complexity Questions**

  At the January meeting, the Research Subcommittee approved the Time-Intensity Workgroup's recommendation to collapse the three mental effort and judgment and three psychological stress intensity and complexity questions each into a single question. The Subcommittee requested for AMA Staff to draft updated survey language for its consideration at the April 2017 RUC meeting. **At the April 2017 RUC meeting, the Subcommittee approved the updated survey intensity and complexity question as proposed by AMA Staff:**

Background for Question 3

In evaluating the work of a service, it is helpful to identify and think about each of the components of a particular service. Focus only on the work that you perform during each of the identified components. The descriptions below are general in nature. Within the broad outlines presented, please think about the specific services that you provide.

Physician work includes the following:

Time it takes to perform the service.

Mental effort and judgment necessary with respect to the amount of clinical data that needs to be considered, the fund of knowledge required, the range of possible decisions, the number of factors considered in making a decision, and the degree of complexity of the interaction of these factors.

Technical Skill required with respect to knowledge, training and actual experience necessary to perform the service.

Physical effort can be compared by dividing services into tasks and making the direct comparison of tasks. In making the comparison, it is necessary to show that the differences in physical effort are not reflected accurately by differences in the time involved; if they are, considerations of physical effort amount to double counting of physician work in the service.

Psychological stress – Two kinds of psychological stress are usually associated with physician work. The first is the pressure involved when the outcome is heavily dependent upon skill and judgment and an adverse outcome has serious consequences. The second is related to unpleasant conditions connected with the work that are not affected by skill or judgment. These circumstances would include situations with high rates of mortality or morbidity regardless of the physician's skill or judgment, difficult patients or families, or physician physical discomfort. Of the two forms of stress, only the former is fully accepted as an aspect of work; many consider the latter to be a highly variable function of physician personality.

Question 3

Compare INTENSITY COMPONENTS of the survey code(s) relative to the corresponding reference code(s) you selected in Question 1. Using your expertise, consider how each survey code compares directly to the corresponding reference code. For example, if you find the mental effort and judgment for the survey code is identical when compared to the corresponding reference code you chose in Question 1, select "identical" in the dropdown box below.

Mental Effort and Judgment Necessary • The range of possible diagnoses and/or management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, or other information that must be analyzed • Urgency of medical decision making	Much Less *[Identified as "-2" in raw data]* Somewhat Less *[Identified as "-1" in raw data]* Identical *[Identified as "0" in raw data]* Somewhat More *[Identified as "+1" in raw data]* Much More *[Identified as "+2" in raw data]*
Technical Skill Required	Much Less *[Identified as "-2" in raw data]* Somewhat Less *[Identified as "-1" in raw data]* Identical *[Identified as "0" in raw data]* Somewhat More *[Identified as "+1" in raw data]* Much More *[Identified as "+2" in raw data]*
Physical Effort Required	Much Less *[Identified as "-2" in raw data]* Somewhat Less *[Identified as "-1" in raw data]* Identical *[Identified as "0" in raw data]* Somewhat More *[Identified as "+1" in raw data]* Much More *[Identified as "+2" in raw data]*
Psychological Stress Involved • The risk of significant complications, morbidity and/or mortality	Much Less *[Identified as "-2" in raw data]* Somewhat Less *[Identified as "-1" in raw data]* Identical *[Identified as "0" in raw data]*

• Outcome depends on skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	Somewhat More *[Identified as "+1" in raw data]* Much More *[Identified as "+2" in raw data]*

- **Research Subcommittee Review of Vignettes – Discussion**

  Following the February 2017 Research call, two subcommittee members requested for Subcommittee to discuss:

  1. What level of specificity/granularity clinical vignettes should contain.
  2. Whether the RUC and CPT should revise their current instructions on vignette composition.

  In preparation for this discussion, AMA Staff prepared the below analyses for the Subcommittee and also collated the RUC's and CPT's current vignette instructions.

  Presence of Age and Gender in Vignettes

	Number of Codes	Percentage
# of Codes with Age	3783	90.4%
# of Codes with Gender	3263	78.0%
# of Codes with Vignette in RUC Database	4185	

  Vignette Word Count

	Word Count
25th Percentile	30
Median	47
75th Percentile	71

  The Subcommittee agreed that, in general, vignettes should include the typical age and gender of the patient, as well as typical indications and comorbidities which are material to the procedure under review. The Subcommittee did not recommend any changes to the RUC's vignette instructions at this time.

  AMA RUC staff noted that it may be beneficial for the CPT Editorial Panel to consider including guidance on the code change application regarding a typical word count range for clinical vignettes, though this word count should just be a suggestion and not mandatory. A Subcommittee member noted that this could be a statement noting that it is rare for vignettes to exceed 75 words. **The Subcommittee recommends for the CPT Editorial Panel to consider adding language to the Code Change Application to explain that the typical word count for a vignette is 50 words and is unlikely to exceed 75 words.**

  The Subcommittee has proposed that specialties requesting vignette revision approval from Research Subcommittee should include the current vignette, the revised vignette and their reason for the revision to simplify and focus the work of the Subcommittee.

- **RUC Pre-service and Post-service Time Packages**

  Time Package Definitions – Straightforward vs. Difficult
  During the RUC's Other Business discussion at the January 2017 RUC meeting, a RUC member raised the point that pre-service time for surgical services are based on location, type of anesthesia, condition of the patient, and difficulty of the procedure. However, several times during the meeting, the RUC member noted that presenters noted that "the survey time was X" and so the reason that it became a difficult patient/difficult procedure is what fit best with the survey. The pre-service time package should be based on the aforementioned factors not the survey time. The RUC referred this issue to the Research Subcommittee to develop definitions for "straightforward/difficult patient" and "straight/difficult procedure" as it pertains to the selection of time packages.

  The Subcommittee discussed whether additional language defining straightforward and difficult patients and procedures would be necessary. Some Subcommittee members thought new definitions would be beneficial whereas others thought that perhaps the pre-time packages should instead be renamed to more appropriately reflect their components. It was noted that the majority of the components of each time package pertained to the difficulty of the procedure and not the difficulty of the patient. **The Subcommittee requested for AMA staff to provide more detailed historical reference materials on how each package was created. The Subcommittee tabled this issue for further discussion at the next RUC meeting.**

  Retroactive application of pre- and post-time packages
  During the RUC's Other Business discussion at the January 2017 RUC meeting, a RUC member noted that while there are now time packages, there are a whole host of services within the fee schedule in which this standard has not been applied. The RUC member questioned whether there should be a retroactive application of pre- and post-time packages within the fee schedule. **This issue was referred to the Research Subcommittee for further discussion. The Research Subcommittee agreed that a retroactive application of time packages would not be appropriate.**

  Non-facility Post-service Time Package
  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, the Subcommittee expressed general interest in developing non-facility post-time packages. **The Subcommittee tabled this item for further discussion at the next RUC meeting.**

Immediate Post-Time Analysis for 000-, 010- & 090-Day Codes Typically Performed in the Non-Facility Setting (Only Codes with 2015 Medicare Utilization >1,000)

		Immediate Post-Time (minutes)				
Global	**# of Codes**	**Minimum**	**25th Percentile**	**Median**	**75th Percentile**	**Maximum**
000, 010 & 090	463	0	5	**8**	10	45
000	220	0	5	**5**	10	30
010	168	0	5	**8**	10	19
090	75	4	8	**10**	15	45

The RUC approved the Research Subcommittee Report.

XIII. Relativity Assessment Workgroup (Tab 38)

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

- **High Growth Codes – Action Plan Review (01936 & 64450)**
  Doctor Collins informed the RUC that the Relativity Assessment Workgroup reviewed two action plans under the high growth screen.

  Anesthesia for Percutaneous Image Guided Procedures - Spine
  CPT code 01936 *Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic* was identified via the high growth screen with Medicare utilization of 10,000 or more that has increased by at least 100% from 2009 through 2014. In January 2017, the Workgroup reviewed the specialty society's action plan and requested that the specialty society research data on what procedures are reported with this anesthesia code to review in April 2017.

  The Workgroup noted it was concerned that this service may still be reported inappropriately as the top surgical services reported with 01936 (22513, 22514, 62322, 62323, 63650, 64483 and 64490) utilization does not show significant increases and some of these services indicate that moderate sedation is included. The Workgroup noted that ASA has provided significant education on the correct reporting of this service, however can not reach all other providers of this service or physicians who request the anesthesia service. **The Workgroup recommends reviewing 01936 after two years of utilization data are available including the utilization for the top surgical services reported with 01936 (October 2019).**

  Injection - Anesthetic Agent
  CPT code 64450 *Injection, anesthetic agent; other peripheral nerve or branch* was identified via the high growth screen with Medicare utilization of 10,000 or more that has increased by at least 100% from 2009 through 2014. In January 2017, the Workgroup requested that the specialty societies review this issue further to determine if there are any other peripheral nerves or branches not specified with a CPT code to determine if this service may be deleted and review an action plan for April 2017.

  The specialty society indicated and the Workgroup agreed that CPT code 64450 Medicare utilization is decreasing and that there may be some miscoding with this service as a few providers in three states account for an explicably high proportion of 25% of Medicare claims. **The Workgroup recommends to notify CMS of the possible inappropriate reporting and to re-review the utilization data for this service in two years (October 2019).**

- **Work Neutrality – Action Plan Review (64633-64636)**
  In September 2014, the Relativity Assessment Workgroup identified CPT codes 64633-64636 to be reviewed for work neutrality. However, the Workgroup was not able to get to this agenda item. Due to the nature of the possible incorrect coding of per nerve instead of per joint, the specialties were encouraged to immediately begin addressing this coding education and clarification. The RUC recommended that the specialty societies develop a CPT Assistant article to address this issue. The specialty societies submitted a CPT Assistant article stressing that each of these codes now includes the entire joint (i.e. two nerves) and not just one nerve, as before (publication date: February 2015). In January 2015, the Workgroup discussed this issue and agreed that the CPT Assistant article is a good proactive step. The RUC recommended that the specialty societies immediately submit revised introductory language to the CPT Editorial Panel to address any inappropriate coding regarding reporting per nerve instead of per joint issue (for CPT 2016). The RUC requested that AMA staff compile data on how many times a services is reported on the same patient on the same day and 2014 preliminary Medicare utilization for the Workgroup to

review the additional data in April 2015. In April 2015, the Workgroup agreed that the specialty societies have taken aggressive action to ensure correct reporting of these services. In May 2015, the CPT Editorial Panel revised the parenthetical instructions for five codes describing paravertebral facet joint nerve destruction to clarify that these codes are reported per joint, not nerve. The Workgroup recommended the multiple aforementioned efforts to take effect and re-review the utilization data for these services in April 2017.

The specialty society indicated and the Workgroup agreed that recent CPT changes did not take effect until 2016 and the Medicare utilization was not available when preparing for this meeting. **The Workgroup recommends that more time is necessary to determine CPT changes were effective and that the Workgroup review these services in October 2019 when two years of Medicare utilization data are available.**

- **Negative IWPUT**
  At the April 2016 meeting, during new business discussion a RUC member requested that the Relativity Assessment Workgroup review services with low or 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, which resulted in 38 services identified. The Workgroup briefly discussed this issue in October 2016 and noted that it will continue discussion in April 2017 after the Administrative Subcommittees' discussion regarding possibly adding a negative IWPUT as a compelling evidence standard.

  In January 2017, the Administrative Subcommittee determined that the services with a negative IWPUT would be considered part if the "flawed methodology" compelling evidence standard. The Subcommittee noted that the process to review any services that specialty societies disagree with the work RVU of an existing code is to submit a letter to CMS as potentially misvalued with a rationale. CMS will nominate any potentially misvalued services in the Notice for Proposed Rule Making (NPRM) and the RUC will examine.

  The Workgroup reviewed this list of codes and determined that this list of services should be revised for negative IWPUT with Medicare utilization over 10,000 and Harvard valued and CMS/Other source codes with utilization over 1,000 and be placed on the level of interest for action plans to review at the October 2017 meeting.

- **New Screens Discussion**

  Low Intra-service Work Per Unit of Time (IWPUT)
  The 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 will review this list of services at the October 2017 Relativity Assessment meeting.**

  CMS/Other Source Codes – Utilization over 30,000
  The 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.**

  The RUC approved the Relativity Assessment Workgroup Report.

XIV. Administrative Subcommittee (Tab 39)

Doctor Gregory DeMeo (Vice Chair) summarized the Administrative Subcommittee report:

- **RUC Member Specialty Designations**

Doctor DeMeo informed the RUC that at the January 2017 RUC meeting a RUC member requested clarification if RUC members are limited from speaking to only issues where an individual from their specialty seat is speaking or from any organization for which they are a member. The Subcommittee noted that RUC members and alternates serve as part of an expert panel and do not advocate for their specialty societies. Additionally, the RUC conflict of interest policy states that RUC members and alternates "have a continuing responsibility to comply with the Conflict of Interest policy and promptly disclose any direct financial interest required under this policy". The Subcommittee noted that the current conflict of interest policy would cover any conflict/financial interest if RUC members or alternates are involved or have additional interests being a member of a secondary or tertiary specialty society. **The Subcommittee recommends maintaining the current conflict of interest policy**.

The RUC approved the Administrative Subcommittee Report.

XV. Anesthesia Workgroup (Tab 40)

Doctor Scott Collins summarized the Anesthesia Workgroup report:

- **Review Anesthesia Methodology**

Doctor Collins indicated that the ASA provided an overview of the Post-Induction Period Procedure Anesthesia (PIPPA), noting that it is not the same as IWPUT but serves as an intensity measure. PIPPA intensity is used to validate base units and/or survey results. Just as with RBRVS-valued services where IWPUT multiplied by the intra-service time is proportional to wRVU, with the Anesthesia Fee Schedule-valued services, PIPPA multiplied by average post-induction time is proportional to base units.

The Workgroup noted that it has been 10 years since the anesthesia fee schedule codes have been reviewed or validated. The Workgroup determined that an alternative approach should be examined comparing anesthesia codes to other codes in the Resource-Based Relative Value Scale (RBRVS) since there is not a current methodology to validate the original 19 representative anesthesia services. The Workgroup indicated that in 2007 the representative number of anesthesia services was expanded to 40 codes to represent 81% of all Medicare allowed charges for anesthesia codes and that this representative sample of services may have changed.

The Workgroup continued discussion about the accuracy of the anesthesiology vignettes, dominant surgical codes and PIPPA intensities, noting that there is not a way to currently determine if the 19 anesthesiology codes are currently correct.

The Workgroup will continue review and discussion of anesthesia services at the October 2017 meeting. AMA staff, working with ASA, will develop an analysis comparing the physician work component of anesthesia base units to work RVUs. The analysis will include codes that are representative of the ASA base units and include a large percentage of total spending.

The ASA indicated they are happy to work with the RUC to provide the resource described in the action item of the Anesthesia Workgroup report, to assist with the development of a discussion

document. At the same time, as the Workgroup acknowledged, the Anesthesia Fee Schedule is set for in statute as a distinct fee schedule from the RBRVS. Under the Anesthesia Fee Schedule, one must consider both base and time units to understand the work furnished during the procedure. Consistent with the statute, base units cannot be reasonably compared to work RVUs.

Doctor Weida reiterated the current statute below and indicated that it sort of links the work and base unit but not exactly.

> **SSA 1848(b)(2)(B):**
> (B) ANESTHESIA SERVICES.—In establishing the fee schedule for anesthesia services for which a relative value guide has been established under section 4048(b) of the Omnibus Budget Reconciliation Act of 1987[176], the Secretary shall use, to the extent practicable, such relative value guide, with appropriate adjustment of the conversion factor, in a manner to assure that the fee schedule amounts for anesthesia services are consistent with the fee schedule amounts for other services determined by the Secretary to be of comparable value. In applying the previous sentence, the Secretary shall adjust the conversion factor by geographic adjustment factors in the same manner as such adjustment is made under paragraph (1)(C).

Doctor Smith indicated that the RUC has more work to complete on this issue and it is very clear that one of the RUC's roles is to know and understand the physician work of all physicians and make sure the relativity is appropriate for the services provided. There are two different ways to determine the payment rate, which means they cannot directly be compared. However, the RUC's job is to work at another level than that and continue examining the Anesthesia Fee Schedule.

The RUC approved the Anesthesia Workgroup Report.

XVI. HCPAC Review Board (Tab 41)

- Doctor Timothy Tillo, DPM (Alt. Co-Chair) called the meeting to order at 3:00 pm. Dr. Tillo announced that this will be the last HCPAC meeting for Emily Hill, PA-C after many years of participation in the HCPAC. We thank her for her many years of service.

- **Relative Value Recommendations for CPT 2019**

  <u>Biopsy of Nail (11755)</u>
  Brooke Bisbee, DPM (APMA) and Lloyd Smith, DPM (APMA)

  In the Final Rule for 2017, CMS finalized the list of 000-day global services reported with an E/M 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. CPT code 11755 was identified as part of this screen.

  11755 ***Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)***
  The HCPAC reviewed the survey results for 72 podiatrists for CPT code 11755 and determined that the proposed work RVU of 1.25, the survey median work RVU and below the current work RVU of 1.31, appropriately accounts for the work required to perform the service.

The specialty noted that although dermatology proposed and surveyed the code when it was new in 1993, they were never the primary providers of the service. Podiatry has always been the primary provider of this service, but they were not included in the survey in 1993. The HCPAC recommends 18 minutes of pre-service time, 15 minutes of intra-service time and 6 minutes of immediate post-service time. The HCPAC compared the survey code to top key reference CPT code 11730 *Avulsion of nail plate, partial or complete, simple; single* (work RVU= 1.05, 10 minutes intra-service time), which has less intra-service time justifying the lower work value. The HCPAC discussed that the work of survey code 11755, includes the work of 11730 plus the work of taking a biopsy of the nail bed, and the recommended value of 1.25 appropriately accounts for this additional work. Additionally, the HCPAC compared the surveyed code to CPT code 51710 *Change of cystostomy tube; complicated* (work RVU = 1.35), which has more total time justifying the higher work value. **The HCPAC recommends a work RVU of 1.25 for CPT code 11730.**

In addition, the HCPAC observed that there are inconsistencies in the Medicare Claims Processing Manual (Manual) related to reporting an E/M service on the same day as a minor procedure. While acknowledging the CMS staff citation from the manual, Chapter 12, Section 40.1, paragraph B, regarding reporting an E/M visit with a 000-day global code and the expectation that all of the focused evaluation work is included in the global period, the presenters noted that in two other sections of the same Manual chapter, the guidance provided is different. Specifically, Section 40.1 paragraph C and Section 40.2 paragraph A (#8) of the Manual confirm that it is permissible to report an E/M code on the same day as a minor surgical procedure when a significant, separately identifiable service is also performed. It is appropriate to append modifier 25 to the E/M code in instances where a significant, separately identifiable evaluation and management service is performed by same physician on the day of a procedure. The HCPAC also noted this Section of the Manual corresponds to CPT Modifier 25 instructions which state: "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported."

Practice Expense
The specialty provided a brief summary of the discussion from the PE Subcommittee review. The PE Subcommittee made one adjustment, to remove 3 minutes of clinical staff time for *complete pre-procedure phone calls and prescriptions* in the pre-service period. The HCPAC discussed that when this service was surveyed by dermatology the time to *Assist physician or other qualified healthcare professional* required only 67% of physician intra-service time, however the specialty recommends 100% because the RN/LPN/MTA is currently assisting the podiatrist throughout the entire service.. The HCPAC recommends the direct practice expense inputs as reviewed and approved by the Practice Expense Subcommittee.

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

<u>Strapping – Lower Extremity (29540 & 29550)</u>
Brooke Bisbee, DPM (APMA) and Lloyd Smith, DPM (APMA)

In October 2009, CPT code 29540 *Strapping; ankle and/or foot* was identified through the Harvard Valued - Utilization over 100,000 Screen and the RUC recommended the family of services be surveyed. During that review the HCPAC determined that it was appropriate to reduce the work value for CPT codes 29540 and 29550. CPT code 29590 was referred to the CPT

Editorial Panel for Deletion. In the Final Rule for 2017, CMS finalized the list of 000-day global services reported with an E/M 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. CPT codes 29540 and 29550 were identified as part of this screen.

29540 *Strapping; ankle and/or foot*
The HCPAC reviewed the survey results for 124 podiatrists for CPT code 29540 and determined that the current work value of 0.39, below the survey 25th percentile, appropriately accounts for the work required to provide this service. The HCPAC recommends a pre-service evaluation time of 5 minutes, pre-service positioning time of 2 minutes, intra-service time of 7 minutes and immediate post-service time of 3 minutes. The HCPAC compared the survey code to 2nd key reference and HCPAC MPC CPT code 29530 *Strapping; knee* (work RVU = 0.39, 18 minutes total time), which has similar total time and should be valued similarly. For additional support the HCPAC compared the surveyed code to key reference CPT code 29515 *Application of short leg splint (calf to foot)* (work RVU= 0.73, 15 minutes intra-service time), which has more than double the intra-service time justifying the greater work value. **The HCPAC recommends a work RVU of 0.39 for CPT code 29540.**

29550 *Strapping; toes*
The HCPAC reviewed the survey results for 124 podiatrists for CPT code 29550 and determined that the current work value of 0.25, below the survey 25th percentile, appropriately accounts for the work required to provide this service. The HCPAC recommends a pre-service evaluation time of 5 minutes, intra-service time of 5 minutes and immediate post-service time of 3 minutes. The HCPAC discussed the top key reference services 29530 *Strapping; knee* (work RVU= 0.39, 7 minutes of pre-service time, 9 minutes of intra-service time, and 2 minutes of immediate post-service time) and 11720 *Debridement of nail(s) by any method(s); 1 to 5* (work RVU = 0.32, 5 minutes intra-service time, 14 minutes total time), and noted that both require more time and work than the surveyed code, justifying higher work values. **The HCPAC recommends a work RVU of 0.25 for CPT code 29550.**

In addition, the HCPAC observed that there are inconsistencies in the Medicare Claims Processing Manual (Manual) related to reporting an E/M service on the same day as a minor procedure. While acknowledging the CMS staff citation from the manual, Chapter 12, Section 40.1, paragraph B, regarding reporting an E/M visit with a 000-day global code and the expectation that all of the focused evaluation work is included in the global period, the presenters noted that in two other sections of the same Manual chapter, the guidance provided is different. Specifically, Section 40.1 paragraph C and Section 40.2 paragraph A (#8) of the Manual confirm that it is permissible to report an E/M code on the same day as a minor surgical procedure when a significant, separately identifiable service is also performed. It is appropriate to append modifier 25 to the E/M code in instances where a significant, separately identifiable evaluation and management service is performed by same physician on the day of a procedure. The HCPAC also noted this Section of the Manual corresponds to CPT Modifier 25 instructions which state: "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported."

Practice Expense
The presenters provided a brief summary of the discussion from the PE Subcommittee meeting and a HCPAC member noted that for 29540 an additional change to the length of foam underwrap from 48 to 24 inches is necessary. The PE Subcommittee also discussed a reduction in the rigid strapping tape for 29540 and the HCPAC agreed with the specialty that it was

appropriate to maintain the specialties recommendation of 48 inches. For CPT code 29550 the additional change was to both supply items; foam underwrap and rigid strapping tape from 22 to 10 inches. With the modifications made by the HCPAC, the HCPAC recommends the direct practice expense inputs as reviewed and approved by the Practice Expense Subcommittee.

Physical Medicine and Rehabilitation Services (97010)
Richard Rausch, PT, MBA (APTA) and Randy Boldt, PT (APTA)

In February 2010, some of the physical medicine and rehabilitation services were identified through the RUC's High Volume Growth screen. Subsequently, some services were identified via the Codes Reported Together 75% of the Time screen and then by CMS via the High Expenditure screen. A CPT Workgroup was formed to address coding for these services, but after several years it was determined by CMS that a new structure was not preferred.

In the NPRM for 2017, CMS indicated that a review of the valuation should move forward for the following codes: 97032, 97035, 97110, 97112, 97113, 97116, 97140, 97530, 97535 and G0283. Eleven codes were added as part of this family of services and were reviewed for work and practice expense at the January 2017 RUC HCPAC Review Board meeting.

For both provider work and practice expense presentation and discussion, the 19 codes that were surveyed were divided into four categories of similar services: supervised modalities (97012, 97014, 97016, 97018, 97022); attended modalities (97032, 97033, 97034, 97035); therapeutic procedures (97110, 97112, 97113, 97116, 97140); and ADL (97530, 97533, 97535, 97537, 97542). CPT code 97010 was not surveyed and was referred to CPT. HCPCS code G0283 was not surveyed and was instead crosswalked to a similar service.

A survey of physical therapists and occupational therapists was conducted. In general, both the survey 25th percentile and median work relative value unit (RVU) were higher than the current work RVU. RUC HCPAC Review Board required compelling evidence to be presented on a code-by-code basis.

In addition to considering compelling evidence for some of the codes, the RUC HCPAC Review Board also considered the typical number of services reported per session. CMS has previously provided data to that indicated a mean of 3.5 codes are reported per session. This mean value of 3.5 units is similar to data APTA provided to CMS in 2010 that showed a median value of 3.0 units based on a review of approximately 3.3 million claims for both Medicare and non-Medicare patient encounters from various practice settings. In developing its recommendations, the RUC HCPAC Review Board considered this information from CMS and the specialties that the typical patient would be scheduled for either a 45 minute or one hour session and typically 3 to 4 codes would be reported. For example, a patient may receive 2 units of 97110 *Therapeutic Exercise* and one modality. The RUC HCPAC Review Board used this information to ensure there was no duplication in the recommended pre or post service time for each individual code.

In most cases, the RUC HCPAC recommended to maintain the current work RVU. However, the RUC HCPAC Review Board accepted compelling evidence for some codes to recommend an increase to the survey 25th percentile.

CMS considers 97010 a bundled service and does not make a separate payment for the service. The organizations surveying the physical medicine and rehabilitation services family at the January 2017 HCPAC meeting, indicated that they were considering deletion or revision of the code and the HCPAC Review Board recommended that 97010 be referred to the CPT Editorial Panel. Upon further examination the specialty determined that deletion or revision of this service is not appropriate because there are payers that use the code. However, because CMS does not pay for this service separately there is no utilization or claims data related to this code within the

RUC database. The specialty did not present the code to the CPT Editorial Panel and this service was placed on the agenda for the April 2017 HCPAC meeting.

The American Physical Therapy Association (APTA) provided a letter to the HCPAC stating that the specialty did not survey or develop practice expense inputs for the service. They explained that "…APTA recently surveyed the majority of codes (approximately 22) in the physical medicine and rehabilitation code family, requiring significant resources for APTA and its members. At this time APTA does not believe an additional survey for this single code warrants the additional burden that would be borne..."The HCPAC discussed that the process does not allow for removing a code from a family identified for survey based on its CMS payment status. In accordance with HCPAC policies, 97010 will again be placed on the LOI for the October 2017 HCPAC meeting and the specialty will be able to indicate their interest level in the manner they deem appropriate. **This code will be placed on the next level of interest to review work and direct practice expense inputs for the October 2017 HCPAC meeting.**

Diabetes Management Training (G0108 & G0109)
Karen Smith, MBA, MS, RD, LD, FADA, FAND (ANDi) and Margaret Powers, PhD, RD, CDE (ANDi)

In October 2016, the Relativity Assessment Workgroup expanded the CMS/Other Source codes screen, lowering the Medicare utilization threshold from 250,000 to 100,000 based on 2015 Medicare utilization data. HCPCS codes G0108 and G0109 were identified as part of this screen. The services were surveyed for physician work and reviewed for direct practice expense inputs for the April 2017 RUC meeting.

When CMS created HCPCS codes G0108 and G0109, they did not establish work RVUs as they believed training would typically be performed by individuals other than a physician or other qualified health care professional. Based on requests from stakeholders to include physician or other qualified health care provider work in valuing diabetes self-management training (DSMT) services, for CY2011 CMS assigned work RVUs for these codes through a modified cross-walk to medical nutrition therapy (MNT), G code 97803 and modified the PE inputs based on those for the Kidney Disease Education HCPCS codes (G0420, G0421).

According to statute Medicare covers 1 hour of individual and 9 hours of group training unless special circumstances warrant more individual training or no group session is available within 2 months of the date the training is ordered. 10 hours of training is currently what is typical.

Compelling Evidence
The specialty provided compelling evidence that the current work RVUs for DSMT service G0108 is undervalued because the code was never surveyed, there was a flawed method used in the valuation and a change in provider work. The HCPAC agreed that compelling evidence had been met, primarily because of the flawed methodology argument, with the caveat that generally this argument refers to the method used by CMS being unknown, however in this case the method is known, but the specialty maintains that it is flawed.

The specialty provided compelling evidence that the current work RVUs for DSMT service G0109 is undervalued because the code was never surveyed and there has been a change in work. The HCPAC agreed that compelling evidence had been met.

HCPAC Survey Sample
Section 1861(qq) of the Social Security Act specifies that DSMT services are furnished by a certified provider, defined as a physician or other individual or entity that also provides, in addition to DSMT, other items or services for which payment may be made under Medicare. The physician, individual or entity that furnishes the training also must meet certain quality standards,

as demonstrated by accreditation by one of the CMS-approved national accreditation organizations. The Academy of Nutrition and Dietetics (ANDi) determined that in addition to surveying a random sample of an applicable subset of its membership, that the quality of the survey data would be enhanced by also surveying a targeted sample of certified providers from accredited DSMT programs as these individuals are most likely to have experience performing the services under review. ANDi therefore requested permission from the Research Subcommittee to survey a random sample of AADE-accredited and ADA-accredited DSMT programs. The Research Subcommittee approved this request. The HCPAC surveys for G0108 and G0109 were completed only by individuals who are eligible to bill Medicare for other items or services. Both AADE and ADA maintain databases that contain not only the name and contact information for each accredited program, but also the names of all staff within these programs that will be filtered for approved Medicare providers (i.e., registered dietitian, nurse practitioner).

G0108 ***Diabetes outpatient self-management training services, individual, per 30 minutes***
The HCPAC reviewed the survey results for 111 registered dietitian nutritionists and diabetes educators for HCPCS code G0108 and discussed the specialty's explanation that the survey was flawed because 9 of the 111 respondents entered a work RVU above 30.00. The specialty contacted these respondents to determine if their entry represented their intended response or if it was a typo. Based on conversations with the respondents whom entered these work RVU outliers, it was obvious they did not understand what the RVU figure was supposed to represent. Rather than using the survey, the specialty used an expert panel to develop the work and practice expense recommendations. The expert panel determined that it was appropriate to use a cross-walk to the current RVU for 97802 *Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes* (work RVU = 0.53) which was the survey top key reference code. This method entails doubling the existing RVU of 97802 based on the recommended intra-service time of 30 minutes for G0108 to yield a recommended work RVU of 1.06.

The HCPAC determined that the proposed work value of 1.06 overvalues the work required to provide this service. The HCPAC proposed a crosswalk to CPT code 97803 *Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes* (work RVU = 0.45). The HCPAC discussed that because the training is for an established patient the re-assessment code is a more accurate crosswalk then the initial assessment code. This is the same crosswalk that is currently used and maintains the current work value. The HCPAC discussed that although the current work RVU accurately describes the work involved, the time crosswalk undervalues the post-service work. A direct crosswalk to the work RVU and time would be 2 minutes of pre-service time, 30 minutes of intra-service time and 2 minutes of post-service time, however the HCPAC recommends pre-service time of 2 minutes, intra-service time of 30 minutes and immediate post-service time of 5 minutes. The extra time for the post-service time is due to the additional patient education and discharge instructions necessary for these patients and puts the post-service time in line with evaluation and management services such as 99213 *Office or other outpatient visit for the evaluation and management of an established patient,* (work RVU = 0.97). For additional support the HCPAC compared G0108 to CPT code 88368 *Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; initial single probe stain procedure* (work RVU = 0.88, 30 minutes intra-service time) which requires slightly less total time, justifying the lower work value. **The HCPAC recommends a work RVU of 0.90 for HCPCS code G0108.**

G0109 ***Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes***
The HCPAC reviewed the survey results for 101 registered dietitian nutritionists and diabetes educators for HCPCS code G0109 and determined that the proposed work value of 0.26 slightly overvalues the work required to provide this service. The HCPAC proposed a direct crosswalk to CPT code 97804 *Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes*

(work RVU = 0.25). This is the same crosswalk that is currently used and maintains the current work value. The specialty explained that based on recommendations from the Research Subcommittee, the standard survey instrument for this code was modified to ask questions about the group session rather than the individual patient and a question was added regarding the average number of patients that attend a typical group session. The survey data showed a median group size of 5 patients. Additionally the HCPAC reviewed Medicare claims data that indicates that the median length of a class session is 2 hours (4 units of G0109 per patient). The specialty used this information to derive the recommended pre-, intra-, and post-service time per individual patient. The HCPAC agreed with the specialty recommendation of pre-service time of 2 minutes, intra-service time of 6 minutes and immediate post-service time of 2 minutes. For additional support the HCPAC compared G0109 to CPT code 93922 *Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)* (work RVU = 0.25, 10 minutes total time) which has the identical total time and identical work value and should be valued identically. **The HCPAC recommends a work RVU of 0.25 for HCPCS code G0109.**

Practice Expense
The PE Subcommittee made significant modifications to the practice expense inputs based on the typical units billed per session. The HCPAC recommends the direct practice expense inputs as approved by the Practice Expense Subcommittee.

- **Appeals and Facilitation Process**

  The appeals process was used in between meetings. The HCPAC discussed that at a future meeting they intend to discuss the process for both appeals and facilitation.

The RUC filed the HCPAC Report.

XVII. Emerging CPT/RUC Issues Workgroup (Tab 42)

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

- **Berenson-Eggers Type of Service (BETOS) Presentation – Robert Berenson, MD – Urban Institute**
  Doctor Senkowski indicated that the RUC has recommended that improvements be made to the Berenson-Eggers Type of Service (BETOS) classification system. MedPAC expressed similar concerns and ultimately hired Robert Berenson, MD from the Urban Institute to revise and update the system. Doctor Berenson presented an early re-evaluation of the BETOS system that may be going through a reclassification. The RUC is hopeful to be involved to dissect or validate families within this new classification. The RUC will wait until further direction if that request is made.

- **Update on CPT Discussion Related to Alternative Payment Models (APMs)**
  Doctor Senkowski indicated that the Workgroup received a second presentation from Ken Brin, MD, Chairman of the CPT Editorial Panel about the evolving need to develop Alternative Payment Models (APMs). There is a plan for a meeting of the interested parties in the summer and the Workgroup looks forward to any forthcoming APMs models through CPT.

- **Other Issues**
  Lastly, Doctor Senkowski indicated that the Workgroup slightly revised their charge to include collaboration to address issues facing the CPT Editorial Panel and the RUC.

  > **Emerging CPT/RUC Issues Workgroup** – (1) Continue work of the former chronic care coordination workgroup to identify coding/payment solutions for non face-to-face services, including to responding to CMS rulemaking; (2) address specific CPT and RUC related questions related to advanced payment models as they arise; (3) address any CMS proposals on BETOS and other potential coding/payment issues in rulemaking; and (4) discuss new issues of challenge for CPT/RUC.

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

XVIII. Other Business (Tab 43)

- A RUC member requested that methodological issues related to 000-day global codes typically billed with E/M be **referred to the Research Subcommittee**.
- 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. Doctor Smith **requests that the Research Subcommittee review instructions regarding trimming of entries of zeros and other outlier data.**

The RUC adjourned at 2:47 p.m. on Saturday, April 29, 2017.

AMA/Specialty Society RVS Update Committee **Tab 36**
Practice Expense Subcommittee
April 26 & 27, 2017

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

Obtain Consent Clinical Activity Time Standard for MR and CT Services

At the October 2016 RUC meeting, the Practice Expense (PE) Subcommittee discussed the appropriate staff time for clinical activity, *Provide pre-service education/obtain consent* for magnetic resonance (MR) imaging services. The PE Subcommittee discussed that they believe that historically the typical time allotted has been 7 minutes for MR services performed without contrast and 9 minutes for MR services performed with contrast.

AMA staff analyzed data on all MR and computed tomography (CT) codes in the database. There are 58 MR services and staff determined that the Subcommittee's assessment of the standard that has developed over the years (7/9/9) for MR services is accurate. There are 15 MR services performed without contrast and of those all services that have PE inputs (14) have 7 minutes of staff time for clinical activity *provide pre-service education/obtain consent.* There are 15 MR services performed with contrast and of those services that have PE inputs (14), 9 have 9 minutes of staff time for clinical activity *provide pre-service education/obtain consent* and 5 have 7 minutes of staff time. There are 15 MR services performed without contrast and with contrast and of those that have PE inputs (14), 10 have 9 minutes of staff time for clinical activity *provide pre-service education/obtain consent* and 4 have 7 minutes of staff time. There are also 6 MR services that are performed with or without contrast and of these services all have 9 minutes of staff time for clinical activity *provide pre-service education/obtain consent.* In addition there are 7 MR codes that do not include language regarding contrast. For these services the most common amount of staff time for clinical activity *provide pre-service education/obtain consent* is 7 minutes.

Staff analyzed data for 45 CT services. There are 14 CT services performed without contrast and of those services 13 have 2 minutes of staff time for clinical activity *provide pre-service education/obtain consent* and 1 has 1 minute of staff time. There are 15 CT services performed with contrast and of those services 13 have 3 minutes of staff time for clinical activity *provide pre-service education/obtain consent* and 2 have 2 minutes of staff time. There are 13 CT services that are performed without and with contrast and of these services all have 3 minutes of staff time for clinical activity *provide pre-service education/obtain consent.* In addition there are 3 CT codes that do not include language regarding contrast and there is no most common amount of staff time for clinical activity *provide pre-service education/obtain consent* for these services. There does not seem to be a standard that has developed for CT services in the same way as MR services, however the data indicate that the time allocated for clinical activity *provide pre-service education/obtain consent* is less.

An Advisor representing Radiology clarified that for MR and CT codes the clinical staff time for *Provide pre-service education/obtain consent* is primarily to educate the patient about the use of contrast rather than to obtain consent. A PE Subcommittee member raised concerns that generally

the work of obtaining consent is performed by the physician and another PE Subcommittee member added that when the physician obtains consent it is a discussion about the service, but the clinical staff have to conduct their own distinct work to help the patient complete the paperwork required to obtain consent and it is not duplicate work.

The PE Subcommittee agreed that further analysis of the clinical staff time for the clinical activity: *provide pre-service education/obtain consent* is needed and will convene a Workgroup to be chaired by Doctor Gregory Barkley.

AAO-HNS Practice Expense Requests

The Practice Expense Subcommittee reviewed two requests made by The American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS). The first is an addition to the clinical activities included in the Practice Expense Spreadsheet.

a) AAO-HNS explained in a letter that Otolaryngologists almost exclusively utilize local/topical anesthesia during virtually all office-based procedures. As presented routinely during review of our services' practice expense, for in-office procedures, this requires the clinical staff and the surgeon to be present while the local anesthesia is sprayed directly into the patient, applied topically via pledgets or injected. Additional time is needed to wait for the local/topical anesthesia to take effect and create the intended numbing for the procedure. Although this has informally been standardized via the PE subcommittee's reviews over the last 5+ years at 2 minutes of clinical staff time, at virtually every RUC meeting this issue comes up because there is not presently a clear place to indicate this staff time on the PE spreadsheet. Currently, the specialty lists the 2 minutes of requested staff time on the line labeled "sedate/apply anesthesia". This routinely poses confusion for the reviewers, as this line is typically associated with the use of moderate sedation or general anesthesia. At each meeting the specialty outlines the history and the PE Subcommittee consistently approves the necessary time for the clinical staff to assist with the administration of local/topical anesthesia. AAO-HNS requested that the PE subcommittee consider the addition of a clinical activity for *apply local/topical anesthesia*. **The PE Subcommittee did not approve the new clinical activity for *apply local/topical anesthesia* and instructed the specialty societies to use the PE SoR to provide additional information about the clinical activity when used for their specialty.**
b) AAO-HNS proposed a package of equipment to be used for their services for post-procedure monitoring. Currently the only equipment that is intended for extended monitoring is; a stretcher (EF018), and when extended monitoring due to concerns regarding bleeding is needed; an ECG, 3-channel (with SpO2, NIBP, temp, resp) (EQ011) and an IV infusion pump (EQ032) and a stretcher (EF018) should be allocated. In a handful of cases oxygen is also included for post-procedure monitoring. None of these items are typically found in an Otolaryngologists office, and as such, would not be properly be included in PE recommendations to the RUC. AAO-HNS requests that additional items be considered by the PE subcommittee for specialties, such as Otolaryngology, who do considerable post-procedure monitoring in their office, but do not utilize the equipment items in the standard monitoring package. AAO-HNS proposes the following two items for an Otolaryngology package for monitoring; an exam chair (EF008) and an SMR cart (EQ234). Of note, these items are immovable and remain in the room with the patient following the procedure and it is not common practice to move the patient to a new place for monitoring when procedures are performed in the office.

The PE Subcommittee did not approve the Otolaryngology post-procedure monitoring equipment package.

Exam Light Workgroup

Throughout the meeting and in past meetings there has been extensive discussion about the type of lights that are used in services and for what reason. For example the exam light (EQ168) is allocated equipment time in many services that are billed with an evaluation and management (E/M) service even though it is not standard equipment in the room for E/M services. PE Subcommittee members have consistently questioned the need for other lights, such as the xenon light source (EQ167). The PE Subcommittee discussed the need for further analysis of various light sources included as equipment. A Workgroup will examine the data and determine if any standard equipment is needed and what guidelines are necessary. The Workgroup will also determine whether or not the problem is significant enough to revise retroactively. **The PE Subcommittee will convene a Workgroup to be chaired by Doctor Tom Weida.**

Practice Expense Recommendations for CPT 2019:

Tab	Title	PE Input Changes
4	Anesthesia for GI Procedures	Affirm January 2017 PE Inputs
5	Skin Biopsy	Minor Modifications
6	Structural Allograft	No PE Inputs
7	Cardiac Event Recorder Procedures	Modifications
8	Continuous Glucose Monitoring - PE Only	Minor Modifications
9	Chronic Care Management Services	No Change
10	Injection Tendon Origin - Insertion	Minor Modifications
11	Application of Long Arm Splint	Minor Modifications
12	Percutaneous Change of G-tube	No Change
13	Diagnostic Proctosigmoidoscopy Rigid	Minor Modifications

Tab	Title	PE Input Changes
14	Removal of Intraperitoneal Catheter	Modifications
15	Vaginal Treatments	Modifications
16	Biopsy of Uterus Lining	No Change
17	Injection Greater Occipital Nerve	Modifications
18	Injection Digital Nerves	Minor Modifications
19	Removal of Foreign Body - Eye	No Change
20	X-Ray Spine	No Change
21	X-Ray Sacrum	No Change
22	X-Ray Elbow - Forearm	No Change
23	X-Ray Heel	No Change
24	X-Ray Toe	No Change
25	X-Ray Esophagus	No Change
26	X-Ray Urinary Tract	Modifications
27	Fluoroscopy	Minor Modifications
28	Ultrasound Exam - Scrotum	Modifications
29	CT Scan for Needle Biopsy	No Change

Tab	Title	PE Input Changes
30	Blood Smear Interpretation	No PE Inputs
31	Bone Marrow Interpretation	No Change
32	Sleep Testing	No Change
33	External Counterpulsation	Minor Modifications
34	Wound Closure by Adhesive	Modifications
35	Removal of Impacted Cerumen	Minor Modifications

AMA/Specialty Society RVS Update Committee **Tab 37**
Research Subcommittee
April 27, 2017

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

I. Research Subcommittee February 27, 2017 Conference Call Meeting Report

The Research Subcommittee report from the February 2017 conference call included in Tab 37 of the April 2017 agenda materials was approved without modification.

II. Proposed Extant Database, RSL, Custom Survey Instrument and Survey Methodology for transcatheter aortic valve replacement (TAVR)

Society of Thoracic Surgeons
American College of Cardiology
The Society for Cardiovascular Angiography and Interventions

The Society of Thoracic Surgeons (STS), American College of Cardiology (ACC) and the Society for Cardiovascular Angiography and Interventions (SCAI) proposed several items pertaining to transcatheter aortic valve replacement (TAVR) codes 33361-33366 for Research Subcommittee approval. The TAVR codes were flagged for review by the RAW based on the new technology screen and are scheduled for review at the October 2017 RUC meeting. The presenters for STS, ACC and SCAI requested for the Research Subcommittee to consider the following items:

- Request to approve the STS/ACC TVT Registry for use as an Extant Database
- If the Registry is approved as an Extant Database, also approve the use of the STS/CTS Alternate Five Year Review Methodology that was used in the 2005 5-year review with modifications to the intensity data collection relative to the TAVR codes that are up for review. Per the established criterion also applied to the STS database, if the specialties find that the database does not meet the 95th/5% criterion (95th percentile confidence interval with a +-5% variability) the database data will not be used to value the codes and will not be revealed.
- The Specialties also requested for the Research Subcommittee to provide guidance on the RUC's intentions regarding the use of the RUC survey in conjunction with the database data valued services and a clear delineation of how each data set will be used in determining the value of the services.
- Review of a Reference Service List which would be used both for RUC survey for work RVUs/physician time as well as for a direct intensity survey methodology
- Survey instrument – the original survey used for the TAVR codes was set up as a joint survey with the cardiac surgeon and the interventional cardiologist sitting down together to complete the survey. Because of coding and coverage requirements, the societies again recommend a joint survey in this style and will work with AMA staff to develop an updated survey instrument using Qualtrics, if possible.

- The societies are still waiting for data from the TVT-R and will plan to develop revised vignettes based on that data and will submit to the Research Subcommittee for review on the Research Subcommittee Call after the June CPT meeting.

As detailed in the letter submitted as part of this request, the specialties noted and the Subcommittee agreed that the TVT registry meets all of the RUC's extant database requirements. The presenters noted that the database includes all US patients which have had TAVR. They also explained that payment for performing TAVR is contingent on participating in the registry, ensuring that 100% participation would continue.

As part of the discussion, the Subcommittee noted that, at the October 2016 RUC meeting, the Time and Intensity Workgroup recommended and the RUC approved that "*If a specialty has a RUC-approved source of extant physician time data, then that Specialty can use this methodology as supporting evidence for their RUC recommendation, though they would still be required to conduct a RUC survey*." The Subcommittee noted that the specialties series of requests complied with this guidance from the Workgroup.

The specialties also proposed that they would provide summary data from the Registry based on the most recent 3 years of data available each time they presented a TAVR service to the RUC. A Subcommittee member questioned whether older data would be representative for a service that is still evolving. The presenters concurred, noting that data that was older than 5 years from the database should not be considered for review. More recently, the patient population TAVR has trended towards a patient population that is relatively younger and less complex than TAVR procedures performed more than 5 years ago.

The Research Subcommittee recommended for the RUC to approve the TVT Registry as a database that meets the RUC's extant database criteria.

The Subcommittee also discussed whether mean or median summary data would be more appropriate for the Registry summary data. **The Research Subcommittee requests 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 on what summary data is most appropriate for datasets of different sizes (ie small sample size, large sample size, total population).**

The Subcommittee also discussed the proposed survey methodology and approved the survey instruments as submitted with the understanding that certain questions would be updated to reflect the latest survey language. The Subcommittee approved use of the modified survey methodology using a joint survey similar to the 2012 TAVR survey. Specialty staff would work with AMA staff to conduct this survey using Qualtrics.

The Subcommittee also approved the concurrent use of a direct intensity survey, noting that both the intensity survey and the work survey instruments would use the same reference service list codes.

The Research Subcommittee also reviewed the proposed reference service list and recommended for the societies to remove any codes last reviewed by the RUC before 2010 and also to remove codes 34812 and 34833, as their global period will be changing to ZZZ.

The Subcommittee also approved for the specialties to use the STS/CTS Alternate Five Year Review Methodology that was used in the 2005 5-year review with modifications to the intensity data collection as support for the survey data collected under the RUC survey process. The Subcommittee agreed with the specialties that a Rausch analysis would not be needed.

III. RUC Survey Intensity and Complexity Questions

As part of its past discussion of the intensity and complexity measures, the Time-Intensity Workgroup had observed at the October 2016 meeting that in addition to the overall intensity question, there are currently 8 other component questions which seems too granular. Several Workgroup members noted their belief that the intensity and complexity questions should be collapsed into fewer questions. One Workgroup member suggested that the 3 Mental Effort and Judgment questions and the 3 psychological stress questions should each be collapsed into a single question, respectively. Several Workgroup members noted their belief that this would help improve survey response rates while also providing a sufficient amount of data for the RUC to review. The Time-Intensity Workgroup recommended for the Research Subcommittee to consider only having 5 total intensity and complexity questions: Mental Effort and Judgment, Technical Skill, Physical Effort, Psychological stress and Overall intensity. Also, the Workgroup recommends for the definitions for each component of intensity and complexity to remain unchanged.

At the January meeting, the Research Subcommittee approved the Time-Intensity Workgroup's recommendation to collapse the 3 mental effort and judgment and 3 psychological stress intensity and complexity questions each into a single question. The Subcommittee requested for AMA Staff to draft updated survey language for its consideration at the April 2017 RUC meeting. This draft language is available for the Subcommittee's review as a separate attachment in the materials. Note, the draft proposal does not change the background definitions text or to question 4 (overall intensity). **The Subcommittee approved the updated survey intensity and complexity question as proposed by AMA Staff:**

Background for Question 3

In evaluating the work of a service, it is helpful to identify and think about each of the components of a particular service. Focus only on the work that you perform during each of the identified components. The descriptions below are general in nature. Within the broad outlines presented, please think about the specific services that you provide.

Physician work includes the following:

Time it takes to perform the service.

Mental effort and judgment necessary with respect to the amount of clinical data that needs to be considered, the fund of knowledge required, the range of possible decisions, the number of factors considered in making a decision, and the degree of complexity of the interaction of these factors.

Technical Skill required with respect to knowledge, training and actual experience necessary to perform the service.

Physical effort can be compared by dividing services into tasks and making the direct comparison of tasks. In making the comparison, it is necessary to show that the differences in physical effort are not reflected accurately by differences in the time involved; if they are, considerations of physical effort amount to double counting of physician work in the service.

Psychological stress – Two kinds of psychological stress are usually associated with physician work. The first is the pressure involved when the outcome is heavily dependent upon skill and judgment and an adverse outcome has serious consequences. The second is related to unpleasant conditions connected with the work that are not affected by skill or judgment. These circumstances would include situations with high rates of mortality or morbidity regardless of the physician's skill or judgment, difficult patients or families, or physician physical discomfort. Of the two forms of stress, only the former is fully accepted as an aspect of work; many consider the latter to be a highly variable function of physician personality.

Question 3

Compare INTENSITY COMPONENTS of the survey code(s) relative to the corresponding reference code(s) you selected in Question 1. Using your expertise, consider how each survey code compares directly to the corresponding reference code. For example, if you find the mental effort and judgment for the survey code is identical when compared to the corresponding reference code you chose in Question 1, select "identical" in the dropdown box below.

Mental Effort and Judgment Necessary • The range of possible diagnoses and/or management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, or other information that must be analyzed • Urgency of medical decision making	Much Less *[Identified as "-2" in raw data]* Somewhat Less *[Identified as "-1" in raw data]* Identical *[Identified as "0" in raw data]* Somewhat More *[Identified as "+1" in raw data]* Much More *[Identified as "+2" in raw data]*
Technical Skill Required	Much Less *[Identified as "-2" in raw data]* Somewhat Less *[Identified as "-1" in raw data]* Identical *[Identified as "0" in raw data]* Somewhat More *[Identified as "+1" in raw data]* Much More *[Identified as "+2" in raw data]*
Physical Effort Required	Much Less *[Identified as "-2" in raw data]* Somewhat Less *[Identified as "-1" in raw data]* Identical *[Identified as "0" in raw data]* Somewhat More *[Identified as "+1" in raw data]* Much More *[Identified as "+2" in raw data]*
Psychological Stress Involved • The risk of significant complications, morbidity and/or mortality • Outcome depends on skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	Much Less *[Identified as "-2" in raw data]* Somewhat Less *[Identified as "-1" in raw data]* Identical *[Identified as "0" in raw data]* Somewhat More *[Identified as "+1" in raw data]* Much More *[Identified as "+2" in raw data]*

IV. Research Subcommittee Review of Vignettes – Discussion

Following the February 2017 Research call, two subcommittee members requested for Subcommittee to discuss:

1. What level of specificity/granularity clinical vignettes should contain.
2. Whether the RUC and CPT should revise their current instructions on vignette composition.

In preparation for this discussion, AMA Staff prepared the below analyses for the Subcommittee and also collated the RUC's and CPT's current vignette instructions.

Presence of Age and Gender in Vignettes

	Number of Codes	Percentage
# of Codes with Age	3783	90.4%
# of Codes with Gender	3263	78.0%
# of Codes with Vignette in RUC Database	4185	

Vignette Word Count

	Word Count
25th Percentile	30
Median	47
75th Percentile	71

The Subcommittee agreed that, in general, vignettes should include the typical age and gender of the patient, as well as typical indications and comorbidities which are material to the procedure under review. The Subcommittee did not recommend any changes to the RUC's vignette instructions at this time.

AMA RUC staff noted that it may be beneficial for the CPT Editorial Panel to consider including guidance on the code change application regarding a typical word count range for clinical vignettes, though this word count should just be a suggestion and not mandatory. A Subcommittee member noted that this could be a statement noting that it is rare for vignettes to exceed 75 words. **The Subcommittee recommends for the CPT Editorial Panel to consider adding language to the Code Change Application to explain that the typical word count for a vignette is 50 words and is unlikely to exceed 75 words.**

The Subcommittee has proposed that specialties requesting vignette revision approval from Research Subcommittee should include the current vignette, the revised vignette and their reason for the revision to simplify and focus the work of the Subcommittee.

V. RUC Pre-service and Post-service Time Packages

Time Package Definitions – Straightforward vs. Difficult
During the RUC's Other Business discussion at the January 2017 RUC meeting, a RUC member raised the point that pre-service time for surgical services are based on location, type of anesthesia, condition of the patient, and difficulty of the procedure. However, several times during the meeting, the RUC member noted that presenters noted that "the survey time was X" and so the reason that it became a difficult patient/difficult procedure is what fit best with the survey. The pre-service time package should be based on the aforementioned factors not the survey time. Doctor Smith agreed that better diligence is needed to ensure that the package applies to the patient**.** The RUC referred this issue to the Research Subcommittee to develop definitions for "straightforward/difficult patient" and "straight/difficult procedure" as it pertains to the selection of time packages.

The Subcommittee discussed whether additional language defining straightforward and difficult patients and procedures would be necessary. Some Subcommittee members thought new definitions would be beneficial whereas others thought that perhaps the pre-time packages should instead be renamed to more appropriately reflect their components. It was noted that the majority of the components of each time package pertained to the difficulty of the procedure and not the difficulty of the patient. **The Subcommittee requested for AMA staff to provide more detailed historical reference materials on how each package was created. The Subcommittee tabled this issue for further discussion at the next RUC meeting.**

Retroactive application of pre- and post-time packages
During the RUC's Other Business discussion at the January 2017 RUC meeting, a RUC member noted that while there are now time packages, there are a whole host of services within the fee schedule in which this standard has not been applied. The RUC member questioned whether there should be a retroactive application of pre- and post-time packages within the fee schedule. **This issue was referred to the Research Subcommittee for further discussion. The Research Subcommittee agreed that a retroactive application of time packages would not be appropriate.**

Non-facility Post-service Time Package
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, the Subcommittee expressed general interest in developing non-facility post-time packages. **The Subcommittee tabled this item for further discussion at the next RUC meeting.**

Immediate Post-Time Analysis for 000-, 010- & 090-Day Codes Typically Performed in the Non-Facility Setting (Only Codes with 2015 Medicare Utilization >1,000)

		Immediate Post-Time (minutes)				
Global	**# of Codes**	**Minimum**	**25th Percentile**	**Median**	**75th Percentile**	**Maximum**
000, 010 & 090	463	0	5	**8**	10	45
000	220	0	5	**5**	10	30
010	168	0	5	**8**	10	19
090	75	4	8	**10**	15	45

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

I. High Growth Codes – Action Plan Review (01936 & 64450)

Anesthesia for Percutaneous Image Guided Procedures - Spine
CPT code 01936 *Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic* was identified via the high growth screen with Medicare utilization of 10,000 or more that has increased by at least 100% from 2009 through 2014. In January 2017, the Workgroup reviewed the specialty society's action plan and requested that the specialty society research data on what procedures are reported with this anesthesia code to review in April 2017.

The Workgroup noted it was concerned that this service may still be reported inappropriately as the top surgical services reported with 01936 (22513, 22514, 62322, 62323, 63650, 64483 and 64490) utilization does not show significant increases and some of these services indicate that moderate sedation is included. The Workgroup noted that ASA has provided significant education on the correct reporting of this service, however can not reach all other providers of this service or physicians who request the anesthesia service. **The Workgroup recommends reviewing 01936 after two years of utilization data are available including the utilization for the top surgical services reported with 01936 (October 2019).**

Injection - Anesthetic Agent
CPT code 64450 *Injection, anesthetic agent; other peripheral nerve or branch* was identified via the high growth screen with Medicare utilization of 10,000 or more that has increased by at least 100% from 2009 through 2014. In January 2017, the Workgroup requested that the specialty societies review this issue further to determine if there are any other peripheral nerves or branches not specified with a CPT code to determine if this service may be deleted and review an action plan for April 2017.

The specialty society indicated and the Workgroup agreed that CPT code 64450 Medicare utilization is decreasing and that there may be some miscoding with this service as a few providers in three states account for an explicably high proportion of 25% of Medicare claims. **The Workgroup recommends to notify CMS of the possible inappropriate reporting and to re-review the utilization data for this service in two years (October 2019).**

II. Work Neutrality – Action Plan Review (64633-64636)

In September 2014, the Relativity Assessment Workgroup identified CPT codes 64633-64636 to be reviewed for work neutrality. However, the Workgroup was not able to get to this agenda item. Due to the nature of the possible incorrect coding of per nerve instead of per joint, the specialties were encouraged to immediately begin addressing this coding education and clarification. The RUC recommended that the specialty societies develop a CPT Assistant article to address this issue. The specialty societies submitted a CPT Assistant article stressing that each of these codes now includes the entire joint (i.e. two nerves) and not just one nerve, as before (publication date: February 2015). In January 2015, the Workgroup discussed this issue and agreed that the CPT Assistant article is a good proactive step. The RUC recommended that the specialty societies immediately submit revised introductory language to the CPT Editorial Panel to address any inappropriate coding regarding reporting per nerve instead of per joint

issue (for CPT 2016). The RUC requested that AMA staff compile data on how many times a services is reported on the same patient on the same day and 2014 preliminary Medicare utilization for the Workgroup to review the additional data in April 2015. In April 2015, the Workgroup agreed that the specialty societies have taken aggressive action to ensure correct reporting of these services. In May 2015, the CPT Editorial Panel revised the parenthetical instructions for five codes describing paravertebral facet joint nerve destruction to clarify that these codes are reported per joint, not nerve. The Workgroup recommended the multiple aforementioned efforts to take effect and re-review the utilization data for these services in April 2017.

The specialty society indicated and the Workgroup agreed that recent CPT changes did not take effect until 2016 and the Medicare utilization was not available when preparing for this meeting. **The Workgroup recommends that more time is necessary to determine CPT changes were effective and that the Workgroup review these services in October 2019 when two years of Medicare utilization data are available.**

III. Negative IWPUT

At the April 2016 meeting, during new business discussion a RUC member requested that the Relativity Assessment Workgroup review services with low or 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, which resulted in 38 services identified. The Workgroup briefly discussed this issue in October 2016 and noted that it will continue discussion in April 2017 after the Administrative Subcommittees' discussion regarding possibly adding a negative IWPUT as a compelling evidence standard.

In January 2017, the Administrative Subcommittee determined that the services with a negative IWPUT would be considered part if the "flawed methodology" compelling evidence standard. The Subcommittee noted that the process to review any services that specialty societies disagree with the work RVU of an existing code is to submit a letter to CMS as potentially misvalued with a rationale. CMS will nominate any potentially misvalued services in the Notice for Proposed Rule Making (NPRM) and the RUC will examine.

The Workgroup reviewed this list of codes and determined that this list of services should revised for negative IWPUT with Medicare utilization over 10,000 and/or including all Harvard valued and CMS/Other source codes and placed on the level of interest for action plans to review at the October 2017 meeting.

IV. New Screens Discussion

Low Intra-service Work Per Unit of Time (IWPUT)

The 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 will review this list of services at the October 2017 Relativity Assessment meeting.**

CMS/Other Source Codes – Utilization over 30,000

The 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.**

AMA/Specialty Society RVS Update Committee **Tab 39**
Administrative Subcommittee
April 27, 2017

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

I. RUC Member Specialty Designations

At the January 2017 RUC meeting a RUC member requested clarification if RUC members are limited from speaking to only issues where an individual from their specialty seat is speaking or from any organization for which they are a member. The RUC Chair referred this issue to the Administrative Subcommittee for review.

The Subcommittee noted that RUC members and alternates serve as part of an expert panel and do not advocate for their specialty societies. Additionally, the RUC conflict of interest policy states that RUC members and alternates "have a continuing responsibility to comply with the Conflict of Interest policy and promptly disclose any direct financial interest required under this policy". The Subcommittee noted that the current conflict of interest policy would cover any conflict/financial interest if RUC members or alternates are involved or have additional interests being a member of a secondary or tertiary specialty society. **The Subcommittee recommends maintaining the current conflict of interest policy**.

AMA/Specialty Society RVS Update Committee **Tab 40**
Anesthesia Workgroup
April 27, 2017

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

I. Review Anesthesia Methodology

ASA provided an overview of the Post-Induction Period Procedure Anesthesia (PIPPA), noting that it is not the same as IWPUT but serves as an intensity measure. PIPPA intensity is used to validate base units and/or survey results. Just as with RBRVS-valued services where IWPUT multiplied by the intra-service time is proportional to wRVU, with the Anesthesia Fee Schedule-valued services, PIPPA multiplied by average post-induction time is proportional to base units.

The Workgroup noted that it has been 10 years since the anesthesia fee schedule codes have been reviewed or validated. The Workgroup determined that an alternative approach should be examined comparing anesthesia codes to other codes in the Resource-Based Relative Value Scale (RBRVS) since there is not a current methodology to validate the original 19 representative anesthesia services. The Workgroup indicated that in 2007 the representative number of anesthesia services was expanded to 40 codes to represent 81% of all Medicare allowed charges for anesthesia codes and that this representative sample of services may have changed.

The Workgroup continued discussion about the accuracy of the anesthesiology vignettes, dominant surgical codes and PIPPA intensities, noting that there is not a way to currently determine if the 19 anesthesiology codes are currently correct.

The Workgroup will continue review and discussion of anesthesia services at the October 2017 meeting. AMA staff, working with ASA, will develop an analysis comparing the physician work component of anesthesia base units to work RVUs. The analysis will include codes that are representative of the ASA base units and include a large percentage of total spending.

HISTORY OF THE REVIEW OF THE RUC METHODOLOGY FOR ANESTHESIA SERVICES

Intent of Statute

Anesthesia Base Unit Methodology (est. 1987, pre-RBRVS)

- RBRVS took effect January 1, 1992
- While the radiology fee schedule, which also preceded RBRVS, was folded into RBRVS; Congress deliberately maintained a separate fee schedule for anesthesia services
- Intent of the statute was that consistency between RBRVS and the anesthesia services is adjusted through the anesthesia conversion factor
  - Anesthesia conversion factor (updated annually)
  - Percent of anesthesia units allocated to physician work (updated annually)

2000 Anesthesia Workgroup Meeting	**2002 Anesthesia Workgroup Meeting** *Second Five Year Review*	**2007 Anesthesia Workgroup Meeting** *Third Five Year Review*	**January 2017 RUC Meeting**
RUC DECISION: Validated PIPPA	**RUC DECISION: Validated PIPPA**	**RUC DECISION: Validated PIPPA**	**RUC ACTION: PIPPA one of multiple criteria used to validate RUC recommendation**
• The RUC reached consensus that the 13 codes identified by ASA representing codes account for 54% of all Medicare allowed charges, and 44% of Medicare anesthesia services were undervalued (00142, 00350, 00540, 00562, 00630,00770, 00790, 00840, 00910, 01230, 01270, 01402, 01844) • Reviewed and Validated: (1) ASA building block methodology (relies primarily on a group of E/M codes to be equated to various components of anesthesia services) (2) PIPPA Quintile Intensity Model	• Reviewed and validated 19 codes (00142, 00210, 00350, 00404, 00540, 00562, 00630, 00770, 00790, 00830, 00840, 00910, 00914, 00944, 01230, 01270, 01382, 01402, 01844) • Additional codes added greater spread in base unit values • Validated PIPPA Intensity Values o Level 1 = 0.0224 o Level 2 = 0.031 o Level 3 = 0.051 o Level 4 = 0.070 o Level 5 = 0.085	• The RUC recognized that regression model was a necessary element for calculating PIPPA work for codes other than the original 19 which used a quintile intensity model to determine work • The RUC discussed the floor and ceiling proposed by ASA for the regression, and agreed that the floor could be no less than 0.031 and a ceiling of 0.090 was reasonable. o Validated PIPPA Intensity Values ▪ Level 1 = 0.031 ▪ Level 2 = 0.044 ▪ Level 3 = 0.055 ▪ Level 4 = 0.07 ▪ Level 5 = 0.09	• RUC determined its recommended Anesthesia Base Units for 5 Anesthesia GI services (007X1, 007X2, 008X1, 008X2, 008X3) based upon a submission that included: o PIPPA Intensity Values o Comparison to Moderate Sedation Values o Comparison to Key Reference Services o Rank Order within the Family

AMA/Specialty Society RVS Update Committee **Tab 41**
Health Care Professionals Advisory Committee Review Board
Thursday, April 27, 2017

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

I. Introductions

Dr. Tillo called the meeting to order at 3:00 pm. Dr. Tillo announced that this will be the last HCPAC meeting for Emily Hill, PA-C after many years of participation in the HCPAC. We thank her for her many years of service.

II. CMS Update

Doctor Edith Hambrick from CMS attended the HCPAC meeting and gave the HCPAC an update on recent activities at the Agency. She noted that the NPRM is in the final stages of preparation but did encourage interested stakeholders to meet with CMS if they have any issues as soon as possible.

III. Relative Value Recommendations for CPT 2019

Biopsy of Nail (11755)

The American Podiatric Medical Association (APMA) surveyed a CPT code (11755) identified by the CMS 000-Day Global Typically Reported with an E/M.

11755 ***Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)***
The HCPAC reviewed the survey results for 72 podiatrists for CPT code 11755 and determined that the proposed work RVU of 1.25, the survey median work RVU and below the current work RVU of 1.31, appropriately accounts for the work required to perform the service. The specialty clarified that dermatology surveyed this service in 1993 although podiatry is the dominant provider of this service. The HCPAC recommends pre-service evaluation time of 10 minutes, pre-service positioning time of 3 minutes, pre-service scrub, dress, wait time of 5 minutes, intra-service time of 15 minutes and immediate post-service time of 6 minutes. The HCPAC discussed the key reference CPT Code 11730 *Avulsion of nail plate, partial or complete, simple; single* (work RVU= 1.05) which includes 18 minutes of pre-service time, 10 minutes of intra-service time, and 5 minutes of immediate post-service time. The presenters provided a brief summary of the discussion from PE. The PE Subcommittee made one adjustment, to remove 3 minutes of clinical staff time for *complete pre-procedure phone calls and prescriptions* in the pre-service period. **The HCPAC recommends a work RVU of 1.25 for CPT code 11730.**

Practice Expense
The HCPAC recommends the direct practice expense inputs as approved by the Practice Expense Subcommittee.

Strapping – Lower Extremity (29540, 29550)

The American Podiatric Medical Association (APMA) surveyed a CPT codes (29540, 29550) identified by the CMS 000-Day Global Typically Reported with an E/M.

29540 ***Strapping; ankle and/or foot***
The HCPAC reviewed the survey results for 124 podiatrists for CPT code 29540 and determined that the proposed work value 0.39, below the survey 25th percentile, appropriately accounts for the work required to provide this service. The HCPAC recommends pre-service evaluation time of 5 minutes, pre-service positioning time of 2 minutes, intra-service time of 7 minutes and immediate post-service time of 3 minutes. The HCPAC discussed the key reference CPT code 29515 *Application of short leg splint (calf to foot)* (work RVU= 0.73) which includes 10 minutes of pre-service time, 15 minutes of intra-service time, and 3 minutes of immediate post-service time. The presenters provided a brief summary of the discussion from PE and a HCPAC member noted that an additional change to the length of foam underwrap from 48 to 24 inches is necessary. The PE Subcommittee also discussed a reduction in the rigid strapping tape and the HCPAC agreed with the specialty that it was appropriate to maintain the specialties recommendation of 48 inches. **The HCPAC recommends a work RVU of 0.39 for CPT code 29540.**

29550 ***Strapping; toes***
The HCPAC reviewed the survey results for 124 podiatrists for CPT code 29550 and determined that the proposed work value of 0.25, below the survey 25th percentile, appropriately accounts for the work required to provide this service. The HCPAC recommends pre-service evaluation time of 5 minutes, intra-service time of 5 minutes and immediate post-service time of 3 minutes. The HCPAC discussed the key reference CPT code 29530 *Strapping; knee* (work RVU= 0.39) which includes 7 minutes of pre-service time, 9 minutes of intra-service time, and 2 minutes of immediate post-service time. The presenters provided a brief summary of the discussion from PE and a HCPAC member noted that an additional change to the length of supply items; foam underwrap and rigid strapping tape from 22 to 10 inches is necessary. **The HCPAC recommends a work RVU of 0.25 for CPT code 29550.**

Practice Expense
With the modifications made by the HCPAC, The HCPAC recommends the direct practice expense inputs as approved by the Practice Expense Subcommittee.

Physical Medicine and Rehabilitation Services

The American Physical Therapy Association (APTA) presented a CPT code (97010) identified by multiple CMS and RUC screens.

CMS considers 97010 a bundled service and does not make a separate payment for the service. The organizations surveying the physical medicine and rehabilitation services family at the January 2017 HCPAC meeting, indicated that they were considering deletion or revision of the code and the HCPAC Review Board recommended that 97010 be referred to the CPT Editorial Panel. Upon further examination the specialty determined that deletion or revision of this service is not appropriate because there are payers that use the code. However, because CMS does not pay for this service separately there is no utilization or claims data related to this code within the RUC database. The specialty did not present the code to the CPT Editorial Panel and this service was placed on the agenda for the April 2017 HCPAC meeting.

The American Physical Therapy Association (APTA) provided a letter to the HCPAC stating that the specialty did not survey or develop practice expense inputs for the service. They explained that "…APTA recently surveyed the majority of codes (approximately 22) in the physical medicine and rehabilitation

code family, requiring significant resources for APTA and its members. At this time APTA does not believe an additional survey for this single code warrants the additional burden that would be borne..." The HCPAC discussed that the process does not allow for removing a code from a family identified for survey based on its CMS payment status. In accordance with HCPAC policies 97010 will again be placed on the LOI for the October 2017 HCPAC meeting and the specialty will be able to indicate their interest level in the manner they deem appropriate. **This code will be placed on the next level of interest to review work and direct practice expense inputs for the October 2017 HCPAC meeting.**

Diabetes Management Training (G0108, G0109)

The Academy of Nutrition and Dietetics (AND) surveyed CPT codes (G0108, G0109) identified by the CMS/Other Source – Utilization over 100,000 screen.

When CMS created HCPCS codes G0108 and G0109, they did not establish work RVUs as they believed training would typically be performed by individuals other than a physician. Based on requests from stakeholders to include physician or other qualified health care provider work in valuing diabetes self-management training (DSMT) services, for CY2011 CMS assigned work RVUs for these codes through a modified cross-walk to medical nutrition therapy (MNT), CPT code 97803 and modified the PE inputs based on those for the Kidney Disease Education HCPCS codes (G0420, G0421).

According to statute these services consist of 1 hour of individual and 9 hours of group training unless special circumstances warrant more individual training or no group session is available within 2 months of the date the training is ordered.

Compelling Evidence
The specialty provided compelling evidence that the current work RVUs for DSMT service G0108 is undervalued because the code was never surveyed, there was a flawed method used in the valuation and a change in work. The HCPAC agreed that compelling evidence had been met, primarily because of the flawed methodology argument, with the caveat that generally this argument refers to the method used by CMS being unknown, however in this case the method is known, but the specialty maintains that it is flawed.

The specialty provided compelling evidence that the current work RVUs for DSMT service G0109 is undervalued because the code was never surveyed and there has been a change in work. The HCPAC agreed that compelling evidence had been met.

G0108 ***Diabetes outpatient self-management training services, individual, per 30 minutes***
The HCPAC reviewed the survey results for 111 nutritionist and diabetes educators for CPT code G0108 and discussed the specialty's explanation that the survey was flawed because 9 of the 111 respondents entered a work RVU above 30.00. The specialty contacted these respondents to determine if their entry represented their intended response or if it was a typo. Based on conversations with the respondents whom entered these work RVU outliers, it was obvious they did not understand what the RVU figure was supposed to represent. Rather than using the survey, the specialty used an expert panel to develop the work and practice expense recommendations. The expert panel determined that it was appropriate to use a cross-walk to the current RVU for 97802 *Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes* (work RVU = 0.53) which was the survey top key reference code. This method entails doubling the existing RVU of 97802 based on the recommended intra-service time of 30 minutes for G0108 to yield a recommended work RVU of 1.06.

The HCPAC determined that the proposed work value of 1.06 overvalues the work required to provide this service. The HCPAC proposed a crosswalk to CPT code 97803 *Medical nutrition therapy; re-*

assessment and intervention, individual, face-to-face with the patient, each 15 minutes (work RVU = 0.45). The HCPAC discussed that because the patient has multiple visits over the course of a year the re-assessment code is a more accurate crosswalk then the initial assessment code. This is the same crosswalk that is currently used and maintains the current work value. The HCPAC discussed that although the current work RVU accurately describes the work involved, the time crosswalk undervalues the post-service work. A direct crosswalk work RVU and time would be 2 minutes of pre-service time, 30 minutes of intra-service time and 2 minutes of post-service time, however the HCPAC recommends pre-service time of 2 minutes, intra-service time of 30 minutes and immediate post-service time of 5 minutes. The extra time for the post-service time is due to the additional patient education and discharge instructions necessary for these patients and puts the post-service time in line with evaluation and management services such as 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and 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 low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family* (work RVU = 0.97). **The HCPAC recommends a work RVU of 0.90 for CPT code G0108.**

G0109 ***Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes***
The HCPAC reviewed the survey results for 101 nutritionist and diabetes educators for CPT code G0109 and determined that the proposed work value of 0.26 overvalues the work required to provide this service. The HCPAC proposed a direct crosswalk to CPT code 97804 *Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes* (work RVU = 0.25). This is the same crosswalk that is currently used and maintains the current work value. The HCPAC recommends pre-service time of 2 minutes, intra-service time of 6 minutes and immediate post-service time of 2 minutes. **The HCPAC recommends a work RVU of 0.25 for CPT code G0109.**

Practice Expense
The PE Subcommittee made significant modifications to the practice expense inputs. The HCPAC recommends the direct practice expense inputs as approved by the Practice Expense Subcommittee.

IV. Appeal Request Report (97140, 97535)

The HCPAC convened a conference call on March 29, 2017 to consider an appeal request for CPT codes 97140 *Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes* and 97535 *Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes.*

APTA appealed the recommendation for CPT 97140 because:

1) The HCPAC recommended to maintain the work value of 0.43 which APTA feels results in a rank order anomaly in relation to other codes in this group. Survey results indicate that CPT code 97140 describes a service that is equal in work to CPT 97112, neuromuscular reeducation (HCPAC rec of 0.50) and CPT 97116, gait training (HCPAC rec of 0.48). APTA recognized that the service has changed over 20 years and accounted for the change in decreased staff time in the practice expense. This decrease in practice expense combined with maintaining current value is a compounding factor in the rank order problem.

2) The HCPAC asked for compelling evidence arguments for each individual code. The presenters were not prepared to present compelling evidence for the individual codes, but rather for the group as a whole. APTA advisors and staff were still identifying a crosswalk code for the previous code (97116), while also initiating the compelling evidence argument for 97140. APTA felt "there was much confusion regarding the information requested." As a result, the compelling evidence was not presented in the same manner for 97140 (manual therapy) as it was for the other services within this group where compelling evidence was determined to be met by the HCPAC.

AOTA appealed the recommendation for CPT 97535 because:

1) The HCPAC recommendation to maintain the current value of 0.45 results in a rank order anomaly in relation to other codes with this group. Maintaining the current value indicates there is considerable less work relative to other similar services such as CPT 97112 (Neuromuscular Reeducation), CPT 97533 (Sensory Integration), and CPT 97537 (Community/Work Reintegration). Currently, these three codes have a wRVU of either 0.44 or 0.45. All three codes are analogous in the time, technical skill and effort, mental effort and judgment, and stress involved from the practitioner.
2) The HCPAC asked for compelling evidence arguments for each individual code. The presenters were not prepared to present compelling evidence for the individual codes, but rather for the procedure codes as a group. As a result, the AOTA presenters feel that they "were not able to convey detailed compelling evidence effectively." Had AOTA been aware of the code-by-code approach, they would have presented compelling evidence that more adequately addresses the specific changes in patient population and technology for CPT 97535.

The HCPAC did not grant the appeal and determined that it would not reconsider its recommendations for CPT codes 97140 or 97535 at the April HCPAC meeting.

At the April 2017 HCPAC meeting the specialties explained that at a future meeting they intend to discuss the process for both appeals and facilitation.

AMA/Specialty Society RVS Update Committee **Tab 42**
Emerging Workgroup
April 27, 2017

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

I. Berenson-Eggers Type of Service (BETOS) Presentation – Robert Berenson, MD – Urban Institute

The RUC has recommended that improvements be made to the Berenson-Eggers Type of Service (BETOS) classification system. MedPAC expressed similar concerns and ultimately hired Robert Berenson, MD from the Urban Institute to revise and update the system. Doctor Berenson utilized a Technical Expert Panel and reached out to Sherry Smith to provide contact information for RUC participants to obtain additional clinical input. Doctor Berenson attended the Emerging Workgroup meeting to provide an update on his work and to seek feedback on the new structure. The Workgroup engaged in productive feedback with Doctor Berenson on the effort. The Workgroup volunteered to coordinate further clinical input, particularly in determining families of services, in the interest of maintaining the most accurate system. The Workgroup is hopeful that CMS will ultimately provide the classification system publicly on the CMS website. The RUC's Summary of Recommendation form includes the specialty assignment for the current BETOS. Once Doctor Berenson's work is complete and implemented, the SOR questions may be updated so that specialties can continue to provide this annual clinical input.

II. Update on CPT Discussion Related to Alternative Payment Models (APMs)

Ken Brin, MD, Chairman of the CPT Editorial Panel, and Laurie McGraw, AMA Senior Vice President, Health Solutions, presented an update on CPT preliminary discussions on coding requirements related to Alternative Payment Models (APMs). Ms. McGraw shared that the AMA has engaged a consultant in providing an environmental scan and conducting interviews with stakeholders. Additional feedback sessions from specialty societies will be convened (eg, a potential fly-in). Doctor Brin reminded the RUC that CPT has created codes for that describe services in a way that are similar to APMs (eg, ESRD, maternity care, chronic care management, psychiatric care collaboration). He discussed the challenges and opportunities in developing additional codes. The Emerging Workgroup will continue to discuss these opportunities and staff will provide updates from the CPT Editorial Panel consultant review and the June CPT Strategic Session discussion.

III. Other Issues

Workgroup Charge
The Workgroup slightly revised their charge to include collaboration to address issues facing the CPT Editorial Panel and the RUC.

Emerging CPT/RUC Issues Workgroup – (1) Continue work of the former chronic care coordination workgroup to identify coding/payment solutions for non face-to-face services, including to responding to CMS rulemaking; (2) address specific CPT and RUC related questions related to advanced payment models as they arise; (3) address any CMS proposals on BETOS and other potential coding/payment issues in rulemaking; and (4) discuss new issues of challenge for CPT/RUC.

AMA/Specialty Society RVS Update Committee **Tab 04**
Anesthesia for GI Procedures
Facilitation Committee # 1

Members: Doug Leahy, MD (Chair), Dee Adams Nikjeh, PhD, CCP-SLP, Michael Bishop, MD, Dale Blasier, MD, Ronald Burd, MD, Verdi DiSesa, MD, Marin Klos, MD, Walter Larimore, MD, Gregory Przybylski, MD, Julia Pillsbury, DO, Ezequiel Silva, III, MD

008X1 ***Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified***
Prior to the Facilitation Committee, the RUC reviewed the survey results from 114 anesthesiologists and determined that the survey 25th percentile base unit of 4 appropriately accounts for the work required to administer anesthesia for these services.

The Facilitation Committee noted that the overall intensity for the lower GI anesthesia services is less than the upper GI services 007X1 and 007X2. Therefore, the survey 25th percentile base unit of 4 is appropriate. **The Facilitation Committee agreed with the previous RUC recommendation of 4 for CPT code 008X1.**

008X2 ***Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy***
The RUC reviewed the survey results from 97 anesthesiologists and determined that the survey 25th percentile base unit of 3 appropriately accounts for the work required to administer anesthesia for these services.

It was noted that screening colonoscopies typically may be less intense than the diagnostic or procedural colonoscopy. The Facilitation Committee agreed that this service should be valued lower than the anesthesia for upper GI services CPT codes 007X1 and 007X2, as well as 008X1, and thus is valued appropriately. **The Facilitation Committee recommends a base unit of 3 for CPT code 008X2.**

The Workgroup also agreed that the RUC's January 2017 recommendations for 007X1, 007X2 and 008X3 should be affirmed without modification.

The Workgroup also agreed that the practice expense recommendations, as approved by the Practice Expense Subcommittee, were appropriate.

AMA/Specialty Society RVS Update Committee **Tab 5**
Skin Biopsy
Facilitation Committee #2

Members: Doctors Norman Smith (Chair), Margie Andreae, James Blankenship, Dale Blasier, Gregory DeMeo, David Han, Alnoor Malick, Brad Marple, Stanley Stead, Timothy Tillo, DPM, Thomas Weida and George Williams.

The RUC passed the work RVU recommendations for 11X02 and 11X03 tangential biopsy of skin.

11X04 Punch biopsy of skin, (including simple closure when performed); single lesion
The Committee indicated a concern whether this service will be reported with an Evaluation and Management (E/M) on the same day as it was typical with the previous deleted code. The specialty society recommended to decrease the pre-evaluation by 2 minutes to account for any possible overlap with an E/M. The Committee recommends 3 minutes pre-evaluation time, 2 minutes positioning and 3 minutes scrub, dress and wait time, 10 minutes intra-service time and 5 minutes immediate post-service time.

The Facilitation Committee agreed with the specialty society to crosswalk 11X04 to 69220 *Debridement, mastoidectomy cavity, simple (eg, routine cleaning)* (work RVU = 0.83 and 10 minutes of intra-service time as these services require the same intra-service time and require the same physician work to perform. The Committee noted that the punch biopsy is deeper and there is more bleeding than the tangential biopsy. Additionally, the Committee compared 11X04 to the key reference service 12011 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less* (work RVU = 1.07 and 12 minutes intra-service time) which the survey respondents indicated that the intensity to complete 11X04 was 57% identical and 33% more. **The Committee recommends a work RVU of 0.83 for CPT code 11X04.**

11X05 Punch biopsy of skin, (including simple closure when performed); each separate/additional lesion (List separately in addition to code for primary procedure)
The Facilitation Committee agreed with the specialty society to crosswalk 11X05 to 92134 *Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina* (work RVU = 0.45 and 10 minutes of intra-service time as these services require the same intra-service time and require the same physician work to perform. **The Committee recommends a work RVU of 0.45 for CPT code 11X05.**

11X06 Incisional biopsy of skin (eg, wedge), (including simple closure when performed); single lesion
The specialty society indicated that this service will never be reported with an E/M on the same day as this service will be a separate appointment. The Committee agreed that 11X06 requires 1 more minute of positioning than 11X02 and 11X04 to have the patient lie down and access the lower extremity. The Committee recommends 6 minutes pre-evaluation time, 3 minutes positioning and 3 minutes scrub, dress and wait time, 15 minutes intra-service time and 6 minutes immediate post-service time.

The Facilitation Committee agreed with the specialty society to crosswalk 11X06 to 11042 *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less* (work RVU = 1.01 and 15 minutes of intra-service time) as these services require the same intra-service time and require the same physician work to perform. **The Committee recommends a work RVU of 1.01 for CPT code 11X06.**

11X07 Incisional biopsy of skin (eg, wedge), (including simple closure when performed); each separate/additional lesion (List separately in addition to code for primary procedure)
The Facilitation Committee agreed with the specialty society to crosswalk 11X07 to 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 and 15 minutes of intra-service time as these services require the same intra-service time and require the same physician work to perform. **The Committee recommends a work RVU of 0.54 for CPT code 11X07.**

CPT Code	Eval	Posit	SDW	Intra	Immed Post	Work RVU
11X02	3	2	2	6	5	**0.66**
11X03				6		**0.38**
11X04	3	2	3	10	5	**0.83**
11X05				10		**0.45**
11X06	6	3	3	15	6	**1.01**
11X07				15		**0.54**

Practice Expense:
The Facilitation Committee reviewed the direct practice expenses and made the following modifications:

- Removed any inputs associated with an Evaluation and Management service for 11X02 and 11X04
- Adjusted the assist physician time to 2/3 for 11X02 and 11X03
- Removed any inputs related to cautery for 11X02 and 11X03
- Confirmed that a sterile environment for all six services was justified

The revised practice expense spreadsheet is attached.

AMA/Specialty Society RVS Update Committee **Tab 8**
Continuous Glucose Monitoring (PE Only)
Facilitation Committee #3

Members: Marc Raphaelson, MD (Chair), Brendan Campbell, MD, Jimmy Clark, MD, Scott Collins, MD, David Hitzeman, DO, David C. Han, MD, Alan Lazaroff, MD, Paul Pessis, AuD, Christopher Senkowski, MD, Jennifer Wiler, MD, James Waldorf , MD

9525X *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training and printout of recording*
This service is a new CPT code to be provided only when the CGM equipment is owned by the patient. In contrast, code 95250 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording* should be reported when the equipment is owned by the physician or practice. The services in Code 9525X are the same as for 95250, except that the physician staff does not clean the patient's equipment.

The society addressed several issues for the Facilitation Committee:
1. The CGM device includes one DME item, the data receiver, and two supply items, the sensor and transmitter. The expected useful life of the CGM device is about 3 years.
2. Code 9525X includes two patient visits to the provider office. During the first visit the staff performs extensive patient education, as indicated on the PE SoR. During the subsequent visit, the staff performs significant data manipulation, as also indicated on the PE SoR. The specialties will provide a letter to the CPT Editorial Panel outlining recommended language for a guideline to be added to the CPT code indicating that when data are collected outside the provider office, as when the patient uses a phone app, Code 9525X cannot be billed.
3. The proposed time for each visit is based on time-and-motion studies performed by the society, that recorded actual service times for 41 patients who were treated by 5 providers.
4. The specialties will provide a letter to the CPT Editorial Panel outlining recommended language for a guideline to be added to the CPT code indicating that 9525X is to be billed only once during the entire period that the patient owns the data receiver. The code cannot be billed for any subsequent use of the CGM device by the patient or physician. Code 9525X cannot be billed when the patient receives a new sensor or transmitter.

Based on these clarifications and limitations, the Facilitation Committee agreed to accept the specialty society's original proposal to crosswalk the PE inputs for CPT code 9525X to CPT code 95250 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording* (work RVU=0.00) with removal of 10 minutes total to remove and clean the equipment. CPT code 95250 was based on a survey conducted by the specialty society when the code was reviewed in October 2016 and at that time the PE Subcommittee approved 47 minutes for training on the device and 25 minutes for downloading and analyzing the data. After subtracting 5 minutes, since staff does not clean the equipment in CPT code 9525X, the Facilitation Committee approved the crosswalk with the following times: 47 minutes to perform procedure which consists of the training on the device and 20 minutes in the post-service period to download and analyze the data. The specialties will provide a letter to the CPT Editorial Panel outlining the recommended language for guidelines outlined above to be added to the CPT code.

The Facilitation Committee recommends that the PE inputs are approved as originally submitted by the specialty society.

AMA/Specialty Society RVS Update Committee **Tab 9**
Chronic Care Management Services
Facilitation Committee #3

Members: Doctors Jimmy Clark (Chair), Brendan Campbell, Scott Collins, David Hitzeman, David Han, Scott Oates, Christopher Senkowski, Jennifer Wiler and James Waldorf.

994X7 Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored

The Facilitation Committee reviewed CPT code 994X7 and determined that the survey 25th percentile of 1.45 work RVUs appropriately accounts for the work required to perform this service. The Committee compared the surveyed code to the top key reference service 99214 (work RVU = 1.50, 25 minutes intra-service time and 40 minutes total time) and determined that the physician work for 994X7 is slightly less as time is spent non face-to-face. For additional support the Committee referenced 99203*Office or other outpatient visit for the evaluation and management of a new patient* (work RVU= 1.42 and 29 minutes total time).

The Facilitation Committee recommends a work RVU of 1.45 for CPT code 994X7.

The Facilitation Committee recommends that this service be placed on the New Technology/New Services list.

The Facilitation Committee recommends the direct practice expense inputs as approved by the Practice Expense Subommittee.

AMA/Specialty Society RVS Update Committee **Tab 12**
Percutaneous Change of G-Tube
Facilitation Committee #1

Members: Doug Leahy, MD (Chair), Dee Adams Nikjeh, PhD, CCP-SLP, Dale Blasier, MD, Ronald Burd, MD, Verdi DiSesa, MD, Marin Klos, MD, Walter Larimore, MD, Gregory Przybylski, MD, Julia Pillsbury, DO, Ezequiel Silva, III, MD

43760 Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance

The Facilitation Committee reviewed the survey 25th percentile work RVU of 0.90 and indicated that it was too high. There were comments and concerns about the more complicated procedures. The specialty societies indicated and the Committee agreed to crosswalk the work value for CPT code 43760 to CPT code 20550 *Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")* (work RVU = 0.75, pre-service evaluation time of 5 minutes, pre-service positioning time of 1 minute, pre-service scrub, dress, wait time of 5 minutes, intra-service time of 5 minutes, and immediate post-service time of 5 minutes). The crosswalk CPT code was last reviewed by the RUC in January 2016. For CPT code 43760, the Committee recommended a pre-service evaluation time of 5 minutes, pre-service positing time of 1 minute, pre-service scrub, dress, wait time of 3 minutes, intra-service time of 7 minutes, and a post-time of 5 minutes. The Committee agreed that the reduction in pre-service evaluation time would appropriately account for the overlap with an E/M service reported on the same day. **The Facilitation Committee recommends a work RVU of 0.75 for CPT code 43760.**

Additionally, the Committee discussed whether the service was typically a sterile procedure in the non-facility setting and also discussed if staff should use the same protective medical supplies as the physician. The Committee revised the Practice Expense summary spreadsheet during the facilitation committee meeting and agreed to the following updates:

- Remove two SB001 *caps, surgical*;
- Keep one SB011 *drape, sterile, fenestrated 16in x 29in*;
- Remove SB019 *one drape-towel, sterile 18in x 26in*;
- Reduce SB024 *gloves, sterile* from two to one*;*
- Reduce two sterile gowns to one SB027 *gown, staff, impervious*;
- Reduce SB034 *mask, surgical, with face shield* from two to one;
- Reduce SB039 *shoe covers, surgical* from two to one.

AMA/Specialty Society RVS Update Committee **Tab 16**
Biopsy of Uterus Lining
Facilitation Committee #2

Members: Norman Smith, MD (Chair),Margie Andreae, MD, John Agens, MD, James Blankenship, MD, Gregory DeMeo, MD, Timothy Laing, MD, Alnoor Malick, MD, Brad Marple, MD, Stanley Stead, MD, Timothy Tillo, DPM, George Williams, MD

58100 Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)

The Facilitation Committee reviewed the specialty's original recommendation of 1.53 work RVUs and determined that the value was too high. The Committee discussed the survey 25th percentile of 1.21 work RVUs and agreed that this value accurately reflected the physician work necessary for this service. The pre-service time for SDW was eliminated and the Committee noted that the one minute needed to apply the topical anesthesia is appropriately performed during the intra-service period. This practice of including the topical anesthesia in the intra-service time period is different than most other services but is not unusual for gynecological procedures and is also standard practice in some ENT services. The committee recommends the 25th percentile value with the following times: 7/3/0 for a total of 10 minutes pre-service, 10 minutes intra-service, 5 minutes post-service time. **The Facilitation Committee recommends a work RVU of 1.21 for CPT code 58100.**

58110 Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)

The Facilitation Committee reviewed the add-on code 58110. The specialty society presented compelling evidence that a flawed methodology was used when this code was originally valued in 2005. Building block methodology was used for the base code 58100 and the 50% multiple surgical reduction was applied to develop the value for 58110. This is an acceptable methodology for an add-on code. The committee determined that compelling evidence was not met and, therefore, could not justify an increase in the work RVU to the 25th percentile work RVU of 1.00. The committee noted the comparison key reference services particularly CPT code 76802 (work RVU = 0.83 and 10 minutes intra-service time). The committee recommends maintaining the current value with the survey intra-service time of 12 minutes, as indicated by survey respondents. **The Facilitation Committee recommends the current work RVU of 0.77 for CPT code 58110.**

Practice Expense:
The Facilitation Committee recommends the practice expenses as approved by the PE Subcommittee.