

**AMA/Specialty Society RVS Update Committee
Renaissance Hotel, Chicago, IL
October 3-6, 2018**

Meeting Minutes

I. Welcome and Call to Order

Doctor Peter Smith called the meeting to order on Thursday, October 4, 2018 at 3:00 p.m. The following RUC Members were in attendance:

Peter K. Smith, MD
Jennifer Aloff, MD
Margie C. Andreae, MD
Michael D. Bishop, MD
James Blankenship, MD
Robert Dale Blasier, MD
Jimmy Clark, MD
Joseph Cleveland, MD
Scott Collins, MD
Gregory DeMeo, MD
David C. Han, MD
David F. Hitzeman, DO
Katharine Krol, MD
Walter Larimore, MD
Alan Lazaroff, MD
M. Douglas Leahy, MD, MACP
Alnoor Malick, MD
Scott Manaker, MD, PhD
Bradley Marple, MD
Daniel McQuillen, MD
Dee Adams Nikjeh, PhD
Marc Raphaelson, MD
Christopher K. Senkowski, MD, FACS
Ezequiel Silva III, MD
Norman Smith, MD
Stanley W. Stead, MD, MBA
G. Edward Vates, MD*
James C. Waldorf, MD
Jennifer L. Wiler, MD, MBA
George Williams, MD

Amr Abouleish, MD, MBA*
Gregory L. Barkley, MD*
William D. Donovan, MD, MPH*
Jeffrey P. Edelstein, MD*
William F. Gee, MD*
Michael J. Gerardi, MD, FACEP*
Gregory Harris, MD*
John Heiner, MD*
Peter Hollmann, MD*
Gwenn V. Jackson, MD*
Thomas Kintanar, MD*
John Lanza, MD*
Mollie MacCormack, MD, FAAD*
Francis Nichols, MD*
Scott D. Oates, MD*
Joseph Schlecht, DO*
M. Eugene Sherman, MD*
Michael J. Sutherland, MD, FACS*
Donna Sweet, MD*
Timothy H. Tillo, DPM*
Thomas J. Weida, MD*
David Wilkinson, MD, PhD*
Robert M. Zwolak, MD, PhD*

*Alternate

II. Chair's Report

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

- Doctor Smith welcomed the following Contractor Medical Directors:
 - Charles Haley, MD, MS, FACP
 - Richard W. Whitten, MD
- Doctor Smith welcomed the following Members of the CPT Editorial Panel:
 - Kathy Krol, MD – CPT RUC Member
 - Observing CPT Members:
 - Daniel Picus, MD,
 - Jordan Pritzker, MD
- Doctor Smith welcomed the following Observer:
 - Jesse M. Ehrenfeld, MD, MPH – BoT Chair-Elect
- Doctor Smith congratulated the following new RUC Alternate Members:
 - Thomas Kintanar, MD – Primary Care Rotating Seat
- Doctor Smith wished a fond farewell to the following departing RUC Members:
 - Jennifer Wiler, MD – American College of Emergency Physicians (ACEP)
 - George Williams, MD – American Academy of Ophthalmology (AAO)
- Doctor Smith explained the following RUC established thresholds for the number of survey responses required:
 - Codes with ≥ 1 million Medicare claims = 75 respondents
 - Codes with Medicare claims between 100,000-999,999 = 50 respondents
 - Codes with $< 100,000$ Medicare claims = 30 respondents
 - Surveys below the established thresholds for services with Medicare claims greater than 100,000 will be reviewed as interim and specialty societies will need to resurvey for the next meeting.
- Doctor Smith conveyed the following guidelines related to Confidentiality:
 - All RUC attendees/participants are obligated to adhere to the RUC confidentiality policy. (All signed an agreement electronically prior to this meeting).
 - This confidentiality is critical because CPT® codes and our deliberations are preliminary. It is irresponsible to share this information with media and others until CMS has formally announced their decisions in rulemaking.
- Doctor Smith shared the following procedural rules for RUC members:
 - Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue and it will be reflected in the minutes.
 - RUC members or alternates sitting at the table may not present or debate for their society.
 - Expert Panel – RUC members exercise their independent judgment and are not advocates for their specialty.
 - RUC members should address the Chair directly throughout the meeting.
- Doctor Smith conveyed the following procedural guidelines and improvements to the Facilitation Committee process:

- Ideal Composition:
 - Knowledgeable regarding the issues at hand
 - Primary and Secondary Reviewers
 - Alternates who serve in the seat during presentation
 - Representative of the RUC as a whole
 - Without conflict of interest
- RUC alternate members may participate in substitution of a RUC member during facilitations, but should not serve in addition to the RUC member.
- RUC members should attend facilitations for tabs in which he/she is the primary reviewer and serve as a vice-chair of that facilitation.
- RUC members or alternates should not serve on facilitation for an issue in which their specialty society has a primary interest (surveyed). If assigned to that facilitation, speak with RUC staff.
- To enhance the fairness and accuracy of the facilitation process, RUC staff may alter the composition of the facilitation committee to more closely approximate an ideal deliberative body.
- The Chair and Vice-Chair of the facilitation committee will meet briefly with RUC staff prior to proceeding to facilitation.
- Doctor Smith conveyed the following procedural guidelines related to RUC Ballots:
 - If a tab fails, all RUC Members/Alternates must complete a ballot to aid the facilitation committee.
 - Alternates should identify themselves on the ballots, and may be asked to serve on the facilitation committee.
 - The RUC will suspend deliberation to allow sufficient time to ensure that all 28 ballots are completed. The function of the facilitation committee will be enhanced greatly by the small amount of time and work as each member carefully considers their estimation of appropriate work value(s).
 - Revised ballots include:
 - Space for more codes per ballot
 - Suggested work RVU (do not provide wRVU ranges)
 - Suggested pre/intra/post times
 - Applicable reference codes
 - Additional comments
- Doctor Smith laid out the following procedural guidelines related to specialty society staff/consultants:
 - Specialty Society Staff or Consultants should not present/speak to issues at the RUC Subcommittee, Workgroup or Facilitation meetings – other than providing a point of clarification.
- Doctor Smith conveyed the following procedural guidelines related to commenting specialty societies:
 - In October 2013, the RUC determined which members may be “conflicted” to speak to an issue before the RUC:
 1. a specialty surveyed (LOI=1) or
 2. a specialty submitted written comments (LOI=2).RUC members from these specialties are not assigned to review those tabs.

- The RUC also recommended that the RUC Chair welcome the RUC Advisor for any specialty society that submitted written comments (LOI=2), to come to the table to verbally address their written comments. It is the discretion of that society if they wish to sit at the table and provide further verbal comments.
- Doctor Smith relayed the following procedural guideline related to presentations:
 - If RUC Advisors/presenters need time to review new resources/data brought up during discussion of a tab, they should notify the RUC Chair.
- Doctor Smith shared the following procedural guidelines related to voting:
 - RUC votes are published annually on the AMA RBRVS website each July for the previous CPT cycle.
 - The RUC votes on every work RVU, including facilitation reports.
 - If members are going to abstain from voting because of a conflict or otherwise, please notify AMA staff so we may account for all 28 votes.
 - Please share voting remote with your alternate if you step away from the table to ensure 28 votes.
- Doctor Smith announced that all meetings are recorded for AMA staff to accurately summarize recommendations to CMS.
- Vote on Financial Disclosure Review Workgroup Report – Tab 5 Drug Delivery Implant Procedures (11980 – 11983, 206X0 – 206X5)
 - Adam Sassoon, MD – AAHKS
 - Financial Disclosure: Consultant for Smith & Nephew, Biocomposites and Orthalign.The Financial Disclosure Review Workgroup came to the consensus that due to his financial interests indicated, Doctor Sassoon may not present this tab to the Practice Expense Subcommittee or the RUC.

The RUC approved the Financial Disclosure Review Workgroup Report.

- Vote on Financial Disclosure Review Workgroup Report – Tab 12 Myocardial PET (78459, 78X29, 78491, 78X31, 78492, 78X32 – 78X35)
 - Manuel Cerqueira, MD – ACC
 - Financial Disclosure: Astallas Pharma USA, Consultant and Speakers Bureau. Company makes vasodilator pharmacologic stress agent that is one of several available for use with cardiac PET. ≥ \$10,000The Financial Disclosure Review Workgroup came to the consensus that due to his financial interests indicated, Doctor Cerqueira may not present this tab to the Practice Expense Subcommittee or the RUC.

The RUC approved the Financial Disclosure Review Workgroup Report.

- **E/M Proposal** – Doctor Smith updated the RUC on the major proposal related to outpatient E/M services in the CY 2019 Proposed Rule. The AMA has submitted its recommendation that CMS should not implement any coding or payment-related changes to office visits for CY2019. The AMA did recommend for the Agency to implement several documentation related changes pertaining to re-documentation and home visits. A joint CPT/RUC Workgroup on E/M has been constituted with Peter Hollmann, MD and Barbara Levy, MD serving as Co-Chairs. The group has met four times via conference call and one time face-to-face. This process has been open and

transparent with the goal of submitting a CPT proposal by the November 7th deadline. Doctor Smith strongly encouraged attendees to discuss the proposal and provide input to the workgroup members, and he thanked them for their service. The next workgroup conference call is scheduled for Tuesday, October 23, at 6-8 pm CT.

III. Director's Report

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

- Background materials, minutes, presentations and information on the CPT/RUC Workgroup on E/M are available on the RUC Collaboration site (scroll down main page) and will continue to be updated.
- The RUC app is available for download and will be updated throughout the meeting.

IV. Approval of Minutes from April 2018 RUC Meeting

- The American Thoracic Society (ATS) and American College of Chest Physicians (CHEST) requested that CPT code 94200 be flagged in the RUC database as not to be used as a comparator for future valuations. **The RUC approved the April 2018 RUC meeting minutes with this addition.**

V. CPT Editorial Panel Update (Informational)

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

- CPT Editorial Panel Meeting Activity. Since the April 2018 RUC meeting, the Panel met twice – in May and in September.

May Meeting:

- RUC member Stan Stead, MD, attended the May meeting as the RUC representative in addition to RUC staff.
- The Panel addressed about 35 code change requests at the May meeting.
- Long-term EEG Monitoring Services was approved at the May meeting. This was an issue referred to CPT by the RUC after hitting a screen for CMS High Volume Services. Numerous societies contributed to the development of this code set, and the codes are being addressed by the RUC at this meeting.
- Many of the codes addressed by the Panel in May are being addressed by the RUC at this meeting.

September Meeting:

- RUC member Jim Clark, MD, attended the September meeting as the RUC representative, in addition to RUC staff.
- CCAs- The Panel addressed 57 coding requests at the September Panel meeting, many of which will come to the RUC in January.
- CPT/RUC Workgroup on E/M – The joint CPT/RUC E/M workgroup met face to face at the September Panel meeting. They voted on aspects of a code change application to be

submitted to the Panel for consideration at its February 2019 meeting. The voting was based on work of the workgroup using their expertise in coding and valuation, writing subgroups of the workgroup, feedback from several conference calls that engaged more 300 stakeholders, and surveys. The workgroup will continue its work by drafting the code change application and having an additional call between now and the February Panel meeting.

- The next Panel meeting will take place February 7-9, 2019 in Tucson, AZ. The submission deadline for code change applications for the February meeting is November 7, 2018.

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

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

- CMS is working on the Final Rules for the CY 2019 Medicare Physicians' Payment Schedule and the Hospital Outpatient Prospective Payment System (OPPS) to be released on or about November 1st.
- Doctor Hambrick introduced staff from CMS attending this meeting:
 - Karen Nakano, MD – Medical Officer
 - Michael Soracoe, PhD – Research Analyst
 - Gift Tee – Acting Director, Division of Practitioner Services

VII. Relative Value Recommendations for CPT 2020

Tissue Grafting Procedures (Tab 4)

Mark Villa, MD (ASPS); Jeffrey Kozlow, MD (ASPS); Peter Manes, MD (AAO-HNS); Jay Shah, MD (AAO-HNS); Lance Manning, MD (AAO-HNS)

In October 2017, the Relativity Assessment Workgroup reviewed services with anomalous sites of service when compared to Medicare utilization data. One service was identified, CPT code 20926 *Tissue grafts, other (eg, paratenon, fat, dermis)*, in which the Medicare data from 2013-2016 indicated that it was performed less than 50% of the time in the inpatient setting, yet includes inpatient hospital Evaluation and Management services within the global period. The specialty societies submitted an action plan and indicated that they believe the site of service issue is due to miscoding. The CPT manual includes a parenthetical that was added in 2011 that states, (For injection(s) of platelet rich plasma, use 0232T). The parenthetical resulted in some decrease in utilization for a few years, but currently the utilization has been increasing again. The specialty societies believe the typical patient receiving this service would be treated in a facility setting and that the site of service anomaly, for both the outpatient and the office setting is the result of miscoding. The specialty societies proposed to address this miscoding by developing a CPT assistant article and possible introductory language to emphasize correct coding. The RUC recommended that CPT code 20926 be referred to the CPT Editorial Panel for the May 2018 CPT Editorial meeting to add/revise the introductory language and referred to CPT Assistant for education on when to report this service. In May 2018 the CPT Editorial Panel replaced CPT code 20926 with five codes in the Integumentary section to better describe tissue grafting procedures. CPT code 15771 is a brand-new code that essentially replaces code 20926 and describes new technology to perform tissue transfer that was unavailable at the time the original code was established. Four additional codes, 15771-15774, were created in addition to CPT code 15769, to describe the use of autologous fat grafting harvested by liposuction technique, prepared with centrifugation, and then injected in multiple small aliquots to fill a soft tissue defect. These codes are volume-based and include both a base code and add-on code depending on the area of the body grafted.

Compelling Evidence

CPT deleted code 20926 as the service was frequently misreported. The RUC understands that the 35% of claims representing services performed in the office represent miscoding. The RUC discussed compelling evidence for the code family and determined that the original CPT code 20926 was poorly described and never surveyed (Harvard study). Therefore, the argument of flawed methodology for compelling evidence was accepted.

15769 Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)

The RUC reviewed the survey results from 163 otolaryngologists and plastic surgeons and determined that the survey 25th percentile work RVU of 6.68 accurately reflects the physician work necessary for this service. CPT code 15769 was created to describe the excision of a block of soft tissue and then placement in to the defect. This code is, in essence, a replacement for CPT code 20926. The previous code served as a catch all code and reflected multiple methods and approaches for obtaining grafting material which are now better identified with greater specification in the newly created code set. The survey code represents significant work and effort in the obtaining and placement of grafting material, accounting for the recommended increase in value when compared to code 20926. The RUC recommends the following physician time components: 38 minutes of pre-service time (25 minutes evaluation time, 3 minutes positioning time, 10 minutes scrub/dress/wait time), 45 minutes of intra-service time and 15 minutes of immediate post-service time, 1-99238 discharge management, 1-99213 and 2-99212 office visits. Unlike the rest of the code family, an overnight stay for the patient is typical for CPT code 15769.

The RUC compared CPT code 15769 to the second key reference service CPT code 21556 *Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm* (work RVU = 7.66 and 60 minutes intra-service time) and noted that the reference code has higher intra-service time and lower intensity. The survey code is a difficult procedure due to graft placement and the cranial/facial nerves being at risk. The RUC noted that there is increased complexity in the contouring of the face and is typically performed in areas that have been previously operated on before. In addition, CPT code 15769 has two surgical sites, so twice the risk of hematoma and infection. For additional support, the RUC reviewed MPC code 67904 *Repair of blepharoptosis; (tarso) levator resection or advancement, external approach* (work RVU = 7.97 and 45 minutes intra-service time) and noted that the intra-service time is identical and total times are similar. The RUC concluded that CPT code 15769 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 6.68 for CPT code 15769.**

15771 Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50cc or less injectate

The RUC reviewed the survey results from 60 plastic surgeons and determined that the survey 25th percentile work RVU of 6.73 accurately reflects the physician work necessary for this service. The RUC recommends the following physician time components: 50 minutes of pre-service time (30 minutes evaluation time, 10 minutes positioning time, 10 minutes scrub/dress/wait time), 60 minutes of intra-service time, and 16 minutes of immediate post-service time, 1-99213 and 2-99212 office visits. The additional minute of survey post-service time compared to CPT code 15773 is due to the need for a bra or post-operative garment to be placed on the patient afterwards since the work is being done on the upper trunk, not the face.

The RUC compared CPT code 15771 to the top key reference service CPT code 15120 *Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)* (work RVU = 10.15 and 75 minutes intra-service time) and noted that the reference code is appropriately valued higher due to the complexity of the procedure where the typical patient is a trauma victim and there is the increased chance

of complications due to the procedure being performed on the face. For additional support, the RUC reviewed MPC code 25076 *Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm* (work RVU= 6.74 and 45 minutes intra-service time) and noted that the survey code has greater intra-service time but less total time than the comparator code and the survey code is more intense. The RUC concluded that CPT code 15771 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 6.73 for CPT code 15771.**

15772 Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50cc injectate, or part thereof (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 60 plastic surgeons and determined that the survey 25th percentile work RVU of 2.50 accurately reflects the physician work necessary for this service. CPT code 15772 is the add-on code for autologous fat grafting to the trunk, breasts, extremities, or scalp for each additional 50cc of injectate. This volume was derived from the typical amount of injectable fat obtained from one round of centrifugation. The RUC recommends 45 minutes of intra-service time. That time is justified because for each additional 50cc, the work is essentially duplicated. The only work that is different is the surgeon does not have to open and close the access site.

The RUC compared CPT code 15772 to the top key reference service CPT code 15121 *Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 2.00 and 30 minutes intra-service time) and noted that the survey code has greater intra-service time and should have a higher physician work value to account for the additional time and effort required to harvest, prepare, and inject additional volumes of grafted fat. However, the reference service is being performed on the face and therefore has greater intensity due to its complexity and increased risk of complications.

For additional support, the RUC reviewed ZZZ global codes with identical intra-service time and similar amount of physician work. CPT code 13153 *Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)* (work RVU= 2.38 and 45 minutes intra-service time) and CPT code 77293 *Respiratory motion management simulation (List separately in addition to code for primary procedure)* (work RVU= 2.00 and 45 minutes intra-service time). The RUC concluded that CPT code 15772 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 2.50 for CPT code 15772.**

15773 Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25cc or less injectate

The RUC reviewed the survey results from 55 plastic surgeons and determined that the survey 25th percentile work RVU of 6.73 accurately reflects the physician work necessary for this service. CPT code 15773 is the base-code for autologous fat grafting to the sensitive areas of the face, hands, feet, and genitalia for up to 25cc of injectate. This volume was derived from the typical volume of fat grafted into these smaller areas compared to the trunk. The RUC recommends the following physician time components: 50 minutes of pre-service time (30 minutes evaluation time, 10 minutes positioning time, 10 minutes scrub/dress/wait time), 60 minutes of intra-service time and 15 minutes of immediate post-service time, 1-99213 and 2-99212 office visits. A discharge day was not included in the survey. The RUC noted that the intra-service time is the same despite the volume of material grafted being only half that of code 15771. This is because, as stated in the vignette, the patient has been previously operated on and the face takes more time per unit grafted.

The RUC compared CPT code 15773 to the top key reference and MPC code 15823 *Blepharoplasty, upper eyelid; with excessive skin weighting down lid* (work RVU = 6.81 and 45 minutes intra-service time) and noted that both services have intra-service time. Although the survey code involves more total time, both services have an overall similar amount of physician work. The RUC also compared the survey code to the second key reference service CPT code 15120 *Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)* (work RVU = 10.15 and 75 minutes intra-service time) and noted that the reference code has higher times and involves more physician work overall but the codes have similar intensity/complexity due to being performed in a similar region.

For additional support, the RUC reviewed MPC code 25076 *Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm* (work RVU= 6.74 and 45 minutes intra-service time) and noted that the survey code has greater intra-service time but very similar physician work as the comparison code. The RUC concluded that CPT code 15773 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 6.83 for CPT code 15773.**

15774 Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25cc injectate, or part thereof (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 54 plastic surgeons and determined that the survey 25th percentile work RVU of 2.41 accurately reflects the physician work necessary for this service. CPT code 15774 is the add-on code for autologous fat grafting to the sensitive areas of the face, hands, feet, and genitalia for up to 25cc of injectate. This volume was derived from the typical volume of fat grafted into these smaller areas compared to the trunk. The RUC recommends 45 minutes of intra-service. Similar to CPT code 15772, that time is justified because for each additional 25cc, the work is essentially duplicated. It is a smaller volume of injectate than in code 15772 but in more difficult areas.

The RUC compared CPT code 15774 to the top key reference service CPT code 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 3.73 and 40 minutes intra-service time) and noted that the reference code has a much higher IWPUT and is appropriately valued higher given its shorter intra-service time and greater intensity. The RUC also compared the survey code to the second key reference service CPT code 15121 *Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 2.00 and 30 minutes intra-service time) and noted that the survey code has greater intra-service time and a higher physician work value to account for the additional time and effort required to harvest, prepare, and inject additional volumes of grafted fat. However, the reference service has less intra-service time and greater intensity.

For additional support, the RUC reviewed ZZZ global codes with identical intra-service time and similar amount of physician work. CPT code 13153 *Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)* (work RVU= 2.38 and 45 minutes intra-service time) and CPT code 77293 *Respiratory motion management simulation (List separately in addition to code for primary procedure)* (work RVU= 2.00 and 45 minutes intra-service time) were the only two comparators that had been RUC-reviewed since 2012. The RUC concluded that CPT code 15774 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 2.41 for CPT code 15774.**

Practice Expense

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

New Technology/New Services

CPT codes 15769 – 15774 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

RAW Flag

In addition to New Technology, CPT code 15769 should be re-reviewed in the first year of utilization by the Relativity Assessment Workgroup to evaluate whether the new code is being coded with other codes (ie, closure of donor site) and whether it is being used in non-facility settings.

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.

Drug Delivery Implant Procedures (Tab 5)

George Hill, MD (ACOG); Jon Hathaway, MD (ACOG); Mitch Schuster, MD (ACOG); Thomas Turk, MD (AUA); Kyle Richards, MD (AUA); Andrew Peterson, MD (AUA); William Creevy, MD (AAOS); Hussein Elkousy, MD (AAOS)

In October 2017, code 11981 was identified as being performed by a different specialty than who originally surveyed this service. In January 2018, the RUC recommended to refer CPT codes 11980 - 11982 to CPT to better define these services and differentiate between the use in musculoskeletal procedures and use in urological or gynecological procedures. In May 2018, the CPT Editorial Panel approved the addition of six add-on codes to describe orthopaedic drug delivery to differentiate the service from the service described in code 11981.

Integumentary System

11980 Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)

The specialty societies indicated that CPT code 11980 was recently surveyed for CPT 2015 and the physician work has not changed since then. The RUC confirmed that the physician time and work remain appropriately relative to CPT codes 11981-11983. **The specialty societies requested and the RUC agreed to affirm the January 2014 RUC recommendation of 1.10 work RVUs 7 minutes evaluation, 2 minutes positioning, 1 minute scrub, dress, wait pre-service time, 12 minutes intra-service time and 5 minutes immediate post-service time for CPT code 11980.**

11981 Insertion, non-biodegradable drug delivery implant

The RUC reviewed the survey results from 111 gynecologists and urologists and determined that the survey 25th percentile work RVU of 1.30, a decrease from the current work RVU, accurately accounts for the work required to perform this service. The RUC recommends 15 minutes evaluation, 1 minute positioning, 4 minutes scrub, dress, wait pre-service time, 5 minutes intra-service time and 5 minutes post-service time. The RUC noted that this service is typically provided for the insertion of a subdermal contraceptive for women or insertion of a drug implant for men with metastatic prostate cancer. The RUC confirmed that the 15 minutes of evaluation time is necessary to explain the risks and benefits of the implant including bleeding, infection, hormone changes, hot flashes, weight gain and muscle loss, examination of the insertion site and obtain consent. The RUC noted that since this is a bimodal service, the median intra-service time was 5 minutes as indicated by the gynecologists who completed the

majority of the surveys. The current source is CMS/Other and that the crosswalk or methodology used in the valuation of this service is unknown and not resource-based, therefore it is invalid to compare the current time and work to the surveyed time and work.

The RUC noted that CPT code 11981 is a different procedure compared to 11980. CPT code 11980 is the subcutaneous implantation of a biodegradable compounded pellet that can be placed anywhere in the body with a needle and trocar. Whereas, CPT code 11981 is the insertion of a non-biodegradable implant that must be placed in a specific location in the arm. CPT code 11981 is the placement of a silastic capsule with a trocar system and removal of the placement device. Therefore, the physician time and work is different.

The RUC compared the surveyed code to the top two key reference services as indicated by the surveyees, CPT code 55876 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple* (work RVU = 1.73, 20 minutes intra-service time and 59 total minutes) and 57500 *Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)* (work RVU = 1.20, 15 minutes intra-service time and 29 total minutes). The majority of survey respondents that selected the top key reference code 55876 had indicated that both services have identical intensity and complexity. The RUC noted that since 11981 has such a low intra-service time and is a 000-day service comparing the intra-service per unit of time (IWPUT) is not a useful comparison. Additionally, the key reference services were established before the pre-service packages therefore making the IWPUTs incongruent. The RUC compared the surveyed code to 67515 *Injection of medication or other substance into Tenon's capsule* (work RVU = 1.40, 5 minutes intra-service time and 21 minutes total time), which also has 5 minutes intra-service time and requires similar physician work to perform. The RUC also referenced MPC codes 12013 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU = 1.22 and 27 total minutes) and 12004 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm* (work RVU = 1.44 and 29 total minutes), both which have similar physician work and total time. **The RUC recommends a work RVU of 1.30 for CPT code 11981.**

11982 Removal, non-biodegradable drug delivery implant

The RUC reviewed the survey results from 110 gynecologists and urologists and determined that the survey 25th percentile work RVU of 1.70 accurately accounts for the work required to perform this service. The RUC recommends 13 minutes evaluation, 1 minute positioning, 4 minutes scrub, dress, wait pre-service time, 15 minutes intra-service time and 5 minutes post-service time. The RUC confirmed that the 13 minutes of evaluation time is necessary to explain the risks and benefits of removal including bleeding, infection and recurrence of cancer with the removal of the hormonal ablation medication for men and for women to explain the procedure, review allergies and obtain consent. CMS questioned if this service is reported with an Evaluation and Management (E/M) service on the same day. The data indicates that CPT code 11982 is only reported with an E/M 6% of the time, so it is not typical. Since this service is not reported with an E/M, the physician must reiterate all the risks associated with this service and discuss any subsequent treatment (for prostate cancer patients) in the pre-service time.

The current source is CMS/Other and that the crosswalk or methodology used in the valuation of this service is unknown and not resource-based, therefore it is invalid to compare the current time and work to the surveyed time and work.

The RUC confirmed that CPT code 11982 requires more intra-service time to perform than the insertion, CPT code 11981, because to remove the capsule, the physician must first dissect away the fibrotic tissue that has formed a pseudo capsule around the actual capsule. A sharp incision into the tissue sheath is required to mobilize and remove the implant.

The RUC compared the surveyed code to the top key reference service as indicated by the surveyees, CPT code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU = 1.90, 15 minutes intra-service time and 45 total minutes). The majority of survey respondents that selected the top key reference code 54150 had indicated that both services have identical intensity and complexity, and should be valued similarly. The RUC noted that since CPT code 11982 has such a low intra-service time and is a 000-day service comparing the intra-service per unit of time (IWPUT) is not a useful comparison. For additional support, the RUC compared the survey code to MPC code 12004 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm* (work RVU = 1.44). **The RUC recommends a work RVU of 1.70 for CPT code 11982.**

11983 Removal with reinsertion, non-biodegradable drug delivery implant

The RUC reviewed the survey results from 112 gynecologists and urologists and determined that the survey 25th percentile work RVU of 2.10 accurately accounts for the work required to perform this service. The RUC recommends 15 minutes evaluation, 1 minute positioning, 4 minutes scrub, dress, wait pre-service time, 15 minutes intra-service time and 5 minutes post-service time. The RUC confirmed that the 15 minutes of evaluation time is necessary to review previous hormone ablation history, alternative therapies with the patient, side effects and risks.

The current source is CMS/Other and that the crosswalk or methodology used in the valuation of this service is unknown and not resource-based, therefore it is invalid to compare the current time and work to the surveyed time and work.

The RUC confirmed that CPT code 11983 requires more intra-service time to perform than the insertion only, CPT code 11981, because to remove the capsule, the physician must first dissect away the fibrotic tissue that has formed a pseudo capsule around the actual capsule. A sharp incision into the tissue sheath is required to mobilize and remove the implant. The RUC noted that the intra-service time for 11982 and 11983 are the same because the only thing that is shared is the incision site, but the physician uses z-type insertion needle to place the new capsule in a slightly different location within the arm.

The RUC compared the surveyed code to the 2nd top key reference service as indicated by the surveyees, CPT code 55700 *Biopsy, prostate; needle or punch, single or multiple, any approach* (work RVU = 2.50, 15 minutes intra-service time and 35 total minutes). The survey respondents indicated that CPT code 11983 overall requires the same or more intensity and complexity to perform as 55700. The RUC noted that since CPT code 11983 has such a low intra-service time and is a 000-day service comparing the intra-service per unit of time (IWPUT) is not a useful comparison. The RUC also referenced MPC codes 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU = 1.90, 15 minutes intra-service time and 45 total minutes) and 52281 *Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female* (work RVU = 2.75 and 20 minutes intra-service time and 46 minutes total time). **The RUC recommends a work RVU of 2.10 for CPT code 11983.**

Musculoskeletal System

Compelling Evidence

Code 11981 was identified as being performed by a different specialty than who originally surveyed this service. In January 2018, the RUC recommended to refer CPT codes 11980 -11982 to CPT to better define these services and differentiate between the use in musculoskeletal procedures and use in urological or gynecological procedures. The musculoskeletal procedures were never meant to be reported with codes 11981-11983 because those codes were clearly created for subcutaneous insertion of a 1-3 year, non-biodegradable drug-releasing implant. CPT required the specialty societies to use the long form

CPT proposal and submit literature to support the proposed musculoskeletal codes. No descriptor changes were requested to the current codes 11981-11983 as those codes will continue to represent insertion and removal of a non-biodegradable drug-releasing implant. **The RUC agreed that these new codes in the 20000 series in CPT describe new technology and it would not be appropriate to review their valuation in comparison to previous time and valuation of 11980-11982.**

20700 Manual preparation and insertion of drug delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 139 orthopaedic surgeons and determined that the survey 25th percentile work RVU of 1.50 accurately accounts for the work required to perform this service. The RUC recommends 5 minutes evaluation pre-service time, 20 minutes intra-service time and 2 minutes post-service time. This add-on code is typically reported with debridement or arthrotomy procedures. The pre-service work includes obtaining informed consent, explaining the risks and benefits, review culture data, select antibiotics if necessary and confirm all materials are available and set up (antibiotic powder and cement). The intra-service work starts after the physician has performed the debridement or cleaned the infected bone. A “dead space” remains, in which the physician will insert the device. The surgeon makes this device on the back table by mixing the cement powder with the antibiotic powder, adds liquid monomer and mixes it under a vacuum. As the cement hardens but is still soft the surgeon rolls it out like dough into tube formations, cuts it into small segments, rolls it into beads, threads the beads on the suture evenly and ties a large knot on the end incorporating a metallic marker for imaging. The RUC confirmed that there is no overlap in work of the clinical staff and the surgeon. The post-service work is documentation and x-ray review.

CMS questioned why the removal of the musculoskeletal drug delivery devices are less than the insertions. The specialties confirmed that the insertions require more physician work and time because of the requirements for preparing materials and limited time of the hardening of the mediums used for the musculoskeletal drug delivery devices.

The RUC compared the surveyed code to the top key reference services as indicated by the surveyees, CPT code 11047 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 1.80, and 30 minutes intra-service time) and agreed with the respondents that 20700 is more intense and complex than CPT code 11047. The RUC referenced MPC codes 64484 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.00 and 10 minutes intra-service time) and 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09 and 20 minutes intra-service time), both which support the relativity of 20700 among similar services. **The RUC recommends a work RVU of 1.50 for CPT code 20700.**

20701 Removal of drug delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 133 orthopaedic surgeons and determined that the survey 25th percentile work RVU of 1.13 accurately accounts for the work required to perform this service. The RUC recommends 1 minute evaluation pre-service time, 15 minutes intra-service time and 2 minutes post-service time. The pre-service work includes explaining the service to the patient, obtaining informed consent, reviewing the x-ray and prior operative report, noting the number beads that previously inserted to ensure all are removed. The intra-service work includes a marginal dissection in addition to what was in the base procedure to expose the drug delivery device and

remove it. The post-service work is the documentation of the removal and confirmation removal with X-rays.

CMS questioned why the removal of the musculoskeletal drug delivery devices are less than the insertions. The specialties confirmed that the insertions require more physician work and time because of the requirements for preparing materials and limited time of the hardening of the mediums used for the musculoskeletal drug delivery devices.

The RUC compared the surveyed code to the top key reference services as indicated by the surveyees, CPT code 11047 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 1.80, and 30 minutes intra-service time) and agreed with the respondents that 20701 is more intense and complex than CPT code 11047. The RUC referenced MPC codes 64484 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.00 and 10 minutes intra-service time) and 64480 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.20 and 15 minutes intra-service time), both which support the relativity of 20701 among similar services. **The RUC recommends a work RVU of 1.13 for CPT code 20701.**

20702 Manual preparation and insertion of drug delivery device(s), intramedullary (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 141 orthopaedic surgeons and determined that the survey 25th percentile work RVU of 2.50 accurately accounts for the work required to perform this service. The RUC recommends 5 minutes evaluation pre-service time, 25 minutes intra-service time and 2 minutes post-service time. This add-on code is typically reported with debridement or arthrotomy procedures. The pre-service work includes obtaining informed consent, explaining the risks and benefits, review culture data, select antibiotics if necessary and confirm all materials are available and set up (antibiotic powder and cement). The pre-service work is slightly more difficult compared to the deep (subfacial) insertion of drug delivery device code 20700 because the surgeon must find a chest tube of the appropriate size to make the device.

The intra-service work starts after the physician has performed the debridement or cleaned the infected bone. A “dead space” remains, in which the physician will insert the device. The surgeon makes this device on the back table by taking the silicone tubing or chest tube, cutting it to the correct length, lubricating the tube with sterile mineral oil, mixing the cement powder with the antibiotic powder, adding the liquid monomer and mixes it under a vacuum. The surgeon then transfers the container with the cement in liquid form to a pressurized insertion gun. One end of the tube is clamped and the liquid cement is injected under pressure to completely fill the tube. While the cement is still soft, a small diameter rod or wire is passed down the tube, the clamp is removed and the wire is advanced until it exits the other end. After the cement has hardened, the tube is cut and stripped off the “antibiotic nail”. Under fluoroscopic control, the surgeon inserts the device down the medullary canal and the position is confirmed. The proximal end of the wire or rod is cut at the appropriate length to allow subsequent removal when performed. The RUC confirmed that there is no overlap in work of the clinical staff and the surgeon. The post-service work is documentation and x-ray review.

The RUC confirmed that 20702 takes longer than 20700 because it takes longer to create the drug delivery device itself as well as longer to insert it into the intramedullary canal under fluoroscopy, check its positioning and trim it. Instead for CPT code 20700, where the surgeon places the drug delivery device in the wound.

CMS questioned why the removal of the musculoskeletal drug delivery devices are less than the insertions. The specialties confirmed that the insertions require more physician work and time because of the requirements for preparing materials and limited time of the hardening of the mediums used for the musculoskeletal drug delivery devices.

The RUC compared the surveyed code to the top key reference services as indicated by the surveyees, CPT code 11047 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 1.80, and 30 minutes intra-service time) and agreed with the respondents that 20702 is more intense and complex than CPT code 11047. The RUC referenced MPC codes 57267 *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)* (work RVU = 4.88 and 45 minutes intra-service time) and 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09 and 20 minutes intra-service time), both which support the relativity of 20702 among similar services. **The RUC recommends a work RVU of 2.50 for CPT code 20702.**

20703 Removal of drug delivery device(s), intramedullary (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 139 orthopaedic surgeons and determined that the survey 25th percentile work RVU of 1.80 accurately accounts for the work required to perform this service. The RUC recommends 1 minute evaluation pre-service time, 20 minutes intra-service time and 2 minutes post-service time. The pre-service work includes explaining the service to the patient, obtaining informed consent, reviewing the x-ray and prior operative report and ensure removal instruments are available. The intra-service work includes a marginal dissection in addition to what was in the base procedure to loosen and expose the drug delivery device and remove it, identifying any shards that broke off with fluoroscopy and remove them as well. The post-service work is the documentation of the removal and confirmation removal with X-rays.

The RUC compared the surveyed code to the top key reference services as indicated by the surveyees, CPT code 11047 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 1.80, and 30 minutes intra-service time) and agreed with the respondents that 20703 is more intense and complex than CPT code 11047. The RUC referenced MPC codes 37253 *Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)* (work RVU = 1.44 and 20 minutes intra-service time) and 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09 and 15 minutes intra-service time), both which support the relativity of 20703 among similar services. **The RUC recommends a work RVU of 1.80 for CPT code 20703.**

20704 Manual preparation and insertion of drug delivery device(s), intra-articular (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 141 orthopaedic surgeons and determined that the survey 25th percentile work RVU of 2.60 accurately accounts for the work required to perform this service. The RUC recommends 5 minutes evaluation pre-service time, 30 minutes intra-service time and 2 minutes post-service time. This add-on code is typically reported with debridement or arthrotomy

procedures. The pre-service work includes obtaining informed consent, explaining the risks and benefits, review culture data, select antibiotics if necessary and confirm all materials are available and set up (antibiotic powder and cement). The pre-service work is slightly different compared to the codes 20700 and 20702 because the surgeon must choose a pre-fabricated silicone mold that is the appropriate size to make the device.

The intra-service work starts after the physician has performed a resection of a joint for infection. The “dead space” remains, in which the physician will insert the drug delivery device. The surgeon makes this device on the back table by mixing the cement powder with the antibiotic powder, adding the liquid monomer and mixing it under a vacuum. The surgeon inserts the cement into the silicone mold. After the cement has hardened, the surgeon peels off the silicone mold and make sure it is the correct side. The surgeon then mixes another batch of cement and attach the device to the end of the bone with the cement. The RUC confirmed that there is no overlap in work of the clinical staff and the surgeon. The post-service work is documentation and x-ray review.

The RUC confirmed that 20704 takes longer than 20700 and 20702 because it takes longer to create the drug delivery device itself as well as longer to insert it within the joint.

CMS questioned why the removal of the musculoskeletal drug delivery devices are less than the insertions. The specialties confirmed that the insertions require more physician work and time because of the requirements for preparing materials and limited time of the hardening of the mediums used for the musculoskeletal drug delivery devices.

The RUC compared the surveyed code to the top key reference services as indicated by the surveyees, CPT code 11047 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 1.80, and 30 minutes intra-service time) and agreed with the respondents that 20704 is more intense and complex than CPT code 11047. The RUC referenced MPC codes 57267 *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)* (work RVU = 4.88 and 45 minutes intra-service time) and 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09 and 20 minutes intra-service time), both which support the relativity of 20704 among similar services. **The RUC recommends a work RVU of 2.60 for CPT code 20704.**

20705 Removal of drug delivery device(s), intra-articular (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 140 orthopaedic surgeons and determined that the survey 25th percentile work RVU of 2.15 accurately accounts for the work required to perform this service. The RUC recommends 1 minute evaluation pre-service time, 25 minutes intra-service time and 2 minutes post-service time. The pre-service work includes explaining the service to the patient, obtaining informed consent, reviewing the x-ray and prior operative report and ensure removal instruments are available. This service is for the removal of the intra-articular drug delivery device, in which the surgeon is not performing a revision. The intra-service work is more difficult and takes longer than 20701 and 20703. The surgeon must remove a device that is cemented to both sides of the joint without removing too much bone in the process. The post-service work is the documentation of the removal and confirmation removal with X-rays.

The RUC compared the surveyed code to the top key reference services as indicated by the surveyees, CPT code 11047 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 1.80, and 30 minutes intra-service time) and agreed with the respondents that 20705 is more intense and complex than CPT code 11047. The RUC referenced MPC codes 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU = 2.09 and 15 minutes intra-service time) and 36476 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU = 2.65 and 30 minutes intra-service time), both which support the relativity of 20705 among similar services. **The RUC recommends a work RVU of 2.15 for CPT code 20705.**

Practice Expense

For CPT 11981-11983 the Practice Expense Subcommittee made minor reductions to the supplies. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee. For CPT codes 20700-20705, there are no direct practice expense inputs associated with these services.

New Technology

CPT codes 20700-20705 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.

Aortic Graft Procedures (Tab 6)

Jim Levett, MD (STS); Kirk Kanter, MD (STS); Joseph Turek, MD (STS); Jacob Schroder, MD (AATS); Richard Freeman, MD (STS)

At the September 2017 CPT Editorial Panel meeting, the Panel created one new add-on code to report hemi-aortic arch graft replacement. Existing CPT codes 33860, 33863 and 33864 were identified as a family codes for review at the January 2018 RUC meeting. At the January 2018 RUC meeting, the specialty societies only presented survey data and a recommendation for new CPT code 33866. The specialties did not survey the ascending aortic replacement codes 33860, 33863 or 33864 for the January 2018 RUC meeting and provided their rationale for not surveying the codes to the RUC at the meeting. Although the new add-on code was designed to be reported with the ascending aortic replacement codes, 33860, 33863 or 33864, the specialty societies noted that the work involved in the hemi-aortic arch replacement procedure represented an advancement in surgical technique that has evolved over the past five years and did not reflect work that is currently accounted for in the ascending aortic procedures. The specialty societies indicated that the hemi-aortic arch replacement is more closely related to the transverse aortic arch replacement code 33870. At the January 2018 meeting, the RUC recommended an interim value for new CPT code 33866 and for the full family of services to be surveyed and presented at the April 2018 RUC meeting, including codes 33860, 33863, 33864, 33866, 33870. The RUC observed that the current draft parenthetical following CPT code 33870, did not preclude 33870 from being coded with base codes 33860-33864 nor did it direct users to instead use 330X1 when hemi-aortic arch graft replacement is performed. The RUC recommended that the CPT Editorial Panel consider parenthetical additions for CPT code 33870. The RUC referred the entire family of codes for review at the April 2018 RUC meeting. Accordingly, at the February 2018 CPT Editorial Panel meeting, the Panel revised the introductory language in addition to parentheticals for code 33870 to clarify that the code is not reported for hemi-aortic arch graft.

At the April 2018 RUC meeting, the specialty societies noted that during their preparations for the April 2018 RUC meeting, they determined that this family of services should be submitted to the CPT Editorial Panel for the following revisions: 1) To develop distinct codes for ascending aortic repair for dissection and ascending aortic repair for other ascending aortic disease such as aneurysms and congenital anomalies. The specialties expressed that there is a sufficient difference in the work associated with these procedures and now there is sufficient volume to allow for more accurate capture of the work and outcomes data for these distinct patient populations, which was not the case when the code was first developed. 2) Revise the descriptor for the transverse arch code, 33870 to further clarify the difference in work between that code and the new add-on code 33866. 3) Revise the guidelines to provide additional instructions on the appropriate use of these codes. The specialty societies had already submitted a new coding proposal for consideration at the May 2018 CPT Editorial Panel meeting for CPT 2020. The RUC supported referral to CPT and rescinded the interim value recommendation to CMS for code 33866 for CPT 2019.

In May 2018, the CPT Editorial Panel approved the deletion of two codes and addition of four new codes to distinguish between repairs for aortic dissection and repairs for aortic diseases other than dissection.

33858 Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic dissection

The RUC reviewed the survey results from 41 cardiothoracic surgeons and agreed on the following physician time components: 40 minutes of pre-service evaluation, 15 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, 300 minutes of intra-service time, 60 minutes of immediate post-service time, 3-99291 visits, 2-99233 visits, 1-99232 visit, 1-99231 visit, 1-99238 discharge visit, 1-99214 office visit and 1-99213 office visit. The RUC agreed with the specialty that the standard evaluation time of 40 minutes is warranted for this emergent procedure. Although this is an emergent procedure, the patient is still evaluated to determine a definitive diagnosis and the extent of the dissection. The surgeon will obtain consent, review and explain the procedure to the patient and/or family. The surgeon will review the pertinent imaging which will include chest x-rays, CT Scan, MRI, aortogram and TEE, if available to identify the extent of the dissection. The trans-esophageal echocardiogram is reviewed with the anesthesiologist and/or cardiologist with special attention to quality of the ascending aorta, location and extent of false lumen, degree and nature of aortic insufficiency and assessment of ventricular function. The RUC agreed with the specialty that a 12-minute increase in time over standard pre-time package 4 for a total positioning time of 15 minutes was warranted, which is common for major cardiothoracic procedures and can be attributed to the time spent for careful protection of pressure points on the patient with this prolonged operation. The RUC agreed with the specialty that the 27 minutes of additional immediate post-service time above standard package 9b was warranted due to the additional time needed for immediate post-operative patient stabilization due to cardiopulmonary bypass, monitoring for bleeding, and more extensive documentation and communication requirements due to the complex aspects of the procedure including the final type of repair that was accomplished. The RUC agreed with the specialties that this emergent code requires more post-operative visits relative to planned procedures. Critical care extends to the third postoperative day due to the complexity of the procedure and the need to carefully monitor several organ systems that can be impacted by the dissection. These organ systems include pulmonary, renal, cardiovascular, gastrointestinal, and neurologic. The STS Database shows a mean intra-service time of 301 minutes and a median time of 281 minutes, however the database data available at this time does not distinguish the time for dissections versus aortic repair for other aortic disease such as aneurysm.

The RUC reviewed the survey respondents' estimated physician work value and agreed that the respondents appropriately valued the physician work involved in performing this service at the median work RVU of 65.00. To justify a work RVU of 65.00, the RUC compared the survey code to top key reference code 33412 *Replacement, aortic valve; with transventricular aortic annulus enlargement*

(*Konno procedure*) (work RVU of 59.00, intra-service time of 300 minutes) and noted that both services have identical intra-service time, whereas the survey code involves more total time and 86 percent of the survey respondents that selected this key reference indicated that the survey code is more intense and complex to perform, justifying the higher work RVU. Ascending aortic grafting for aortic dissection is an emergent procedure that requires a median sternotomy, cardiopulmonary bypass with cardiac arrest. The ascending aorta involved in the dissection is transected, resected and replaced with a graft. Reinforcement of the proximal ascending aortic wall with sewn-in circumferential Teflon felt strip is required and distal aortic wall reinforcement may also be necessary depending on the extent of the dissection and the friability of aortic tissue. The patients that require this intervention face very high mortality without both expeditious diagnosis and technically proficient surgery. **The RUC recommends a work RVU of 65.00 for CPT code 33858.**

33859 Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic disease other than dissection (eg, aneurysm)

The RUC reviewed the survey results from 40 cardiothoracic surgeons and agreed on the following physician time components: 60 minutes of pre-service evaluation, 15 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, 240 minutes of intra-service time, 60 minutes of immediate post-service time, 2-99291 visits, 2-99233 visits, 1-99232 visit, 1-99231 visit, 1-99238 discharge visit and 1-99214 office visit. The RUC agreed with the specialty that the additional evaluation time of 20 minutes above standard pre-time package 4 is warranted for the time the surgeon spends with the patient obtaining consent, reviewing the procedure and explaining the various aspects of the procedure including the associated aftercare. Extensive planning and review of pertinent imaging, which includes chest x-rays, coronary angiogram, echocardiogram, cardiac catheter report, CT scans and echocardiography is required to identify the extent of the aortic disease, the amount of aortic resection necessary, the type and size of the aortic valve and the graft. The RUC agreed with the specialty that a 12-minute increase in time over standard pre-time package 4 for a total positioning time of 15 minutes was warranted, which is common for major cardiothoracic procedures and can be attributed to the time spent for careful protection of pressure points on the patient with this prolonged operation. The RUC agreed with the specialty that the 27 minutes of additional immediate post-service time above standard package 9b was warranted due to the additional time needed for patient stabilization due to cardiopulmonary bypass, monitoring for bleeding, and more extensive documentation and communication requirements due to the complex aspects of the procedure including the final type of repair that was accomplished. The STS Database shows a mean intra-service time of 301 minutes and a median time of 281 minutes, however the database data available at this time does not distinguish the time for dissections versus aortic repair for other aortic disease such as aneurysm.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 50.00. To justify a work RVU of 50.00, the RUC compared the survey code to top key reference code 33430 *Replacement, mitral valve, with cardiopulmonary bypass* (work RVU of 50.93, intra-service time of 232) and noted that the survey code involves slightly more intra-service time and is somewhat more intense to perform. Even though the reference code involves more total time, both services involve a similar total amount of physician work as the higher intensity of the survey code mitigates the difference in total time. The RUC compared 33859 to 33858 and noted that the proposed times and values have appropriate relativity with each other — 33858 is a more intense emergent service whereas 33859 is a planned procedure which typically involves a shorter length of stay and fewer post-operative visits. **The RUC recommends a work RVU of 50.00 for CPT code 33859.**

33863 Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)

The RUC reviewed the survey results from 41 cardiothoracic surgeons and agreed on the following physician time components: 60 minutes of pre-service evaluation, 15 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, 300 minutes of intra-service time, 60 minutes of immediate post-service time, 2-99291 visits, 2-99233 visits, 1-99232 visit, 1-99231 visit, 1-99238 discharge visit and 1-99214 office visit. The RUC agreed with the specialty that the additional evaluation time of 20 minutes above standard pre-time package 4 is warranted for the time the surgeon spends with the patient obtaining consent, reviewing the procedure and explaining the various aspects of the procedure and the associated aftercare. Extensive planning and review of pertinent imaging, which includes chest x-rays, CT Scan, MRI, aortogram and trans-esophageal echocardiogram (TEE) is required to identify the aortic valve pathology, the extent of the aortic disease, the amount of aortic resection necessary and the size of the graft. The TEE is reviewed with the anesthesiologist and/or cardiologist with special attention to quality of ascending aorta, degree and nature of aortic valve pathology and ventricular function. The RUC agreed with the specialty that a 12-minute increase in time over standard pre-time package 4 for a total positioning time of 15 minutes was warranted, which is common for major cardiothoracic procedures and can be attributed to the time spent for careful protection of pressure points on the patient with this prolonged operation. The RUC agreed with the specialty that the 27 minutes of additional immediate post-service time above standard package 9b was warranted due to the additional time needed for patient stabilization due to cardiopulmonary bypass, monitoring for bleeding, and more extensive documentation and communication requirements due to the complex aspects of the procedure including the final type of repair that was accomplished. The RUC noted that the current physician times for 33863 included a longer length of stay, which was not proportionate to the existing valuation. The STS Database intra-service time shows a mean time of 298 minutes and a median time of 322 minutes. Based on the STS Database time, the specialty recommended and the RUC agreed that the survey respondents underestimated the intra-service time of the procedure and the 75th percentile of intra-service time from the survey is supported, which is 300 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 59.00. To justify a work RVU of 59.00, the RUC compared the survey code to top key reference code 33412 *Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)* (work RVU of 59.00, intra-service time of 300 minutes) and note that both services have identical intra-service times, similar total time and should be valued the same. The RUC compared 33863 to 33858 and noted that the proposed times and values have appropriate relativity with each other — 33858 is a more intense emergent service whereas 33863 is a planned procedure which typically involves a shorter length of stay and fewer post-operative visits. **The RUC recommends a work RVU of 59.00 for CPT code 33863.**

33864 Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub procedure)

The RUC reviewed the survey results from 40 cardiothoracic surgeons and agreed on the following physician time components: 60 minutes of pre-service evaluation, 15 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, 300 minutes of intra-service time, 60 minutes of immediate post-service time, 2-99291 visits, 2-99233 visits, 1-99232 visit, 1-99231 visit, 1-99238 discharge visit and 1-99214 office visit. The RUC agreed with the specialty that the additional evaluation time of 20 minutes above standard pre-time package 4 is warranted for the time the surgeon spends with the patient obtaining consent, reviewing the procedure and explaining the various aspects of the procedure including the associated aftercare. Extensive planning and review of pertinent imaging, which includes chest x-rays, coronary angiogram, echocardiogram, cardiac catheter report, CT scan and echo is required to identify the extent the aortic disease, the feasibility of a valve-sparing operation and the size of the graft. The trans-

esophageal echocardiogram is reviewed with the anesthesiologist and/or cardiologist with special attention to the size and function of the native aortic valve as well as an assessment of the patient's ventricular function. The RUC agreed with the specialty that a 12-minute increase in time over standard pre-time package 4 for a total positioning time of 15 minutes was warranted, which is common for major cardiothoracic procedures and can be attributed to the time spent for careful protection of pressure points on the patient with this prolonged operation. The RUC agreed with the specialty that the 27 minutes of additional immediate post-service time above standard package 9b was warranted due to the additional time needed for patient stabilization due to cardiopulmonary bypass, monitoring for bleeding, and more extensive documentation and communication requirements due to the complex aspects of the procedure including the final type of repair that was accomplished. The STS Database intra-service time shows a mean time of 308 minutes and a median time of 320 minutes. This service involves more difficult and intense to perform than the Bentall procedure (CPT code 33863), as this procedure involves preserving the patient's native valve and only replacing the root. The Bentall procedure alternatively involves also implanting a mechanical or bioprosthetic valve which is a less intense and complex procedure. Due to this differentiation in work, the specialties noted and the RUC agreed that 33864 should be valued at a somewhat higher IWPOT even though both codes have identical physician time inputs.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 63.00. To justify a work RVU of 63.00, the RUC compared the survey code to top key reference code 33412 *Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)* (work RVU of 59.00, intra-service time of 300 minutes) and noted that both services have identical intra-service time, whereas 78 percent of the survey respondents that selected this key reference indicated that the survey code is more intense and complex to perform. **The RUC recommends a work RVU of 63.00 for CPT code 33864.**

33866 Aortic hemiarch graft including isolation and control of the arch vessels, beveled open distal aortic anastomosis extending under one or more of the arch vessels, and total circulatory arrest or isolated cerebral perfusion (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 32 cardiothoracic surgeons and agreed on the following physician time components: 123 minutes of intra-service time. Aortic hemiarch grafting is a procedure that is performed in addition to an ascending aortic repair (33858, 33859, 33863 or 33864) when the ascending aortic disease extends into the proximal portion of the transverse aortic arch. In these cases, the surgical procedure includes isolation of the arch vessels to establish antegrade or retrograde cerebral protection/perfusion, cooling the patient for circulatory arrest, rewarming the patient and obtaining hemostasis at the end of the procedure. The graft is anastomosed under one or more of the arch vessels during the circulatory arrest or perfusion portion of the procedure.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 17.75. To justify a work RVU of 17.75, the RUC compared the survey code to top key reference code 33369 *Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)* (work RVU of 19.00, intra-service time of 160 minutes) and noted that although the reference code has more intra-service time, 92 percent of the respondents that selected the reference code rate the survey code as being much more intense and complex to perform. The specialties noted and the RUC agreed that this is a very intense service to perform and an IPWUT of 0.144 is appropriate. **The RUC recommends a work RVU of 17.75 for CPT code 33866.**

33871 Transverse aortic arch graft, with cardiopulmonary bypass, with profound hypothermia, total circulatory arrest and isolated cerebral perfusion with reimplantation of arch vessel(s) (eg, island pedicle or individual arch vessel reimplantation)

The RUC reviewed the survey results from 39 cardiothoracic surgeons and agreed on the following physician time components: 60 minutes of pre-service evaluation, 15 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, 363 minutes of intra-service time, 60 minutes of immediate post-service time, 2-99291 visits, 2-99233 visits, 1-99232 visit, 1-99231 visit, 1-99238 discharge visit and 1-99214 office visit.

The RUC agreed with the specialty that the additional evaluation time of 20 minutes above standard pre-time package 4 is warranted for the time the surgeon spends with the patient obtaining consent, reviewing the procedure and explaining the various aspects of the procedure including the associated aftercare. Extensive planning and review of pertinent imaging, which includes chest x-rays, CT scans, MRI, aortogram and TEE is required to identify the extent the aortic arch disease/dissection and the amount or resection, the best method for reimplantation of the arch vessels and the size of the graft(s). The RUC agreed with the specialty that a 12-minute increase in time over standard pre-time package 4 for a total positioning time of 15 minutes was warranted, which is common for major cardiothoracic procedures and can be attributed to the time spent for careful protection of pressure points on the patient with this prolonged operation. The RUC agreed with the specialty that the 27 minutes of additional immediate post-service time above standard package 9b was warranted due to the additional time needed for patient stabilization due to cardiopulmonary bypass, monitoring for bleeding, and more extensive documentation and communication requirements due to the complex aspects of the procedure including the final type of repair that was accomplished. The STS Database intra-service time shows a mean time of 390 minutes and a median time of 400 minutes. Based on the STS Database time, the specialty noted and the RUC concurred that the survey respondents underestimated the intra-service time of the procedure and the 75th percentile of intra-service time from the survey is supported, which is 363 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 65.75. To justify a work RVU of 65.75, the RUC compared the survey code to top key reference code 33877 *Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass* (work RVU of 69.03, intra-service time of 324 minutes) and noted that the survey code involves more intra-service time whereas the reference code involves more total time. 72 percent of the respondents that selected this key reference code indicated that the survey code was more intense and complex to perform. The RUC noted that a work RVU of 65.75 would establish the appropriate relativity with 33877 and with other major cardiothoracic procedures. The RUC compared 33863 to 33858 and noted that the proposed times and values have appropriate relativity with each other — 33858 is a more intense emergent service whereas 33863 is a planned procedure which typically involves a shorter length of stay and fewer post-operative visits. **The RUC recommends a work RVU of 65.75 for CPT code 33871.**

Practice Expense

The RUC reviewed and approved the direct practice expense inputs as approved without modification by the Practice Expense Subcommittee. The 090-day global codes included the standard 090-day clinical labor pre-service times, except for the appropriate reductions for the emergent aortic dissection code 33858. For two of the clinical inputs, the specialties recommended and the Practice Expense Subcommittee agreed that the times are typically higher than the standard emergent procedure clinical staff times. Although this is an emergent procedure, the clinical staff still assists with the following in a manner that is similar to the work involved for some aspects of a typical 090-day cardiothoracic procedure. The recommendations include the following changes to the standard times for an emergent procedure:

- For activity code CA002 *Coordinate pre-surgery services* the standard emergent time is 7 minutes. The RUC is recommending 10 minutes for this clinical activity because there are a number of tests and services that must be coordinated. Diagnostic tests may include chest x-rays, CT Scan, MRI, aortogram and TEE and any laboratory studies if available. The clinical staff must also coordinate with the other specialists that will be needed to diagnose and perform the procedure, this will include, at a minimum coordination with neurology, anesthesia, assistant surgeon, the ICU, cardiology for the TEE, and perfusion.
- For activity code CA003 *Schedule space and equipment in facility* the standard emergent time is 4 minutes. The RUC is recommending the 8 minutes for this clinical activity. The clinical staff need to provide all of the same services to ensure that the correct space and all of the necessary equipment for a cardiothoracic procedure are available, which includes the equipment and supplies for cardiopulmonary bypass which is required for the procedure and deep hypothermic arrest which may be necessary in some cases.

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.

New Technology/New Services

Codes 33866 will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions. The whole family of services should be reviewed in 3 years when reviewing the utilization data.

Transanal Hemorrhoidal Dearterialization (Tab 7)

Steve Sentovich, MD (ASCRS); Guy Orangio, MD (ASCRS); Charles Mabry, MD (ACS); Nader Massarweh, MD (ACS)

In May 2018, the CPT Editorial Panel approved the replacement of a Category III code with a new Category I code and revision of two codes to report transanal hemorrhoidal dearterialization, including ultrasound guidance. In addition, codes 46945 and 46946 were revised to clearly indicate that they are performed without imaging guidance.

Compelling Evidence

The specialty societies presented compelling evidence that incorrect assumptions were made in the previous valuations of 46945 and 46946 due to a flawed methodology, ultimately resulting in a negative IWP/UT for CPT code 46945 and a very low IWP/UT for CPT code 46946. The first flawed valuation occurred in the First Five-Year Review in 1995, when the Contractor Medical Directors (CMD) nominated these services as overvalued when compared to in-office code 46221 *Hemorrhoidectomy, internal, by rubber band ligation(s)*. The CMDs stated that the Harvard study indicated the intra-service and pre/post-work for 46221 as being equal to CPT codes 46945 and 46946. However, the Harvard pre- and post-service work for CPT codes 46945 (Harvard intra = 120 minutes and pre/post-time = 187 minutes) and 46946 (Harvard intra = 163 minutes and pre/post time = 190 minutes) were more than twice the work value for CPT 46221, which is a 010-day global service (Harvard intra-time = 80 minutes and pre/post time = 81 minutes) and the Harvard intra-service work was not "equal". At the time of RUC review in 1995, the specialty society did not have the Harvard Study data to refute the CMD rationale about the Harvard data and agreed to the recommended reduction in work RVUs without conducting a survey. The work RVU for 46945 was reduced by 38% and the work RVU for 46946 was reduced by 32% for 1997. Similarly, in the Fourth Five-Year Review in 2000, CPT codes 46945 and 46946 were included in a group of "Anus/Rectum – Hemorrhoids/ Fistula" codes. The work RVUs for both codes were not based on survey data but decreased by 14% based on the RUC Workgroup recommendation to decrease the family anchor code 46262 by 14% from 8.73 to 7.50. This reduction resulted in a negative

IWPUT (-0.04) for 46945 and a low IWPUT (0.03) for 46946. **The RUC agreed with the compelling evidence supporting previous flawed methodologies for valuing these services.**

Family of Services

The specialty societies indicated there are three sets of procedures to manage hemorrhoids. The first set of procedures are performed in the office: CPT code 46221 *Hemorrhoidectomy, internal, by rubber band ligation(s)*, which is reported to treat the majority of internal hemorrhoids in the United States, CPT code 46930 *Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)* and CPT code 46500 *Injection of sclerosing solution, hemorrhoids*. All three of these codes typically involve a single hemorrhoid or a few independent small hemorrhoids.

The second set of hemorrhoidectomy procedures are for patients who have internal hemorrhoid column(s), who fail in-office procedures or have continued prolapse and bleeding. These patients are recommended for in-facility non-incisional therapy reported with CPT codes 46945, 46946 or 46948.

Lastly, the third set of hemorrhoidectomy procedures are excisional and include such as codes 46250 *Hemorrhoidectomy, external, 2 or more columns/groups* and 46255 *Hemorrhoidectomy, internal and external, single column/group*, which require excision and sutures. These are an represent a distinct approach to the treatment of complex hemorrhoids.

The RUC questioned why code 46930 *Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)* is not part of the family of ligation codes since cautery would be similar to ligation. The specialty indicated that destruction of the hemorrhoid represented by CPT code 46930 is not typically accomplished with cautery, but rather by use of an infrared light source to treat grade 1 hemorrhoid(s). Further, CPT code 46930 does not require anesthesia and is typically performed during a brief office visit. In addition, it is not appropriate to use an infrared light source for treatment of grade 2 and 3 internal hemorrhoids. CPT codes 46945 and 46946 are reported to treat the higher-grade hemorrhoid column(s) in which suture ligation is used.

The current recommendations do not cause a rank order anomaly across the entire set of hemorrhoid treatment codes. **The RUC agreed with the explanation of the family of services identified and surveyed for this set of internal hemorrhoid treatment.**

46945 Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group, without imaging guidance

The RUC reviewed the survey results from 76 colorectal and general surgeons and determined that the survey 25th percentile work RVU of 3.69 accurately accounts for the work required to perform this procedure. The RUC recommends 25 minutes evaluation, 10 minutes positioning, 10 minutes scrub/dress/wait pre-service time, 15 minutes intra-service time, 15 minutes immediate post-service time, a half day discharge management 99238, one 99213 and one 99212 post-operative Evaluation and Management (E/M) office visits. The RUC confirmed that an extra 7 minutes of positioning time over the pre-time package are necessary for a total of five individuals to place the patient in the prone position after induction of anesthesia, to pad the head and extremities and efface the buttocks. The RUC confirmed that a 99213 E/M visit is required to discuss the patients' pain, diet, and activity restrictions, perform an anoscopy (not separately reportable) to assess for postoperative complications which may include delayed bleeding, sepsis, urinary retention, urinary tract infection, and/or fecal impaction. Also, one 99212 E/M office visit is required to discuss the patients' pain, diet, and activity restrictions, and perform a digital rectal exam to assess the wound.

The RUC compared the surveyed code to the two key reference services indicated by the survey respondents, codes 46270 *Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous* (work RVU = 4.92 and 15 minutes intra-service time, 169 minutes total time) and 46275 *Surgical treatment of anal fistula (fistulectomy/fistulotomy); intersphincteric* (work RVU = 5.42 and 30 minutes intra-service time and 184 minutes total time) and determined that the surveyed code had the exact same intra-service time as CPT 46270, but is overall identical to somewhat more intense. The RUC referenced MPC codes 46930 *Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)* (work RVU = 1.61 and 5 minutes intra-service time) and 33240 *Insertion of implantable defibrillator pulse generator only; with existing single lead* (work RVU = 5.80 and 45 minutes intra-service time), which support the relativity among similar well recognized and established services. The RUC also noted that a work RVU of 3.69 for CPT code 46945 demonstrates the appropriately relativity among other 090-day global services with low intra-service time. **The RUC recommends a work RVU of 3.69 for CPT code 46945.**

The RUC compared the surveyed code to the two key reference services indicated by the survey respondents, codes 46270 *Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous* (work RVU = 4.92 and 15 minutes intra-service time, 169 minutes total time) and 46275 *Surgical treatment of anal fistula (fistulectomy/fistulotomy); intersphincteric* (work RVU = 5.42 and 30 minutes intra-service time and 184 minutes total time) and determined that the surveyed code had the exact same intra-service time as CPT 46270, but is overall identical to somewhat more intense. The RUC referenced MPC codes 46930 *Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)* (work RVU = 1.61 and 5 minutes intra-service time) and 33240 *Insertion of implantable defibrillator pulse generator only; with existing single lead* (work RVU = 5.80 and 45 minutes intra-service time), which support the relativity among similar well recognized and established services. The RUC also noted that a work RVU of 3.69 for CPT code 46945 demonstrates the appropriately relativity among other 090-day global services with low intra-service time. **The RUC recommends a work RVU of 3.69 for CPT code 46945.**

46946 Hemorrhoidectomy, internal, by ligation other than rubber band; 2 or more hemorrhoid columns/groups, without imaging guidance

The RUC reviewed the survey results from 79 colorectal and general surgeons and determined that the survey 25th percentile work RVU of 4.50 accurately accounts for the work required to perform this service. The RUC recommends 30 minutes evaluation, 10 minutes positioning, 10 minutes scrub/dress/wait pre-service time, 25 minutes intra-service time, 15 minutes immediate post-service time, half a day of discharge management 99238, one 99213 and one 99212 post-operative Evaluation and Management (E/M) office visits. The RUC confirmed that an extra 7 minutes of positioning time over the pre-time package are necessary for a total of five individuals to place the patient in the prone position after the induction of anesthesia to pad the head and extremities and efface the buttocks. The RUC confirmed that a 99213 E/M visit is required to discuss the patients' pain, diet, and activity restrictions, perform an anoscopy (not separately reportable) to assess for postoperative complications which may include delayed bleeding, sepsis, urinary retention, urinary tract infection, and/or fecal impaction. Also, one 99212 E/M office visit is required to discuss the patients' pain, diet, and activity restrictions, and perform a digital rectal exam to assess the wound.

The RUC compared the surveyed code to the two key reference services indicated by the survey respondents, codes 46247 *Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids) by stapling* (work RVU = 5.57 and 30 minutes intra-service time and 170 minutes total time) and 46270 *Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous* (work RVU = 4.92 and 15 minutes intra-service time, 169 minutes total time) and determined that the physician work, time and intensity required to performed 46946 are perfectly relative compared to these services. The RUC compared the surveyed code to 64721 *Neuroplasty and/or transposition; median nerve at carpal tunnel* (work RVU = 4.97 and 25

minutes intra-service time), noting that both services require the same intra service time and similar work to perform. The RUC referenced MPC codes 46930 *Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)* (work RVU = 1.61 and 5 minutes intra-service time) and 33240 *Insertion of implantable defibrillator pulse generator only; with existing single lead* (work RVU = 5.80 and 45 minutes intra-service time), which support the relativity among similar well recognized and established services. **The RUC recommends a work RVU of 4.50 for CPT code 46946.**

46948 Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy when performed

The RUC reviewed the survey results from 74 colorectal and general surgeons and determined that the survey 25th percentile work RVU of 5.57 accurately accounts for the work required to perform this service. The RUC recommends 30 minutes evaluation, 10 minutes positioning, 10 minutes scrub/dress/wait pre-service time, 40 minutes intra-service time, 15 minutes immediate post-service time, half a day of discharge management 99238, one 99213 and one 99212 post-operative Evaluation and Management (E/M) office visits. The RUC confirmed that an extra 7 minutes of positioning time over the pre-time package are necessary for a total of five individuals to place the patient in the prone position after anesthesia, to pad the head and extremities and efface the buttocks. The RUC confirmed that a 99213 E/M visit is required to discuss the patients' pain, diet, and activity restrictions, perform an anoscopy (not separately reportable) to assess for postoperative complications which may include delayed bleeding, sepsis, urinary retention, urinary tract infection, and/or fecal impaction. Also, one 99212 E/M office visit is required to discuss the patients' pain, diet, and activity restrictions, and perform a digital rectal exam to assess the wound.

This service includes the use of a large anoscope with an integrated Doppler where the physician can hear the blood pulsing in the vessels going to the hemorrhoid. Using the ultrasound probe, hemorrhoid artery ligation is performed with figure-of-eight ligation using absorbably suture at six positions correlating with the odd numbers of the clock. After each suture is tied by the device, ultrasound is used to confirm artery ligation. If an ultrasound signal is detected after 6 ligations, then additional suture ligation is performed, up to a maximum of eight. If significant mucosal/hemorrhoidal prolapse is present, mucopexy may also be performed by running the suture previously tied in a proximal-to-distal fashion, stopping 1 cm above the dentate line. At this point, the suture is tied back to itself at the apex of the hemorrhoidal column (location of initial ultrasound signal), creating a mucopexy of any redundant hemorrhoidal tissue. This procedure is repeated for each of the six terminal branches of the superior rectal artery so that six ligations and pexy sutures are performed. The RUC compared the surveyed code to the two key reference services indicated by the survey respondents, codes 46247 *Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids) by stapling* (work RVU = 5.57 and 30 minutes intra-service time and 170 minutes total time) and 46280 *Surgical treatment of anal fistula (fistulectomy/fistulotomy); transsphincteric, suprasphincteric, extrasphincteric or multiple, including placement of seton, when performed* (work RVU = 6.39 and 45 minutes intra-service time, 199 minutes total time) and determined that the physician work, time and intensity for 46948 are appropriately relative to these services. The specialty noted and the RUC agreed that the intensity for 46948 is appropriately slightly less than 46947 because ligation is less intense than excision. The RUC referenced MPC codes 46930 *Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)* (work RVU = 1.61 and 5 minutes intra-service time) and 33240 *Insertion of implantable defibrillator pulse generator only; with existing single lead* (work RVU = 5.80 and 45 minutes intra-service time), which support the relativity among similar well recognized and established services. **The RUC recommends a work RVU of 5.57 for CPT code 46948.**

Practice Expense

The Practice Expense Subcommittee approved compelling evidence for several inputs that increased due to changes in site of service and or omissions from submission in 2003. The RUC recommends the direct practice expense inputs as submitted by the specialty societies.

New Technology

CPT code 46948 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.

Preperitoneal Pelvic Packing (Tab 8)

Charles Mabry, MD, FACS (ACS); Nader Massarweh, MD (ACS)

In May 2018 the CPT Editorial Panel approved the addition of two codes for preperitoneal pelvic packing, removal and/or repacking for hemorrhage associated with pelvic trauma.

49013 Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration

The RUC reviewed the survey results from 38 surgeons, a majority of which had experience performing this procedure in the past 12 months. The RUC also noted that although this is a rare procedure, every trauma surgeon is trained to perform this procedure as part of the educational curriculum of trauma courses such as the American College of Surgeons' Committee on Trauma ASSET course. The RUC agreed on the following physician time components: 30 minutes of pre-service evaluation, 10 minutes of pre-service positioning, 10 minutes of pre-service scrub/dress/wait, 45 minutes of intra-service time, 60 minutes of immediate post-service time, for a total of 155 minutes. The RUC agreed with the reduction of 10 minutes to the pre-time package evaluation time to be consistent with the survey median and to acknowledge the urgent nature of this service. The RUC agreed with the specialty recommendation for an additional 7 minutes for positioning the patient. Although the patient will be supine, additional preparation of the entire torso for possible emergent chest or abdominal surgery will be required. In addition, a patient with pelvic trauma requiring this service will likely have a pelvic c-clamp for stabilization and other injuries that need to be considered while positioning the patient. Pre-service time for scrub, dress, wait was reduced from the pre-service package time of 20 minutes to 10 minutes to acknowledge the urgent nature of this service. Postoperatively, 27 minutes was added to the post-time package, for a total of 60 minutes. The postoperative time for this 000-day global code includes all postoperative until midnight on the day of the procedure. Postoperative, the patient will still be unstable and critical and their hemodynamic status will be monitored very closely for more than the 10 minutes included in the package for monitoring patient recovery. Significant coordination with other treating physicians, surgeons and ICU staff will be necessary. Time for this activity is not included in the post-operative package and the RUC agreed that 60 minutes of postoperative work on the day of this procedure is appropriate.

The RUC noted that code 49013 is not scheduled, but rather a rare emergency procedure. The RUC thoroughly discussed the atypical nature of this service and that a 000-day global service period is appropriate to avoid overlap with variable post-operative care that will be unpredictable because of the variability of the site of service (rural versus urban), in terms of the post-operative team available to treat the trauma patient. The injury requiring pelvic packing can be the result of a motor vehicle accident or a bomb.

The RUC thoroughly reviewed the recommended survey median work RVU of 8.35 and agreed that this value correctly estimates the amount of physician work involved. To justify a work RVU of 8.35, the RUC compared the survey code to the top key reference services, codes 37244 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation* (work RVU= 13.75, pre-service time of 31 minutes, intra-service time of 90 minutes, and post-service time of 45 minutes) and 31603 *Tracheostomy, emergency procedure; transtracheal* (work RVU= 6.00, pre-service time of 45 minutes, intra-service time of 30 minutes, and post-service time of 30 minutes) and noted that the top key reference codes appropriately bracket the survey code in terms of total

time and amount of physician work. Additionally, the RUC agreed that the intensity and complexity of the survey code is appropriately similar to code 37244 which is the alternative treatment for exactly the same patient and the intensity is appropriately less than code 31603, further justifying a recommended work RVU of 8.35. **The RUC recommends a work RVU of 8.35 for CPT code 49013.**

49014 Re-exploration of pelvic wound with removal of preperitoneal pelvic packing including repacking, when performed

The RUC reviewed the survey results from 38 surgeons and agreed on the following physician time components: 40 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 15 minutes of pre-service scrub/dress/wait, 45 minutes of intra-service time, and 30 minutes of immediate post-service time. The RUC acknowledged that this procedure is not an emergency and will be scheduled when appropriate in concert with the work of other physicians and surgeons involved with the trauma patient. The RUC agreed with the reduction of 5 minutes to the scrub, dress, wait time and reduction of 3 minutes to the post-service time to be consistent with the survey median.

The RUC thoroughly reviewed the recommended survey median work RVU of 6.73 and agreed that this value correctly estimates the amount of physician work involved. To justify a work RVU of 6.73, the RUC compared the survey code to the top key reference codes as indicated by the survey respondents, 37193 *Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU=7.10, pre-service time of 31 minutes, intra-service time of 45 minutes, and post-service time of 15 minutes) and 31600 *Tracheostomy, planned (separate procedure)*; (work RVU=5.56, pre-service time of 60 minutes, intra-service time of 30 minutes, and post-service time of 30 minutes) and noted that these reference codes appropriately bracket the survey code in the amount of physician work involved. The survey code and key reference codes are all scheduled procedures, typically in critically ill and complex patients. The RUC and specialties agreed that the surveyed code was less intense, but similarly complex given each patient's health status at the time the procedures are performed. The RUC also agreed that the recommended work RVU correctly ranked the surveyed code with the key reference codes. Additionally, the RUC also reviewed MPC code 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* (work RVU= 6.75, pre-service time of 53 minutes, intra-service time of 45 minutes, and post-service time of 20 minutes) and agreed that the relativity of both codes in terms of time and physician work further warrants a recommended work RVU of 6.73 for the survey code. **The RUC recommends a work RVU of 6.73 for CPT code 49014.**

Practice Expense

The RUC recommends the direct practice expense inputs as submitted by the specialty society.

Somatic Nerve Injection (Tab 9)

Neal Cohen, MD (ASA); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA); Eduardo Fraifeld, MD (AAPM); Matthew Grierson, MD (AAPMR); Jon Hathaway, MD (ACOG); George Hill, MD (ACOG); Kevin Kerber, MD (AAN); Peter Manes, MD (AAO-HNS); Lance Manning, MD (AAO-HNS); Gregory Polston, MD (AAPM); Mitch Schuster, MD (ACOG); Jay Shah, MD (AAO-HNS); Raissa Villanueva, MD (AAN)

Facilitation Committee #2

In May 2018, the CPT Editorial Panel approved the revision of descriptors and guidelines for codes 64400- 64450 and deletion of 3 codes to clarify reporting (ie, separate reporting of imaging guidance, number of units, change of CPT codes 64421 from a 0-day global to ZZZ). Codes 64400-64450 describe the injection of an anesthetic agent(s) and/or steroid into a nerve plexus, nerve, or branch. These codes are reported once per nerve plexus, nerve, or branch as described in the descriptor regardless of the number of

injections performed along the nerve plexus, nerve, or branch described by the code. Image guidance (ultrasound, fluoroscopy, CT) and localization may be reported separately. The physician work for this family of services varies based on the anatomic location of each nerve, whether the services is typically performed in the facility setting, the typical approach used by the dominant specialty to access the nerve that performs each service and whether the service involves continuous infusion by catheter.

64400 Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)

The RUC reviewed the survey results from 56 physicians and agreed on the following physician time components: 7 minutes of pre-service evaluation, 1 minute of pre-service positioning, 1 minute of pre-service scrub/dress/wait, 6 minutes of intra-service time and 5 minutes of immediate post-service time. The RUC noted that the current times for this service are over 25 years old from the Harvard study and not valid for comparison. The IWP/UT for the current times is similar to scrub/dress/wait IWP/UT, which strongly implies the current times are highly inflated relative to the current work RVU and not valid for comparison to the new times.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents somewhat overvalued the work involved in performing this service, with a 25th percentile work RVU of 1.14. To find an appropriate work RVU, the RUC reviewed the survey 25th percentile for only the neurologist survey respondents of 1.00, noting that neurology is the top performing specialty yet there were fewer survey responses from neurology than from anesthesiology. Neurology is 47 percent of the 2017 Medicare claims whereas anesthesiology is only 10 percent of the claims, the RUC noted that it would be appropriate to value the service at the Neurology 25th percentile of 1.00. To justify a work RVU of 1.00, the RUC compared the survey code to CPT code 31575 *Laryngoscopy, flexible; diagnostic* (work RVU = 0.94, intra-service time of 5 minutes) and noted that the reference code more intra-service time and involves slightly more physician work. The RUC also compared the survey code to MPC code 36620 *Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous* (work RVU = 1.00, intra-service time of 7 minutes, total time of 17 minutes) and noted that although the survey code has 1 minute less of intra-service time, it has 3 more minutes of total time and both services involve a similar amount of physician work. **The RUC recommends a work RVU of 1.00 for CPT code 64400.**

64408 Injection(s), anesthetic agent(s) and/or steroid; vagus nerve

The RUC reviewed the survey results from 37 physicians and agreed on the following physician time components: 7 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 5 minutes of intra-service time and 5 minutes of immediate post-service time.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 0.90. To justify a work RVU of 0.90, the RUC compared the survey code to CPT code 31575 *Laryngoscopy, flexible; diagnostic* (work RVU = 0.94, intra-service time of 5 minutes) and noted that both services have identical intra-service times and involve a similar amount of physician work, and therefore should be valued similarly. The RUC also compared the survey code to MPC code 36620 *Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous* (work RVU = 1.00, intra-service time of 7 minutes, total time of 17 minutes) and noted that the survey code involves 2 minutes less of intra-service time and it would be appropriate to value the survey code somewhat less as it involves somewhat less overall work. **The RUC recommends a work RVU of 0.90 for CPT code 64408.**

64415 Injection(s), anesthetic agent(s) and/or steroid; brachial plexus

The RUC reviewed the survey results from 57 physicians and agreed on the following physician time components: 13 minutes of pre-service evaluation, 1 minute of pre-service positioning, 4 minutes of pre-service scrub/dress/wait, 12 minutes of intra-service time and 10 minutes of immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than services in this family that are typically performed in the non-facility setting.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 1.42. To justify a work RVU of 1.42, the RUC compared the survey code to CPT code 64612 *Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)* (work RVU = 1.41, intra-service time of 10 minutes) and noted that the survey code involves slightly more intra-service time and slightly less total time and both services include a similar amount of physician work. The RUC also compared the survey code to CPT code 30903 *Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method* (work RVU = 1.54, intra-service time of 15 minutes, total time of 39 minutes) and noted that the survey code involves less intra-service time and valuing the survey code at 1.42 would maintain appropriate relativity with the reference code. **The RUC recommends a work RVU of 1.42 for CPT code 64415.**

64416 Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement)

The RUC reviewed the survey results from 42 physicians and agreed on the following physician time components: 13 minutes of pre-service evaluation, 1 minute of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, 20 minutes of intra-service time and 10 minutes of immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than services in this family that are typically performed in the non-facility setting.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 1.81. To justify a work RVU of 1.81, the RUC compared the survey code to CPT code 32554 *Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance* (work RVU = 1.82, intra-service time of 20 minutes) and noted that both services involve identical intra-service time and have typically require a similar amount of physician work. **The RUC recommends a work RVU of 1.81 for CPT code 64416.**

64417 Injection(s), anesthetic agent(s) and/or steroid; axillary nerve

The RUC reviewed the survey results from 45 physicians and agreed on the following physician time components: 13 minutes of pre-service evaluation, 1 minute of pre-service positioning, 4 minutes of pre-service scrub/dress/wait, 10 minutes of intra-service time and 10 minutes of immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than services in this family that are typically performed in the non-facility setting. The RUC noted that the current times for this service are over 25 years old from the Harvard study and not valid for comparison.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 1.27. To justify a work RVU of 1.27, the RUC compared the survey code to CPT code 49082 *Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance* (work RVU = 1.24, intra-service time of 10 minutes) and noted that both services involve identical intra-service time and total time and a similar amount of physician work. The RUC also compared the code to CPT code 32562 *Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of*

multiloculated effusion); *subsequent day* (work RVU = 1.24, intra-service time of 10) and noted that both services have identical intra-service times and involve a similar amount of physician work. The RUC noted that 64417 has appropriate relativity with the rest of the family. For example, 64415 and 64417 involve a similar work intensity and therefore the RUC recommendations for both services have similar IWPUs. **The RUC recommends a work RVU of 1.27 for CPT code 64417.**

64420 Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level

The RUC reviewed the survey results from 60 physicians and agreed on the following physician time components: 13 minutes of pre-service evaluation, 1 minute of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, 10 minutes of intra-service time and 5 minutes of immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than services in this family that are typically performed in the non-facility setting. The RUC noted that the current times for this service are from the Harvard study more than 20 years ago; in 1994, the RVU for this service was lowered substantially but the intra-service time was not changed to reflect the decrease. Therefore, a reduction in time would not necessarily imply a reduction in work value as the previous times used a flawed methodology.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents somewhat overvalued the work involved in performing this service, with a 25th percentile work RVU of 1.24. The RUC also reviewed the current value for this service of 1.18 and noted that would continue to be the appropriate value for this service. To verify a value of 1.18, the RUC compared the survey code to CPT code 49082 *Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance* (work RVU = 1.24, intra-service time of 10 minutes) and noted that both codes involve identical intra-service time, whereas the reference code involves somewhat more total time and that the survey code should be valued somewhat lower. The RUC also compared the code to CPT code 32562 *Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day* (work RVU = 1.24, intra-service time of 10) and noted that both services have identical intra-service times and involve a similar amount of physician work. The RUC noted that 64417 has appropriate relativity with the rest of the family. For example, 64420 and 64417 involve a similar work intensity and therefore the RUC recommendations for both services have similar IWPUs. **The RUC recommends a work RVU of 1.18 for CPT code 64420.**

64421 Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, each additional level (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 60 physicians and agreed on the following physician time components: 10 minutes of intra-service time. The RUC noted that the coding structure for 64421 changed when the code was revised by CPT; 64421 switched from a 000-day global code that code only be reported a single time to an add-on code for 64420. Furthermore, the current physician times for 64421 are over 25 years old and from the Harvard study.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overvalued the work involved in performing this service, with a 25th percentile work RVU of 1.00. To find an appropriate work RVU crosswalk, the RUC compared the survey code to CPT code 77063 *Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)* (work RVU = 0.60, intra-service time of 8 minutes) and noted that although the survey code involves somewhat more intra-service time, both services require a very similar amount of physician work. Therefore, the RUC recommends a direct work RVU crosswalk from 77063 to 64421. **The RUC recommends a work RVU of 0.60 for CPT code 64421.**

64425 Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves

The RUC reviewed the survey results from 54 physicians and agreed on the following physician time components: 7 minutes of pre-service evaluation, 1 minute of pre-service positioning, 1 minute of pre-service scrub/dress/wait, 11 minutes of intra-service time and 5 minutes of immediate post-service time. The RUC noted that the current times for this service are over 25 years old from the Harvard study and not valid for comparison.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 1.19. To justify a work RVU of 1.19, the RUC compared the survey code to CPT code 49082 *Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance* (work RVU = 1.24, intra-service time of 10 minutes) and noted that both services involve identical intra-service time and whereas the reference code involves somewhat more total time and it would be appropriate to value the survey code somewhat lower than the reference code at a value of 1.19. The RUC also compared the code to CPT code 32562 *Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day* (work RVU = 1.24, intra-service time of 10) and noted that both services have similar intra-service times and the survey code should be valued slightly less than the reference code to maintain appropriate relativity. **The RUC recommends a work RVU of 1.19 for CPT code 64425.**

64430 Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve

The RUC reviewed the survey results from 67 physicians and agreed on the following physician time components: 13 minutes of pre-service evaluation, 5 minutes of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, 10 minutes of intra-service time and 10 minutes of immediate post-service time. The specialty noted and the RUC agreed that this service requires more post-time than CPT code 64425 as the pudendal nerve is deeper. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than services in this family that are typically performed in the non-facility setting. The post-service time is longer for 64430 compared to 64435 because the approach involves going much deeper and the physician typically stays longer as the patient tends to have pelvic muscle weakness. Unlike for 64435, for 64430, the patient is then re-examined digitally to confirm pelvic stability and pelvic floor tonicity during the post-service period. The patient is then evaluated for safety in ambulation.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 1.15. To justify a work RVU of 1.15, the RUC compared the survey code to CPT code 49082 *Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance* (work RVU = 1.24, intra-service time of 10 minutes) and noted that both services involve identical intra-service time and whereas the reference code involves somewhat more total time and it would be appropriate to value the survey code somewhat lower than the reference code at a value of 1.15. The RUC also compared the code to CPT code 32562 *Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day* (work RVU = 1.24, intra-service time of 10) and noted that both services have identical intra-service times and the survey code should be valued slightly less than the reference code to maintain appropriate relativity. **The RUC recommends a work RVU of 1.15 for CPT code 64430.**

64435 Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve

The RUC reviewed the survey results from 42 physicians and agreed on the following physician time components: 7 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 5 minutes of intra-service time and 5 minutes of immediate post-service time.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 0.75. To justify a work RVU of 0.75, the RUC compared the survey code to top key reference code 20551 *Injection(s); single tendon origin/insertion* (work RVU = 0.75, intra-service time of 5, total time of 20 minutes) and noted that both services involve identical intra-service time and total time and the same amount of physician work. The RUC also compared the survey code to CPT code 31575 *Laryngoscopy, flexible; diagnostic* (work RVU = 0.94, intra-service time of 5 minutes) and noted that although both services have identical intra-service time, the reference code involves more total time, justifying a somewhat lower valuation for the survey code. **The RUC recommends a work RVU of 0.75 for CPT code 64435.**

64445 *Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve*

The RUC reviewed the survey results from 68 physicians and agreed on the following physician time components: 7 minutes of pre-service evaluation, 1 minutes of pre-service positioning, 1 minutes of pre-service scrub/dress/wait, 10 minutes of intra-service time and 5 minutes of immediate post-service time.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overvalued the work involved in performing this service, with a 25th percentile work RVU of 1.30. To find an appropriate work RVU crosswalk, the RUC compared the survey code to CPT code 67810 *Incisional biopsy of eyelid skin including lid margin* (work RVU = 1.18, intra-service time of 13 minutes, total time of 27 minutes) and noted that although the survey code involves somewhat less intra-service time, it involves somewhat more total time and a very similar amount of physician work. The RUC recommends a direct work RVU crosswalk from CPT code 67810 to CPT code 64445. The RUC also compared the code to CPT code 32562 *Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day* (work RVU = 1.24, intra-service time of 10) and noted that both services have identical intra-service times and whereas the survey code involves slightly more overall physician work. **The RUC recommends a work RVU of 1.18 for CPT code 64445.**

64446 *Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement)*

The RUC reviewed the survey results from 48 physicians and agreed on the following physician time components: 13 minutes of pre-service evaluation, 1 minute of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, 15 minutes of intra-service time and 6 minutes of immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than services in this family that are typically performed in the non-facility setting.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overvalued the work involved in performing this service, with a 25th percentile work RVU of 1.80. To find an appropriate work RVU crosswalk, the RUC compared the survey code to CPT code 30903 *Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method* (work RVU = 1.54, intra-service time of 15 minutes, total time of 39 minutes) and noted that both services have identical intra-service time and total time and involve an identical amount of physician work. The RUC recommends a direct work RVU crosswalk from CPT code 30903 to CPT code 64446. **The RUC recommends a work RVU of 1.54 for CPT code 64446.**

64447 *Injection(s), anesthetic agent(s) and/or steroid; femoral nerve*

The RUC reviewed the survey results from 62 physicians and agreed on the following physician time components: 12 minutes of pre-service evaluation, 1 minute of pre-service positioning, 3 minutes of pre-service scrub/dress/wait, 6 minutes of intra-service time and 5 minutes of immediate post-service time.

This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than services in this family that are typically performed in the non-facility setting.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overvalued the work involved in performing this service, with a 25th percentile work RVU of 1.29. To find an appropriate work RVU crosswalk, the RUC compared the survey code to CPT code 31231 *Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)* (work RVU = 1.10, intra-service time of 7 minutes, total time of 21 minutes) and noted that although the survey code involves slightly less intra-service time, it requires more total time and a very similar amount of physician work. The RUC recommends a direct work RVU crosswalk from CPT code 31231 to CPT code 64447. **The RUC recommends a work RVU of 1.10 for CPT code 64447.**

64448 Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement)

The RUC reviewed the survey results from 51 physicians and agreed on the following physician time components: 13 minutes of pre-service evaluation, 1 minute of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, 13 minutes of intra-service time and 6 minutes of immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than services in this family that are typically performed in the non-facility setting.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overvalued the work involved in performing this service, with a 25th percentile work RVU of 1.78. To find an appropriate work RVU crosswalk, the RUC compared the survey code to 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, intra-service time of 11 minutes, total time of 39 minutes) and noted that the survey code involves somewhat more intra-service time whereas both services only differ on total time by 1 minute and require a very similar total amount of physician work. The RUC recommends a direct work RVU crosswalk from CPT code 62322 to CPT code 64448. The RUC also compared the survey code to MPC code 57452 *Colposcopy of the cervix including upper/adjacent vagina;* (work RVU = 1.50, intra-service time of 15 minutes, total time of 40 minutes) and noted that both services involve similar intra-service time and total time and should be valued similarly. **The RUC recommends a work RVU of 1.55 for CPT code 64448.**

64449 Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)

The RUC reviewed the survey results from 36 physicians and agreed on the following physician time components: 13 minutes of pre-service evaluation, 1 minutes of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, 14 minutes of intra-service time and 5 minutes of immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than services in this family that are typically performed in the non-facility setting.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overvalued the work involved in performing this service, with a 25th percentile work RVU of 1.80. To find an appropriate work RVU crosswalk, the RUC compared the survey code to 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, intra-service time of 11 minutes, total time of 39 minutes) and noted that the survey code involves somewhat more intra-service time whereas both services only differ on total time by 1 minute

and require a very similar total amount of physician work. The RUC recommends a direct work RVU crosswalk from CPT code 62322 to CPT code 64449. The RUC also compared the survey code to MPC code 57452 *Colposcopy of the cervix including upper/adjacent vagina*; (work RVU = 1.50, intra-service time of 15 minutes, total time of 40 minutes) and noted that both services involve similar intra-service time and total time and should be valued similarly. The RUC noted that survey codes 64448 and 64449 have identical total times, only one minute difference in intra-service time and involve the same amount of physician work. **The RUC recommends a work RVU of 1.55 for CPT code 64449.**

64450 Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch

The RUC reviewed the survey results from 88 physicians and agreed on the following physician time components: 7 minutes of pre-service evaluation, 1 minute of pre-service positioning, 1 minute of pre-service scrub/dress/wait, 5 minutes of intra-service time and 5 minutes of immediate post-service time.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents somewhat overvalued the work involved in performing this service, with a 25th percentile work RVU of 1.00. The RUC also reviewed the current value for this service of 0.75 and noted that would continue to be the appropriate value for this service. To justify a work RVU of 0.75, the RUC compared the survey code to CPT code 20551 *Injection(s); single tendon origin/insertion* (work RVU = 0.75, intra-service time of 5, total time of 20 minutes) and noted that both services involve identical intra-service time and very similar total time and the same amount of physician work. The RUC also compared the survey code to CPT code 31575 *Laryngoscopy, flexible; diagnostic* (work RVU = 0.94, intra-service time of 5 minutes) and noted that although both services have identical intra-service time, the reference code involves more total time and somewhat more intensity, justifying a somewhat lower valuation for the survey code. **The RUC recommends a work RVU of 0.75 for CPT code 64450.**

RUC Referral to CPT

During the October 2018 RUC presentation for this family of services, the specialty societies stated that codes 64415, 64416, 64417, 64446, 66447, and 64448 were reported with code 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* more than 50 percent of the time. Specifically, 76 percent with 64415, 85 percent with 64416, 68 percent with 64417, 77 percent with 64446, 77 percent with 66447, and 79 percent with 64448. The societies indicated they would submit a code change application to bundle 76942 into codes 64415, 64416, 64417, 64446, 64447, and 64448 for the 2021 cycle. This overlap was accounted for in the above RUC recommendations for these services. **The RUC refers CPT codes 64415, 64416, 64417, 64446, 64447 and 64448 to be bundled with ultrasound guidance, CPT code 76942 to the CPT Editorial Panel for CPT 2021.**

Practice Expense

The RUC reviewed and approved the direct practice expense inputs as approved by the Practice Expense Subcommittee, with the only revision to account for the reduction in procedure time for codes 64400 and 64450.

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.

Affirmation of RUC Recommendations

The RUC affirmed the recent RUC recommendations for CPT codes 64405 (work RVU= 0.94, pre-evaluation time of 5 minutes, pre-positioning time of 1 minute, intra-service time of 5 minutes and post-service time of 5 minutes) and 64418 (work RVU= 1.10, pre-evaluation time of 6 minutes, pre-

positioning time of 3 minutes, pre-scrub/dress/wait time of 3 minutes, intra-service time of 10 minutes, post-service time of 10 minutes). The relativity within the family remains correct.

Do Not Use to Validate for Physician Work

The RUC agreed that CPT codes 64400 and 64418 should be labeled in the RUC database with a flag that it should not be used to validate physician work.

Genicular Injection and RFA (Tab 10)

Eddy Fraifeld, MD (AAPM); Matthew Grierson, MD (AAPMR); Wesley Ibazebo, MD (SIS); Richard Rosenquist, MD (ASA); Neal Cohen, MD (ASA); Marc Leib, MD (ASA); Gregory Polston, MD (AAPM)

Facilitation Committee #2

In May 2018 the CPT Editorial Panel approved the addition of two codes to report injection of anesthetic and destruction of genicular nerves by neurolytic agent.

In October 2018, the RUC facilitated this tab and thoroughly discussed the issues surrounding the survey of this family of services. The specialties noted their concern that many survey respondents appeared to be confused about the number of nerve branch injections involved with these three codes. The RUC supports the specialty societies' request for CPT codes 64454, 64640, and 64624 to be resurveyed and presented at the January 2019 RUC meeting. **The RUC recommends resurveying these services for January 2019.**

Practice Expense:

The RUC also discussed the practice expense and noted that the change in intra-service time for codes 64450 would need to also be made to the clinical labor time.

Lower Gastrointestinal Tract Imaging (Tab 11)

Kurt Schoppe, MD (ACR); Andrew Moriarity, MD (ACR)

In October 2017, the RAW requested that AMA staff compile a list of CMS/Other codes with Medicare utilization of 30,000 or more. In January 2018, the RUC recommended to refer to CPT May 2018 to revise to condense this family of services and combine fluoroscopy. In May 2018, the CPT Editorial Panel approved the revision of nine codes, addition of two codes and deletion of five codes to conform to other families of radiologic examinations. The existing codes omitted key information regarding study types and provided inconsistent guidance on whether certain components are included in each code and the revisions will address these limitations and reflect the work inherent in each examination. The specialty society requested to delay survey of the upper GI codes in this family (CPT codes 74210, 74220, 74221, 74230, 74240, 74246, and 74248) until January 2019, as three of these codes for X-Ray Esophagus (74210, 74220, 74230), were already surveyed in April 2017 for the CPT 2019 cycle, thus their values are still pending. The specialty societies surveyed the lower GI codes (CPT codes 74250, 74251, 74270, 74280) for the October 2018 RUC meeting.

Compelling Evidence

The specialty societies presented compelling evidence for this family of codes based on flawed methodology and a change in patient population. The two codes identified on the screen, codes 74250 and 74270, are both CMS/Other sourced. Therefore, how the times and values were established are unknown or flawed. The RUC accepted compelling evidence for these two codes based on flawed methodology. The RUC also supported compelling evidence for CPT code 74251 as based on flawed methodology due to the devaluation by CMS of the original RUC recommendation in 1994. The RUC recommendation of 1.00 RVUs was arbitrarily reduced to 0.48 then raised to 0.69 in 1995.

CPT code 74280 was most recently reviewed in September 2011, and since that time, there have been advances in technology which have changed the typical patient. Most patients are typically first evaluated by colonoscopy and, increasingly, CT colonography. While previously used as a screening exam for the colon, that indication has seen a progressive decline and is now less than 6% of the claims. This code is now used for patients who fail either or both of those procedures or to problem-solve inconclusive findings on an initial examination. The RUC questioned whether this was the same argument as was made in 2011. The specialty indicated that the complexity of patients has been winnowed down to the most complex patients as demonstrated by the claims data. The RUC approved compelling evidence for the family based on change in patient population and a flawed previous methodology.

74250 Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study

The RUC reviewed the survey results from 47 radiologists and determined that the survey 25th percentile work RVU of 0.81 accurately reflects the physician work necessary for this service. This is the only study in the family that does not include catheter placement as the contrast is ingested. The RUC agreed that the survey respondents maintained rank order within the family when considering the intensity of services. The RUC recommends 3 minutes pre-service time, 15 minutes intra-service time, and 5 minutes immediate post-service time.

The RUC compared CPT code 74250 to the top key reference code 74160 *Computed tomography, abdomen; with contrast material(s)* (work RVU = 1.27 and 15 minutes intra-service time) and noted that while the times are identical, the reference code includes IV contrast material and is therefore appropriately valued higher than the survey code. The small intestine study, CPT code 74250, is a more focused examination evaluating a specific problem or possible etiologies in one organ system. The CT abdomen with contrast includes a larger number of anatomic structures and a wider range of pathologic conditions and as a result appropriately has a higher IWPOT. The survey respondents indicated somewhat less intensity of code 74250 compared to code 74160.

For additional support, the RUC referenced the two MPC codes, CPT code 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU = 0.81 and 11 minutes intra-service time) and CPT code 92002 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient* (work RVU = 0.88 and 15 minutes intra-service time); these codes were strong comparators with similar amount of physician work and time. While CPT code 74250 requires slightly more intra-service time than CPT code 76700, as it includes periods of less intensive work, supporting the identical work RVU recommendation and lower IWPOT. Similarly, the survey code has similar times but overall less intense work when compared to evaluation of the eye, CPT code 92002, supporting a lower recommended work RVU and IWPOT. The RUC concluded that CPT code 74250 should be valued at the 25th percentile work RVU as supported by the survey. Further, the recommendation maintains relativity within the lower gastrointestinal tract family and greater RBRVS. **The RUC recommends a work RVU of 0.81 for CPT code 74250.**

74251 Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; double-contrast (eg, high-density barium and air via enteroclysis tube) study, including glucagon, when administered

The RUC reviewed the survey results from 47 radiologists and determined that the survey 25th percentile work RVU of 1.17 accurately reflects the physician work necessary for this service. The RUC recommends 5 minutes pre-service time, 22 minutes intra-service time, and 5 minutes immediate post-service time.

For this family of services, the RUC noted that the double-contrast small bowel examination codes require more work than the single-contrast counterpart. Additionally, all of the examinations (except for code 74250) require placement of a catheter into the enteric track, which increases the risk of perforation. The RUC clarified that CPT code 74251 is not currently reported together with a tube placement. Tube placement or advancement would be performed by the surgeon not the radiologist, and most of the patients (70%) are in-patient, and already have the tube in place. The RUC clarified that in 2020, there will be a parenthetical in place that states a separate code should be used for placement of enteroclysis tube.

The RUC compared CPT code 74251 to the top key reference code 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.40 and 18 minutes intra-service time) and noted that the reference code includes without followed by contrast material and further sections, so it is appropriately valued higher than the survey code. The RUC also compared the survey code to the second key reference service CPT code 74160 *Computed tomography, abdomen; with contrast material(s)* (work RVU = 1.27 and 15 minutes intra-service time) and noted that while both codes include contrast material, the reference code has a shorter intra-service time and is therefore more intense and appropriately valued higher than the survey code. While CPT code 74251 has a greater intra-service and total time, there are periods of less intense work compared to the top key reference services, resulting in an appropriately lower work RVU and IWPOT. The small bowel examination is typically performed to evaluate for a specific disease process while both CT procedures involve evaluation of a larger number of organs and consideration of a greater potential number of disease processes.

For additional support, the RUC referenced the key MPC codes 70460 *Computed tomography, head or brain; with contrast material(s)* (work RVU = 1.13 and 12 minutes intra-service time) and 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27 and 15 minutes intra-service time). CPT code 74251 is bracketed by the two radiology codes which both have less time but appropriately higher IWPOTs, considering the intense work required to evaluate the brain and intracranial structures. The RUC concluded that CPT code 74251 should be valued at the 25th percentile work RVU as supported by the survey. Further, the recommendation maintains relativity within the lower gastrointestinal tract family and greater RBRVS. **The RUC recommends a work RVU of 1.17 for CPT code 74251.**

74270 Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study

The RUC reviewed the survey results from 47 radiologists and determined that the survey 25th percentile work RVU of 1.04 accurately reflects the physician work necessary for this service. The examination of the colon is more complex than the small bowel single-contrast study due to differences in patient positioning, placement of the catheter necessitated by the colon code, and the larger number of potential lesions and pathologies in evaluation of the colon. In addition, this code is now most frequently used to evaluate complex pre-operative anatomy, post-operative complications, or indeterminate CT findings. The RUC recommends 4 minutes pre-service time, 15 minutes intra-service time and 5 minutes immediate post-service time.

The RUC compared CPT code 74270 to the top key reference code 74160 *Computed tomography, abdomen; with contrast material(s)* (work RVU = 1.27 and 15 minutes intra-service time) and noted that the codes have identical intra times and similar total times. The X-ray colon study is a more focused examination evaluating a specific problem in one specific organ. The CT abdomen with contrast includes a larger number of anatomic structures and a wider range of pathologic conditions, supported by the higher work RVU and IWPOT. The RUC also compared the survey code to the second key reference

service CPT code 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.40 and 18 minutes intra-service time) and noted that the recommended value and times are appropriately lower for the survey code. Both examinations are tailored to examine one specific disease process or focused differential; however, the CT abdomen without and with contrast includes a larger number of anatomic structures, a wider range of potential pathologic conditions and review of two entire CT examinations.

For additional support, the RUC referenced key MPC code 76805 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation* (work RVU = 0.99 and 15 minutes intra-service time) and noted that the survey code has identical intra-service time and similar total time to CPT code 76805, but the invasive nature of this procedure accounts for the greater intensity and slightly higher work RVU and IWPUT. The RUC also compared the survey code to MPC code 70460 *Computed tomography, head or brain; with contrast material(s)* (work RVU = 1.13 and 12 minutes intra-service time) and noted that CPT code 74270 has slightly more time but is less intense than code 70460, which is a CT examination of the brain involving evaluation of a larger number of anatomic structures and consideration of a greater potential number of disease processes and complexity. The RUC concluded that CPT code 74270 should be valued at the 25th percentile work RVU as supported by the survey. Further, the recommendation maintains relativity within the lower gastrointestinal tract family and greater RBRVS. **The RUC recommends a work RVU of 1.04 for CPT code 74270.**

74280 Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high density barium and air) study, including glucagon, when administered

The RUC reviewed the survey results from 47 radiologists and determined that the survey 25th percentile work RVU of 1.26 accurately reflects the physician work necessary for this service. Per the compelling evidence argument, this code is decreasing in claims and is used on a more complex patient population. The RUC agreed with the survey respondents that this code with the installation of air and contrast has higher risk. The RUC recommends 4 minutes pre-service time, 20 minutes intra-service time and 5 minutes immediate post-service time.

The RUC compared CPT code 74280 to the top key reference codes 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.40 and 18 minutes intra-service time) and 74160 *Computed tomography, abdomen; with contrast material(s)* (work RVU = 1.27 and 15 minutes intra-service time). While the survey respondents reported a greater intra-service and total time for CPT code 74280, there are periods of less intense work compared to the two CT of the abdomen procedures, resulting in an appropriately lower work RVU and IWPUT. The X-ray colon study is typically performed to evaluate for a specific disease process, while both of the CT procedures involve evaluation of a larger number of organs and consideration of a greater potential number of disease processes.

For additional support, the RUC referenced the key MPC codes 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27 and 15 minutes intra-service time) and 70460 *Computed tomography, head or brain; with contrast material(s)* (work RVU = 1.13 and 12 minutes intra-service time). CPT code 74280 is bracketed by the two radiology codes which both have appropriately higher IWPUT when considering the longer intra-service period of 74280, which contains periods of overall less intense work compared to a CT examination of the brain involving evaluation of a larger number of anatomic structures and consideration of a greater potential number of disease processes and complexity. The RUC also compared CPT code 74280 to MPC code 99238 *Hospital discharge day management; 30 minutes or less* (work RVU = 1.28 and 20 minutes intra-service time) and noted that the survey code has identical intra-service time and

higher IWPOT compared to the hospital discharge management code, which accounts for the invasive nature of the colon procedure. The RUC concluded that CPT code 74280 should be valued at the 25th percentile work RVU as supported by the survey. Further, the recommendation maintains relativity within the lower gastrointestinal tract family and greater RBRVS. **The RUC recommends a work RVU of 1.26 for CPT code 74280.**

Practice Expense

The PE Subcommittee added two minutes of clinical staff time in the non-facility for clinical activity, *confirm availability of prior images/studies* (CA006) and removed a few minutes from the highly technical equipment [EL014]. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Myocardial PET (Tab 12)

Scott Bartley, MD (ACNM); Gary Dillehay, MD (SNMMI); Kurt Schoppe, MD (ACR); Richard Wright, MD (ACC); William Van Decker, MD (ACNM/ACC); Ed Tuohy, MD (ACC); Daniel Wessell, MD (ACR)

In January 2017, CPT code 78492 was identified via the High Volume Growth screen with total Medicare utilization over 10,000 which increased by at least 100% from 2009 through 2014. The RUC recommended referring this code to the CPT Editorial Panel to undergo substantive descriptor changes to reflect newer technology aspects such as wall motion, ejection fraction, flow reserve, and technology updates for hardware and software. In May 2018 the CPT Editorial Panel approved deletion of a Category III code, addition of six Category I codes, and revision of three codes to separately identify component services included for myocardial imaging using positron emission tomography.

In October 2018, the RUC pre-facilitated this tab and thoroughly discussed the issues surrounding the survey of this family of services. The RUC recognized significant problems, such as these services are essentially incremental studies, of myocardial PET metabolic, myocardial PET perfusion, with or without CT studies. However, the surveyed work RVUs fell between non-consistent increments and the physician time increments were only 0, 2, 3 or 5 minutes different. Noting that if these were stand-alone services, the differences would most likely be larger, like 5 or 10 minutes. Likewise, the difference of work was also not consistent. The RUC explored various alternative accepted methodologies and alternative methodologies and nothing produced an appropriate valuation of these services. The RUC also noted there are limited crosswalk codes to develop work RVUs for these services. Due to the survey outcome and concern with relativity among this family of services the RUC recommends resurveying these services for January 2019. The specialty societies indicated they will request via the Research Subcommittee to resurvey using an arrayed surveyed tool. Therefore, the respondents will be presented with a table throughout the survey with the physician time questions and the work RVU question on the same page, to value the family consistently. The specialty societies will also request to include additional explanatory language. **The RUC recommends resurveying these services for January 2019.**

Practice Expense:

The Practice Expense Subcommittee made minor modifications to the direct practice expense inputs to include additional wipes for cleaning the room twice. The RUC will make any changes to the clinical staff time that are linked to physician time in January 2019.

Long-Term EEG Monitoring (Tab 13)

Marianna V. Spanaki, MD (AAN); Marc Nuwer, MD (ACNS)

In January 2017, CPT code 95951 was identified via the High-Volume Growth screen with total Medicare utilization of 10,000 or more and increased by at least 100% from 2009 through 2014. The RUC recommended that this service be referred to the CPT Editorial Panel for needed changes, including code deletions, revision of code descriptors, and the addition of new codes to this family. Revisions to this family of codes are needed to capture that video is now an element of most long-term EEG monitoring tests and to better differentiate inpatient and ambulatory monitoring services. In May 2018, the CPT Editorial Panel approved the revision of one code, deletion of five codes, and addition of twenty-three codes for reporting long-term EEG professional and technical services.

Thirteen new codes were created for reporting the technical component of long-term EEG services (95700 – 95716) and 10 new codes were created for reporting the professional component of long-term EEG services (95717 – 95726). The Long-Term EEG codes are diagnostic services primarily used to evaluate patients with intractable epilepsy as well as patients with new-onset seizures to determine if spells are seizures, to characterize seizure type, and to localize seizure focus for pre-surgical evaluation. The new professional services code set is used to report the professional service of reviewing, analyzing, interpreting and reporting the results of the continuous recording of EEG or EEG with simultaneous video recording with recommendations based on the findings. The professional code set is divided into **2 groups** defined by the timing of the physician report generation and the ability of the physician to access the EEG (and video) data during the recording period.

- **Codes 95717 – 95720** are reported for services when the physician has access to EEG and video (when recorded) data throughout the recording and review, analysis and report generation of collected data occurs at specific time intervals such as 2-12 or 12-26 hours). While the entire code set is *site of service agnostic*:
 - The 2-12-hour codes are typically for day-time testing, done in an outpatient clinic or physician office setting for 8 hours,
 - The 12-26-hour codes are typically provided in the inpatient hospital epilepsy monitoring unit or intensive care unit.
- **Codes 95721 – 95726** are reported for services when the physician does NOT have access to EEG and video (when recorded) data during the recording period and review, analysis, and report generation occurs at the conclusion of a multiple day study. There is not site of service designation for 95721 – 95726 but they will typically be used for ambulatory services where the recording takes place in the patient's home or outside a facility.

Reporting of these services

At the October 2018 RUC meeting, a RUC member inquired whether this new family of long-term EEG services would typically be reported with CPT code 95957 *Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)*. The specialties noted that the current codes for reporting long-term EEG are not typically reported with code 95957. Also, code 95957 should not be reported with this new family of service per the CPT introductory language:

Use of automated spike and seizure detection and trending software is included in 95700-95726, when performed. Do not report 95957 for use of automated software.

95717 Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and report, 2-12 hours of EEG recording; without video

The RUC reviewed the survey results from 133 physicians and agreed on the following physician time components: 8 minutes of pre-service time, 28 minutes of intra-service time and 10 minutes of immediate post-service time. The specialties noted that the typical amount of monitoring time for this service is 8 hours. For this service, the physician has access to EEG data throughout the recording period and review and analysis of collected data occurs at specific time intervals.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 2.00. To justify a work RVU of 2.00, the RUC compared the surveyed code to MPC Code 99204 *Office or other outpatient visit for the evaluation and management of a new patient, ...* (work RVU =2.43, intra-service time of 30 minutes and total time of 45 minutes) and noted that the reference code has slightly more intra-service time and both services have similar total times, whereas the reference code is a slightly more intense service to perform. The RUC also compared the surveyed code to MPC code 74178 *Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions* (work RVU =2.01, intra-service time of 30 minutes, total time of 40 minutes) and noted that the survey code has slightly less intra-service time and more total time — also both services involve a similar amount of physician work. **The RUC recommends a work RVU of 2.00 for CPT code 95717.**

95718 Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and report, 2-12 hours of EEG recording; with video (VEEG)

The RUC reviewed the survey results from 149 physicians and agreed on the following physician time components: 10 minutes of pre-service time, 35 minutes of intra-service time and 10 minutes of immediate post-service time. The specialties noted that the typical amount of monitoring time for this service is 8 hours. For this service, the physician has access to EEG and video (when recorded) data throughout the recording period and review and analysis of collected data occurs at specific time intervals.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 2.50. To justify a work RVU of 2.50, the RUC compared the survey code to CPT Code 75573 *Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)* (work RVU = 2.55, intra-service time of 30 minutes, total time of 60 minutes) and noted that the survey code involves more intra-service time, whereas the reference code involves more total time and slightly more intensity. The RUC also compared the survey code to MPC code 99204 *Office or other outpatient visit for the evaluation and management of a new patient, ...* (work RVU =2.43, intra-service time of 30 minutes and total time of 45 minutes) and noted that the survey code involves somewhat more intraservice time and it would be appropriate to value the survey code somewhat higher than the reference code. The specialty noted and the RUC agreed that video EEG is a more intense service to perform than EEG without video. **The RUC recommends a work RVU of 2.50 for CPT code 95718.**

95719 *Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video*

The RUC reviewed the survey results from 133 physicians and agreed on the following physician time components: 10 minutes of pre-service time, 40 minutes of intra-service time and 10 minutes of immediate post-service time. For this service, the physician has access to EEG data throughout the recording period and review and analysis of collected data occurs at specific time intervals

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 3.00. To justify a work RVU of 3.00, the RUC compared the survey code to top key reference code 99223 *Initial hospital care, per day, for the evaluation and management of a patient, ...* (work RVU = 3.86, intra-service time of 55, total time of 90 minutes) and noted that the survey code involves less intra-service time and total time, though is a somewhat more intense service to perform. One-hundred percent of the survey respondents that selected code 99223 as their key reference service indicated that the survey code was at least as intense as the reference code and a majority felt that they survey code was a more intense service to perform. The RUC also compared the survey code to CPT code 44405 *Colonoscopy through stoma; with transendoscopic balloon dilation* (work RVU = 3.23, intra-service time of 38 minutes) and noted that the survey code involves slightly more intra-service time and slightly lower amount of physician work. **The RUC recommends a work RVU of 3.00 for CPT code 95719.**

95720 *Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)*

The RUC reviewed the survey results from 152 physicians and agreed on the following physician time components: 10 minutes of pre-service time, 55 minutes of intra-service time and 10 minutes of immediate post-service time. The typical patient for code 95720 is for a pre-surgical evaluation, which often includes the withdrawal of anti-seizure medications to invoke seizures and identify the seizure focus (requiring detailed review as this is the principal determinant for the site for surgical brain resection). For this service, the physician has access to EEG and video (when recorded) data throughout the recording period and review and analysis of collected data occurs at specific time intervals.

The RUC reviewed the survey respondents' estimated physician work values and agreed that an appropriate value is between the 25th percentile work RVU of 3.50 and median work RVU of 5.00. To find an appropriate work RVU crosswalk, the RUC compared the surveyed code to CPT code 99223 *Initial hospital care, per day, for the evaluation and management of a patient, ...* (work RVU = 3.86, intra-service time of 55, total time of 90 minutes) and noted that both services typically involve an identical amount of intra-service time; although the reference code involves more total time, the survey code is a more intense service to perform given the intensity involved in making an appropriate reading/diagnosis prior to neurosurgery. The typical patient for this service is a candidate for epilepsy surgery and the long-term EEG physician report will inform the neurosurgeon on whether epilepsy surgery is appropriate. The RUC agreed that both services involve a very similar total amount of physician work. Therefore, the RUC recommends a direct work RVU crosswalk from code 99223 to code 95720. The RUC also compared the survey code to CPT code 99236 *Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, ...* (work RVU = 4.20, intra-service time of 55 minutes, total time of 94 minutes) and noted that although both service have identical intra-service time, the reference code involves more total time, justifying a somewhat lower value for the survey code. The specialty noted and the RUC agreed that

video EEG is a more intense service to perform than EEG without video. **The RUC recommends a work RVU of 3.86 for CPT code 95720.**

95721 Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, without video

The RUC reviewed the survey results from 133 physicians and agreed on the following physician time components: 10 minutes of pre-service time, 65 minutes of intra-service time and 10 minutes of immediate post-service time. For this service, the physician does not have access to EEG data during the recording period and the review and analysis occurs at the conclusion of the multiple day study.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 3.86. To justify a work RVU of 3.86, the RUC compared the survey code to MPC code 99337 *Domiciliary or rest home visit for the evaluation and management of an established patient, ...* (work RVU = 3.58, intra-service time of 60 minutes) and noted that the survey code involves more intra-service time and more physician work. The specialty noted and the RUC agreed that video EEG is a more intense service to perform than EEG without video. **The RUC recommends a work RVU of 3.86 for CPT code 95721.**

95722 Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, with video (VEEG)

The RUC reviewed the survey results from 145 physicians and agreed on the following physician time components: 10 minutes of pre-service time, 80 minutes of intra-service time and 10 minutes of immediate post-service time. For this service, the physician does not have access to EEG and video data during the recording period and the review and analysis occurs at the conclusion of the multiple day study.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 4.70. To justify a work RVU of 4.70, the RUC compared the survey code to CPT Code 31653 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures* (work RVU = 4.96, intra-service time of 75 minutes) and noted that the survey code involves more intra-service time, whereas the reference code involves more total time and both services involve a similar amount of physician work. The specialty noted and the RUC agreed that video EEG is a more intense service to perform than EEG without video. **The RUC recommends a work RVU of 4.70 for CPT code 95722.**

95723 Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, without video

The RUC reviewed the survey results from 132 physicians and agreed on the following physician time components: 10 minutes of pre-service time, 90 minutes of intra-service time and 10 minutes of immediate post-service time. For this service, the physician does not have access to EEG data during the recording period and the review and analysis occurs at the conclusion of the multiple day study.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 4.75. To justify a work RVU of 4.75, the RUC compared the survey code to CPT Code 77772 *Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels* (work RVU= 5.40, intra-service time of 100 minutes and total time of 124 minutes) and noted that the survey code involves less intra-service and total time and a work value of 4.75 for the survey code would have appropriate relativity with the reference code. **The RUC recommends a work RVU of 4.75 for CPT code 95723.**

95724 Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of EEG recording, with video (VEEG)

The RUC reviewed the survey results from 147 physicians and agreed on the following physician time components: 10 minutes of pre-service time, 110 minutes of intra-service time and 10 minutes of immediate post-service time. For this service, the physician does not have access to EEG and video data during the recording period and the review and analysis occurs at the conclusion of the multiple day study.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 6.00. To justify a work RVU of 6.00, the RUC compared the survey code to top key reference code 95965 *Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)* (work RVU= 7.99, intra-service time of 180 minutes) and noted that the survey code involves much less intra-service and total time and a work value of 6.00 for the survey code would have relativity to the reference code. The specialty noted and the RUC agreed that video EEG is a more intense service to perform than EEG without video. **The RUC recommends a work RVU of 6.00 for CPT code 95724.**

95725 Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, without video

The RUC reviewed the survey results from 124 physicians and agreed on the following physician time components: 10 minutes of pre-service time, 110 minutes of intra-service time and 10 minutes of immediate post-service time. For this service, the physician does not have access to EEG data during the recording period and the review and analysis occurs at the conclusion of the multiple day study.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents somewhat overvalued the work involved in performing this service, with a 25th percentile work RVU of 6.50. To find an appropriate work RVU crosswalk, the RUC compared the survey code to CPT code 77772 *Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels* (work RVU = 5.40, intra-service time of 100 minutes, total time of 124 minutes) and noted that the survey code involves somewhat more intra-service time and total time, whereas the reference code is a somewhat more intense service to perform. The RUC agreed that both services involve a very similar total amount of physician work. Therefore, the RUC recommends a direct work RVU crosswalk from code 77772 to code 95725. The RUC noted that it would be appropriate rank order to value code 95725 at lower value than code 95724, even though both services have identical times, as the typical patient for this service without video is less intense and complex. **The RUC recommends a work RVU of 5.40 for CPT code 95725.**

95726 Electroencephalogram, continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of EEG recording, with video (VEEG)

The RUC reviewed the survey results from 142 physicians and agreed on the following physician time components: 10 minutes of pre-service time, 140 minutes of intra-service time and 10 minutes of immediate post-service time. For this service, the physician does not have access to EEG and video data during the recording period and the review and analysis occurs at the conclusion of the multiple day study.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 7.58. To justify a work RVU of 7.58, the RUC compared the survey code to CPT code to top key reference code 95965 *Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)* (work RVU = 7.99, intra-service time of 180 minutes) and noted that the survey code involves much less intra-service and total time and a work value of 7.58 for the survey code would have relatively to the reference code. The specialty noted and the RUC agreed that video EEG is a more intense service to perform than EEG without video. **The RUC recommends a work RVU of 7.58 for CPT code 95726.**

Practice Expense

The Practice Expense (PE) Subcommittee reviewed the direct PE inputs for CPT codes 95700-95716, which are PE only codes used to describe the technical work performed by a Registered Electroencephalographic Technologist (REETG). The specialty societies conducted a PE survey. The time from the survey was used for the direct PE inputs for code 95700 and the clinical staff time other than the monitoring time for continuous and intermittent monitoring codes. The survey was also used for the typical length of monitoring (8 hours or 24 hours). The specialty society explained that the technologists misunderstood the question on total monitoring time to imply checking for events rather than the actual monitoring, so the expert panel determined the monitoring time for continuous and intermittent monitoring codes. The PE Subcommittee also reviewed the minimal direct practice expense inputs for equipment used by the physician to perform CPT codes 95717-95726 in the non-facility setting. Claims data indicates that the site of the typical patient remains the facility setting, however in the non-facility setting the service is typically performed in an Independent Diagnostic Testing Facility (IDTF). At the IDTF or physicians' office the patient stays at the location for the 2-12 hours test and takes the equipment home and is monitored remotely by staff at the IDTF or physicians' office for the 12-26 hour test.

PE for Physician Work Services CPT codes 95717-95726

The only change was to remove equipment item EQ013, *EEG analysis software* from all the codes. The only direct practice expense input associated with the physician work only services is equipment item EQ016, *EEG review station, ambulatory* which is used by the physician.

Compelling Evidence for CPT codes 95700-95716

In January 2017, CPT code 95951 *Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours* was identified via the High-Volume Growth screen with total Medicare utilization of 10,000 or more and increased by at least 100% from 2009 through 2014. Since the service was last reviewed the technical work has had many changes in that the monitoring can be with or without video, and or with or without two different types of monitoring, or with no monitoring at all. The New CPT codes define continuous, intermittent and unmonitored as the following:

- Unmonitored: Services that have no real-time monitoring by an EEG technologist(s) during the continuous recording. If the criteria for intermittent or continuous monitoring are not met, then the study is an unmonitored study.
- Intermittent monitoring (remote or on-site): Requires an EEG technologist(s) to perform and document real-time review of data at least every two hours during the entire recording period to assure the integrity and quality of the recording (ie, EEG, VEEG), identify the need for maintenance, and, when necessary, notify the physician or other qualified health care professional of clinical issues. For intermittent monitoring, a single EEG technologist may monitor a maximum of 12 patients concurrently. If the number of intermittently monitored patients exceeds 12, then all the studies are reported as unmonitored.
- Continuous real-time monitoring (remote or on-site): Requires all elements of intermittent monitoring. In addition, the EEG technologist(s) performs and documents real-time concurrent monitoring of the EEG data and video (when performed), during the entire recording period. The EEG technologist(s) identifies when events occur and notifies, as instructed, the physician or other qualified health care professional. For continuous monitoring, a single EEG technologist may monitor a maximum of four patients concurrently. If the number of concurrently monitored patients exceeds four, then all of the studies are reported as either unmonitored or intermittent studies. If there is a break in the real-time monitoring of the EEG recording, the study is an intermittent study.

For many years CPT code 95951 was predominantly an inpatient service, however over the more recent years there are now varying patient populations some still requiring the inpatient stays for medication withdrawal and other studies that could be conducted in an Independent Diagnostic Testing Facility (IDTF) or in the patients' home with monitoring through advanced technologies. The specialty society presented the following practice expense compelling evidence arguments:

1. Technique (there are now varying levels of monitoring, whereas previously there was only monitored or unmonitored)
2. Site of service (due to population shift services are now performed in the outpatient/ambulatory setting, and patients' homes and not exclusively in the inpatient setting)
3. Technology changes and advancements (improved technology has created more options for remote/ambulatory monitoring of patients in various settings; increased remote video capabilities.)

Set-up and Take-down

95700 Electroencephalogram (EEG) continuous recording, with video when performed, set-up, patient education, and take down when performed, administered in-person by EEG technologist, minimum of 8 channels

This service encompasses both the set-up and take-down of the supplies, equipment and clinical staff time to perform any of the EEG monitoring services. This service includes all the supplies needed for monitoring regardless of the length of the service. The PE Subcommittee first consolidated and reduced the amount of staff time for clinical activity CA013, *Prepare room, equipment and supplies* because the PE Subcommittee agreed that in the typical office setting this would be done during the service period (pre-service (of service period)). The Subcommittee maintained 45 minutes of clinical staff time for clinical activity, CA016 *Prepare, set-up and start IV, initial positioning and monitoring of patient* because this is when the technologist applies the electrodes. Additional consolidation and reductions were made for clinical activities, CA011, *Provide education/obtain consent* (in the service period (post-service (of service period))), CA024, *Clean room/equipment by clinical staff* and CA035, *Review home care instructions, coordinate visits/prescriptions*. In supplies the PE Subcommittee adjusted the quantity or removed a number of items, most significantly, the PE Subcommittee removed two supply items for SD054, *electrode, EEG, tin cup (12 pack uou)* because it was established that the electrodes are reusable.

Unmonitored (13+ patients monitored)

95705 Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored

95708 Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored

95711 Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored

95714 Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored

The PE Subcommittee discussed that there is REEGT involved with the unmonitored codes. The technologist performing clinical activity, CA021 *Perform procedure/service---NOT directly related to physician work time* is performing activities other than monitoring such as review history, maintenance during patient session, patient/family education, internal communication and preparing the data (line 55 on the PE spreadsheet). The technologist performs clinical activity, CA038 *Coordinate post-procedure services* to retrieve and manage the data. The PE Subcommittee reduced the times, 22 min for the 2-12 hour codes and 44 minutes for the 12-26 hour code respectively by 50% to 11 and 22 minutes, in order to account for partial automation of this task. The associated equipment time related to this clinical activity is ED050, *Technologist PACS workstation*. The equipment time remains 100%. Only one of the following pieces of equipment is used for each code for the entire test. For both non-video unmonitored codes equipment item, EQ014, *EEG monitor, digital, portable*, is used. For the 2-12 hour video unmonitored code where the patient stays in the office, equipment item, EQ017, *EEG, digital, prolonged testing system (computer w-remote camera)* is used. For the 12-26 code video unmonitored codes where the patient takes the equipment home, new equipment item, *EEG, digital, prolonged testing system with remote video, for patient's home use* is used.

1. EQ015 EEG recorder, ambulatory
2. EQ014 EEG monitor, digital, portable
3. NEW EQUIP EEG, digital, prolonged testing system with remote video, for patient's home use
4. EQ017 EEG, digital, prolonged testing system (computer w-remote camera)

Intermittent (Up to 12 patients monitored)

95706 Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance

95709 Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance

95712 Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring, and maintenance

95715 Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring, and maintenance

The PE Subcommittee discussed that there are two REEGT involved with the intermittent monitoring codes. The first technologist performing clinical activity, CA021 *Perform procedure/service---NOT directly related to physician work time* is doing the monitoring (line 54 on the PE spreadsheet) and the second technologist performing clinical activity, CA021 *Perform procedure/service---NOT directly related to physician work time* is performing other activities such as review history, maintenance during patient session, patient/family education, internal communication and preparing the data (line 55 on the PE spreadsheet). The survey results indicated that the typical number of patients monitored is 12 patients. This is also the maximum allowed based on CPT coding before an unmonitored code should be used. The specialty societies' expert panel determined that the number of hours monitored for the 2-12 hour codes 95706 and 95712, are typically for 8 hours. 8 hours or 480 minutes divided by 12 patients is 40 minutes of monitoring time. The 12-26 hour codes 95709 and 95715, are typically for 24 hours. 24 hours or 1440 minutes divided by 12 patients is 120 minutes of monitoring time. The technologist performs clinical

activity, CA038 *Coordinate post-procedure services* to retrieve and manage the data. The PE Subcommittee reduced the times, 22 min for the 2-12 hour codes and 44 minutes for the 12-26 hour code respectively by 50% to 11 and 22 minutes, in order to account for partial automation of this task. The associated equipment time related to this clinical activity is ED050, *Technologist PACS workstation*. The equipment time remains 100%. Only one of the following pieces of equipment is used for each code for the entire monitoring time. For both non-video intermittent codes equipment item, EQ014, *EEG monitor, digital, portable*, is used. For the 2-12 hour video intermittent code where the patient stays in the office to be monitored equipment item, EQ017, *EEG, digital, prolonged testing system (computer w-remote camera)* is used. For the 12-26 hour video intermittent code where the patient takes the equipment home, new equipment item, *EEG, digital, prolonged testing system with remote video, for patient's home use* is used.

5. EQ015 EEG recorder, ambulatory
6. EQ014 EEG monitor, digital, portable
7. NEW EQUIP EEG, digital, prolonged testing system with remote video, for patient's home use
8. EQ017 EEG, digital, prolonged testing system (computer w-remote camera)

Continuous (Up to 4 patients monitored)

95707 Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance

95710 Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance

95713 Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance

95716 Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance

The PE Subcommittee discussed that there are two REEGT involved with the continuous monitoring codes. The first technologist performing clinical activity, CA021 *Perform procedure/service---NOT directly related to physician work time* is doing the monitoring (line 54 on the PE spreadsheet) and the second technologist performing clinical activity, CA021 *Perform procedure/service---NOT directly related to physician work time* is performing other activities such as review history, maintenance during patient session, patient/family education, internal communication and preparing the data (line 55 on the PE spreadsheet). The survey results indicated that the typical number of patients monitored is 3 patients. The PE Subcommittee discussed that the survey respondents underestimated or were unrepresentative of the typical testing site. The members thought that at most IDTF that specialize in long-term EEG monitoring the facility would certainly be monitoring the max number of 4 patients based on CPT coding. Four patients are the maximum allowed based on CPT coding before an intermittent code should be used. The specialty societies' expert panel determined that the number of hours monitored for the 2-12 hour codes 95707 and 95713, are typically for 8 hours. 8 hours or 480 minutes divided by 4 patients is 120 minutes of monitoring time. The 12-26 hour codes 95710 and 95716, are typically for 24 hours. 24 hours or 1440 minutes divided by 4 patients is 360 minutes of monitoring time. The technologist performs clinical activity, CA038 *Coordinate post-procedure services* to retrieve and manage the data. The PE Subcommittee reduced the times, 22 min for the 2-12 hour codes and 44 minutes for the 12-26 hour code respectively by 50% to 11 and 22 minutes, in order to account for partial automation of this task. The associated equipment time related to this clinical activity is ED050, *Technologist PACS workstation*. The equipment time remains 100%. Only one of the following pieces of equipment is used for each code for the entire monitoring time. For both non-video continuous codes equipment item, EQ014, *EEG monitor, digital, portable*, is used. For the 2-12 hour video continuous code where the patient stays in the office to be monitored equipment item, EQ017, *EEG, digital, prolonged testing system (computer w-remote camera)* is used. For the 12-26 hour video continuous code where the patient takes the equipment home,

new equipment item, *EEG, digital, prolonged testing system with remote video, for patient's home use* is used.

1. EQ015 EEG recorder, ambulatory
2. EQ014 EEG monitor, digital, portable
3. NEW EQUIP EEG, digital, prolonged testing system with remote video, for patient's home use
4. EQ017 EEG, digital, prolonged testing system (computer w-remote camera)

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.

New Technology/New Services

Codes 95700-95726 will be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Affirmation of RUC Recommendations

The RUC affirmed the recent RUC recommendations for CPT codes 95812 and 95813. The relativity within the family remains correct.

VIII. CMS Request/Relativity Assessment Identified Codes

Intravascular Ultrasound (Tab 14)

Matthew Sideman, MD (SVS); Francesco Aiello, MD (SVS); Michael Hall, MD (SIR); Curtis Anderson, MD (SIR); John Blebea, MD (ACPh); Richard Wright, MD (ACC); Edward Tuohy, MD (ACC); Marie-Frances Poulin, MD (SCAI); Clifford Kavinsky, MD (SCAI)

Each year AMA staff reviews the utilization assumptions for work neutrality when the Medicare Utilization data for that year/cycle is available. Any code family that has an increase in work RVUs over 10% of what was estimated is reviewed by the RAW to determine what is occurring to impact claims. Intravascular ultrasound, CPT codes 37252 and 37253 were reviewed at the January 2015 meeting and assumed to be a savings. The codes have had a 44% increase in work RVUs over the old codes from 2015 to 2016 and the utilization was double from that of the coding structure, not considering the radiological activities. In April 2018, the RUC had a robust discussion regarding these services, noting that physician work is identical regardless whether the procedure is performed for a diagnostic or therapeutic indication. The RUC indicated that this is a process issue. The utilization of the bundling of these services was underestimated. Therefore, the RUC recommended that these services be surveyed for October 2018, noting that there must be something driving the increased utilization. The RUC indicated that the specialty societies should research why there was such an increase in the utilization (possible compelling evidence).

Compelling Evidence

The specialty societies are recommending maintaining the current work RVUs for CPT codes 37252 and 37253. The specialties societies indicated that while there was a reduction in work RVUs with the original bundling in 2014, there was an overall increase in utilization offsetting the projected work savings. The increase in utilization came from the concurrent CMS decision to price these services in the non-facility setting and to expand coverage to venous disease. The RUC agreed that the site of service changes (migrating into the office setting) for these services and change in patient population (venous disease) constitute compelling evidence to allow for the observed growth. The RUC noted that these services are performed approximately 35,000 in the Medicare 2017 estimated utilization data. Likewise, the *Physician and Other Supplier Data for CY 2016* indicates that 11% of the utilization for CPT code 37252 are

performed by 10 specific individuals and 18% of the utilization of CPT code 37253 are performed by 10 specific individuals. The claims for these services in the office appear to be highly concentrated in relatively few offices. Due these reasons, the RUC determined there is compelling evidence explaining the growth of these services. The specialty presented new survey data that support the current valuation of these services. **The RUC recommends that if CMS is concerned about the unanticipated increase in utilization of these services, the Agency should explore the reporting of CPT codes 37252 and 37253 with specific practices.**

37252 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (List separately in addition to code for primary procedure) The RUC reviewed the survey results from 103 physicians and determined that the survey 25th percentile and current work RVU of 1.80 appropriately accounts for the work required to perform this service. The RUC confirmed that this service includes the work of both the IVUS intervention and radiological supervision and interpretation. The survey also supported the current physician time of 1 minute evaluation pre-service time, 20 minutes intra-service time and 1 minute immediate post-service time. The specialty reported that during the 1 minute of pre-service time, the physician assesses the approach to the procedure, ensures appropriate equipment is available and often discusses with the patient what will be happening during the procedure. The 1 minute of post-service time include the dictation and review of the final operative report and discussion of the results of the procedure with the patient and referring physician. The RUC compared the surveyed code to the key reference services indicated by the survey respondents. CPT code 92978 *Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)* (work RVU = 1.80 and intra-service time of 25 minutes) and 92979 *Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)* (work RVU = 1.44 and 25 minutes intra-service time). The RUC indicated that although CPT code 37252 has 3 minutes less total time compared to 92978, it is more intense service, warranting the same work value. **The RUC recommends a work RVU of 1.80 for CPT code 37252.**

37253 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure) The RUC reviewed the survey results from 73 physicians and determined that the survey 25th percentile and current work RVU of 1.44 appropriately accounts for the work required to perform this service. The RUC confirmed that this service includes the work of both the IVUS intervention and radiological supervision and interpretation. The survey also supported the current physician time of 20 minutes intra-service time and 1 minute immediate post-service time. The specialty society explained and the RUC agreed that the intra-service time for intravascular ultrasound of the initial noncoronary vessel, CPT code 37252, and each additional vessel, CPT code 37253 are the same because the catheter is already inserted and some of the work that is performed in CPT code 37252 is not replicated. Therefore, where some time is saved with the catheter already in place, is then replaced by the additional time for the work on the additional vessel.

The specialty reported that the 1 minute of post-service time include the dictation and review of the final operative report and discussion of the results of the procedure with the patient and referring physician. The RUC confirmed that the additional minute of post-service time is not duplicative as the previously obtained images are re-reviewed for accuracy and dictated into the final operative report. This post-service work is necessary for each additional vessel, just as it is for the initial vessel.

The RUC compared the surveyed code to the key reference services indicated by the survey respondents. CPT code 92978 *Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)* (work RVU = 1.80 and intra-service time of 25 minutes) and 92979 *Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)* (work RVU = 1.44 and 25 minutes intra-service time). The RUC noted that the intensity and complexity to perform these services are similar warranting a similar work RVU. **The RUC recommends a work RVU of 1.44 for CPT code 37253.**

Practice Expense

The Practice Expense Subcommittee modified the direct practice expense inputs and reduced the clinical staff time by 1 minute and confirmed that this service is performed in an angiography room. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

X-Ray Exam – Neck (PE Only) (Tab 15)

Megan Adamson, MD (AAFP); Melissa Chen (ASNR); Andrew Moriarity, MD (ACR); Gregory Nicola, MD (ASNR); Daniel Wessell, MD (ACR)

In April 2018, the Practice Expense (PE) Subcommittee noted that the Medicare non-facility reported together data show multiple codes are reported on the same day. The specialty societies did not think the codes reported together in the non-facility setting were clinically appropriate, and they requested additional time to review the non-facility data. Further, the PE Subcommittee and the specialty society agreed additional analysis of local and regional variations was necessary. The PE Subcommittee and the specialty societies also agreed to review the practice expense inputs again at the October 2018 PE Subcommittee meeting and remove any staff time, supplies, and equipment found to be duplicative.

At the October 2018 RUC meeting, the specialty society presented information that, because 70360 is a relatively low-volume code, particularly in the non-facility setting, miscoding by a small number of providers in one locality is having an outsized impact on the reported together data. The specialty reviewed information provided by AMA staff and confirmed that CPT code 70360 is being reported together with either 74240 *Radiologic examination, gastrointestinal tract, upper; with or without delayed images, without KUB*, 74230 *Swallowing function, with cineradiography/videoradiography*, or 72040 *Radiologic examination, spine, cervical; 2 or 3 views* inappropriately. Further, data from the *Physician/Other Supplier Data for CY 2016* indicate that the majority of the reported together claims are from the state of Texas and may indicate regional miscoding. The specialty society explained that, given the miscoding, it would be inappropriate to remove any clinical staff time and it is appropriate to affirm the direct practice expense reviewed and approved by the PE Subcommittee at the April 2018 RUC meeting. **The RUC reaffirms its recommendations from April 2018 and suggests that CMS address any potential miscoding via its Medicare contractor in Texas.**

CT – Orbit/Ear/Fossa (Tab 16)

Kurt Schoppe, MD (ACR); Daniel Wessell, MD (ACR); Lauren Golding, MD (ACR); Gregory Nicola, MD (ASNR); Melissa Chen, MD (ASNR)

In October 2017, the RAW requested that AMA staff compile a list of CMS/Other codes with Medicare utilization of 30,000 or more. CPT code 70480 was identified as part of this screen and the code family was expanded to include two other computed tomography codes pertaining to the orbit, fossa, sella,

and/or ear, CPT codes 70481 and 70482. In January 2018, the RUC recommended to survey these services for October 2018.

70480 Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material

The RUC reviewed the survey results from 42 radiologists and neuroradiologists and determined that the current work RVU of 1.28, which is also the survey 25th percentile, appropriately accounts for the physician work involved to perform this service. CPT code 70480 is used to investigate diverse causes for hearing loss and vertigo and in assessing for temporal bone fractures or facial nerve injury in the setting of trauma, assessment of the ossicular chain, epitympanum, oval window, round window, cochlea, vestibular aqueduct, and semicircular canals for causes of congenital and acquired hearing loss. The code includes axial, sagittal, and coronal reconstructed images with uniquely thin slices (less than 1 mm). In addition to these planes, oblique, coronal, and sagittal reconstructions are also created for the evaluation of the cochlea and semicircular canals to be carefully assessed. The RUC recommends 4 minutes pre-service time, 15 minutes intra-service time and 3 minutes immediate post-service time for CPT code 70480. Although the total time is decreasing by 3 minutes without a change in work RVUs, the source of the code is CMS/Other so the methodology that produced the original times was flawed.

Importantly, the RUC noted that this family of CT codes will not have the normal step-up in times and work RVU related to the use of contrast as is the case for most other radiology code families due to differences in anatomy and typical diagnosis for the three codes in this family. The without IV contrast code, code 70480, is fundamentally different work than the with IV contrast codes 70481 and 70482. This is supported by the claims where the most commonly reported diagnosis for CPT code 70480 is hearing loss, while the most commonly reported diagnosis for both CPT codes 70481 and 70482 is orbital disorders. The 70480 code involves the detailed assessment of thin sections, 0.625 mm slices, of the complex temporal bone anatomy including the external auditory canal, middle ear cavity, inner ear structures, cranial nerves, and vascular structures which are in close proximity to each other. The 70481 and 70482 codes involve the evaluation of the orbit, including the globe, extraocular muscles, lacrimal glands, optic nerve sheath/complex, adjacent skull base foramen, and adjacent spaces and sinuses. Since the work is completely different, this family of codes will not have the typical increase in times that is seen in other radiology code families. The without IV contrast code 70480 should be viewed as a uniquely separate procedure from codes 70481 and 70482.

The RUC compared CPT code 70480 to the top key reference service CPT code 70542 *Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)* (work RVU = 1.62 and 20 minutes intra-service time), which is an MRI of a similar region as the survey code (orbit, face, and/or neck) with contrast, and noted that the reference code has a higher intra-service time and work RVU, with a slightly lower IWPOT. This is supported by the intensity/complexity survey results in which respondents felt that CPT code 70480 was identical or more complex than CPT code 70542. Although magnetic resonance imaging is a technically challenging modality, specialized anatomic knowledge is needed to evaluate the compact and complex area in code 70480. The RUC also compared the survey code to the second key reference service CPT code 70490 *Computed tomography, soft tissue neck; without contrast material* (work RVU = 1.28 and 15 minutes intra-service time) and noted that the reference code has the same intra-service time, identical work RVU, and slightly lower IWPOT in comparison to the survey code. The intensity/complexity survey results support the IWPOT differential as most respondents felt that CPT code 70480 was slightly more intense and complex than CPT code 70490. Although the neck anatomy is complex, the lack of intravenous contrast in code 70490 limits the assessment of the region. In contrast, the middle and inner ear structures are bony structures that can be evaluated without IV contrast.

For additional support, the RUC referenced MPC code 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27 and 15 minutes intra-service time) and noted that the comparison code has identical intra-service time, nearly identical RVUs, and a lower IWPUT. CPT code 70480 is more intense with more complex anatomic structures to evaluate compared to code 70470, which accounts for the differences in IWPUT.

The RUC concluded that CPT code 70480 should maintain its current value as supported by the survey 25th percentile. Further, relativity is maintained across the family of RUC-reviewed CT and neuroimaging codes. **The RUC recommends a work RVU of 1.28 for CPT code 70480.**

70481 *Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)*

The RUC reviewed the survey results from 42 radiologists and neuroradiologists and determined that a work RVU of 1.13, below the survey 25th percentile, appropriately values this service. The RUC recommends a direct work RVU crosswalk to the second highest key reference service CPT code 70487 *Computed tomography, maxillofacial area; with contrast material(s)* (work RVU = 1.13 and 12 minutes intra-service time). CPT code 70481 has similarly intense physician work with clinical concern for orbital pathology compared to the crosswalk code which typically involves evaluation of a patient with facial cellulitis or dental infection. The RUC recommends the median survey times of 4 minutes pre-service time, 13 minutes intra-service time and 3 minutes immediate post-service time.

Unlike CPT code 70480, in which bony structures are primarily being evaluated without contrast, CPT code 70481 is typically ordered to evaluate the orbital structures. Contrast is needed to evaluate the soft tissues for abnormal nerve enhancement, muscle enhancement, rim-enhancing fluid collections, and enhancing lesions in the globe. For this service, axial, coronal, and sagittal reconstructed thin slices are evaluated to assess structures that may be a few millimeters in size. In addition, sagittal oblique images for each orbit are created to assess structures in the orientation of the orbit in the skull.

For additional support, the RUC referenced MPC code 70460 *Computed tomography, head or brain; with contrast material(s)* (work RVU = 1.13 and 12 minutes intra-service time) and noted that the comparison code has identical physician work and nearly identical intra-service time and IWPUT. The RUC concluded that CPT code 70481 should be valued below the survey 25th percentile work RVU as supported by a crosswalk to CPT code 70487. **The RUC recommends a work RVU of 1.13 for CPT code 70481.**

70482 *Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections*

The RUC reviewed the survey results from 42 radiologists and neuroradiologists and determined a work RVU of 1.27, below the survey 25th percentile appropriately values this service. The RUC recommends a direct work RVU crosswalk to the second highest key reference service CPT code 70488 *Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27 and 15 minutes intra-service time). The crosswalk code covers similar anatomic regions compared to CPT code 70482 and has identical physician work and intra-service time which is why it was selected as an appropriate crosswalk. The RUC recommends the median survey times of 4 minutes pre-service time, 15 minutes intra-service time and 4 minutes immediate post-service time.

Similar to CPT code 70481, CPT code 70482 typically involves the evaluation of axial, coronal, and sagittal reconstructed thin slices. In addition, sagittal oblique images for each orbit are created to allow for assessment of the optic nerve in continuity. Not only is it important to assess the orbital structures, but also the adjacent skull base foramen and spaces which may be a dangerous conduit to the intracranial compartment in a multitude of disease processes such as infection, trauma or tumor.

For additional support, the RUC referenced MPC code 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.40 and 18 minutes intra-service time) and noted that the survey code and the MPC code have similar intra-service times, but the survey code has a higher IWPUT. This higher IWPUT is expected given the dangers of missing pathology in and around the orbits given the close proximity to the brain. The RUC concluded that CPT code 70482 should be valued below the survey 25th percentile work RVU as supported by a crosswalk to CPT code 70488. Further, relativity within the contrast codes of this family is maintained, and across the family of RUC-reviewed CT codes. **The RUC recommends a work RVU of 1.27 for CPT code 70482.**

Practice Expense:

The RUC recommends the practice expenses 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 Exam – Clavicle/Shoulder (PE Only) (Tab 17)

William Creevy, MD (AAOS); Hussein Elkousy, MD (AAOS); Kurt Schoppe, MD (ACR)

At the April 2018 RUC meeting, the PE Subcommittee noted that the Medicare non-facility reported together data show that multiple codes are reported on the same day. The specialty societies did not think that the codes reported together in the non-facility setting were clinically appropriate and they requested additional time to review the non-facility data. Further, the PE Subcommittee and the specialty society agreed that further analysis of local and regional variations is necessary. The PE Subcommittee and the specialty societies agreed to review the practice expense inputs again at the October 2018 PE Subcommittee meeting and remove any staff time, supplies and equipment that is found to be duplicative.

At the October 2018 RUC meeting the specialty reviewed information provided by AMA staff confirming that CPT codes 73010 *Radiologic examination; scapula, complete* and 73050 *Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction* from the family of services reviewed at the April 2018 RUC meeting are reported together with code 73030 *Radiologic examination, shoulder; complete, minimum of 2 views* more than fifty percent. Starting with the spreadsheet that was reviewed and approved at the April 2018 meeting, the specialty society removed the duplicative time for clinical activities, CA013 *Prepare room, equipment and supplies* and CA024 *Clean room/equipment by clinical staff*. These reductions are in addition to changes that were made at the April 2018 RUC meeting to account for services with only one view. In April, the PE Subcommittee also ensured that the specialties recommendation did not include any duplicative PE inputs for codes 73010, 73020, 73030 and 73050 which are typically reported with and Evaluation and Management (E/M) service in the non-facility setting. CPT code 73000 is not typically reported with an evaluation and management service in the non-facility setting.

The PE Subcommittee reviewed and approved the direct practice expense inputs as submitted by the specialty society without modification.

Urography (Tab 18)

Michael Hall, MD (SIR); Curtis Anderson, MD (SIR); Kurt Schoppe, MD (ACR); Andrew Moriarity, MD (ACR); Daniel Wessell, MD (ACR); Thomas Turk, MD (AUA); Kyle Richards, MD (AUA); Andrew Peterson, MD (AUA)

In October 2012, CPT code 74425 was identified as part of the family to bundle the genitourinary catheter procedures, which were surveyed for the January and April 2015 RUC meetings. The specialty societies noted that this service is now bundled into the new codes established for CPT 2016. While this code was not deleted, it was unclear what the typical vignette would be for this procedure once the majority of its utilization has migrated to the new codes. The RUC agreed with the specialty societies that two years of Medicare claims data should be reviewed prior to re-survey. The RUC recommended a delay to the survey of CPT code 74425 until at least two years of Medicare claims data was available (October 2018).

Compelling Evidence

The RUC reviewed the information provided by the specialty societies' indicating the physician work for CPT code 74425 was incorrectly determined based on CMS/Other valuation and currently lacks a vignette and typical patient. The patient population has changed as a result of code bundling in 2016. Previously, this procedure would have been most frequently performed for a patient requiring antegrade nephrostogram from a nephrostomy tube or needle placed percutaneously into the kidney to evaluate hydronephrosis, stricture, or stone disease in a patient with conventional anatomy. Utilization for this procedure has decreased and the patient population has changed. As a result of bundling, the typical patient is now one with an ileal conduit through which nephrostomy tubes have been placed for a post-operative obstruction. The RUC agreed that there is compelling evidence that the current work RVU for code 74425 is not accurate.

74425 Urography, antegrade (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation

The RUC reviewed the survey results from 107 physicians and agreed on the following physician time components: 5 minutes of pre-service time, 14 minutes of intra-service time, and 5 minutes of immediate post-service time. The RUC thoroughly reviewed the recommended work RVU of 0.51 and agreed that this value correctly estimates the amount of physician work involved. To justify a work RVU of 0.51, the RUC compared the survey code to KRS codes 74400 *Urography (pyelography), intravenous, with or without KUB, with or without tomography* (work RVU=0.49, pre-service time of 5 minutes, intra-service time of 15 minutes, and post-service time of 5 minutes) and 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* (work RVU=0.67, pre-service time of 7 minutes, intra-service time of 15 minutes, and post-service time of 5 minutes) and noted that the reference codes appropriately bracket the survey code for the amount of physician work involved. The survey code in comparison to top key reference code 74400 involves higher intensity and complexity, warranting a recommended work RVU of 0.51. Additionally, the RUC also reviewed 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= 0.52, pre-service time of 2 minutes, intra-service time of 15 minutes, and post-service time of 7 minutes) and agreed that the relativity of both codes in terms of time and physician work further warrants a recommended work RVU of 0.51 for the survey code. **The RUC recommends a work RVU of 0.51 for CPT code 74425.**

Practice Expense

The Practice Expense Subcommittee made a one-minute change in equipment time to account for the highly technical equipment time formula for radiographic fluoroscopic room (EL014). The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Referral to CPT

Referred to CPT for editorial changes to the descriptor and vignette to clarify between pyelostogram, nephrostogram, and loopogram.

Abdominal Aortography (Tab 19)

Matthew Sideman, MD (SVS); Francesco Aiello, MD (SVS); Richard Wright, MD (ACC); Edward Tuohy, MD (ACC); Michael Hall, MD (SIR); Curtis Anderson, MD (SIR); Clifford Kavinsky, MD (SCAI)

In October 2017, the RAW requested that AMA staff compile a list of CMS/Other codes with Medicare utilization of 30,000 or more. In January 2018, the RUC recommended to survey these services for October 2018.

Compelling Evidence

The specialty society presented compelling evidence for CPT codes 75625 and 75630 based on a flawed methodology that incorrect assumptions were made in the previous valuations. For CPT code 75625, CMS assigned a value and time in 1992 based on an unknown methodology. In 1992, the typical patient for an aortogram was a patient suspected of having aortoiliac occlusive disease. Imaging focused mainly on simple analog diagnostic films. Today, the patient population has changed. CTA and MRA have largely replaced diagnostic imaging for the vast majority of patients. Invasive catheter based imaging is reserved for the most complex patients. Improvements in technology including the transition from analog to digital imaging allow for the safer acquisition of significantly more and higher quality images of the aorta and iliac vessels. In 1995, code 75630 was not surveyed for time or work, but instead a non-dominant specialty, interventional radiology, recommended a work RVU based on the addition of two codes believed to represent the work of code 75630. Additionally, physician work has increased due to changes in technique, knowledge/technology, and patient population, and the dominant specialty has changed. For CPT code 75630, the typical patient for an aortogram with bilateral lower extremity angiogram in 1995 was a patient suspected of having atherosclerotic disease. Imaging focused mainly on simple analog diagnostic films. Today, the patient population has changed. CTA and MRA have largely replaced diagnostic imaging for the vast majority of patients. Invasive catheter based imaging is reserved for the most complex patients. Improvements in technology including the transition from analog to digital imaging allow for significantly more and higher quality images of the aorta, iliac and lower extremity vessels. The RUC agreed with the societies' compelling evidence based primarily on flawed methodology of CMS/Other source and change in patient population.

75625 Aortography, abdominal, by serialography, radiological supervision and interpretation

The RUC reviewed the survey results from 54 physicians and agreed on the following physician time components: 15 minutes of pre-service time, 30 minutes of intra-service time, and 15 minutes of immediate post-service time. The RUC thoroughly reviewed the recommended survey 25th percentile work RVU of 1.75 and agreed that this value correctly estimates the amount of physician work involved. To justify a work RVU of 1.75, the RUC compared the survey code to code 95924 *Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt* (work RVU= 1.73, pre-service time of 15 minutes, intra-service time of 30 minutes, and post-service time of 15 minutes) and noted that the reference code appropriately supports the survey code for physician work involved. The survey code in comparison to reference code 95924 involves identical pre-, intra-, and post-service times, warranting a recommended work RVU of 1.75. **The RUC recommends a work RVU of 1.75 for CPT code 75625.**

75630 Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation

The RUC reviewed the survey results from 54 physicians and agreed on the following physician time components: 15 minutes of pre-service time, 35 minutes of intra-service time, and 15 minutes of immediate post-service time. The RUC thoroughly reviewed the recommended survey 25th percentile work RVU of 2.00 and agreed that this value correctly estimates the amount of physician work involved. To justify a work RVU of 2.00, the RUC compared the survey code to reference code 94002 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day* (work RVU= 1.99, pre-service time of 15 minutes, intra-service time of 30 minutes, and post-service time of 15 minutes) and noted that the reference code appropriately brackets the survey code for the amount of physician work involved. The survey code in comparison to the reference codes involves 5 additional minutes of intra-service time, warranting a recommended work RVU of 2.00. Additionally, the RUC also reviewed MPC code 36456 *Partial exchange transfusion, blood, plasma or crystalloid necessitating the skill of a physician or other qualified health care professional, newborn* (work RVU=2.00, pre-service time of 15 minutes, intra-service time of 30 minutes, and post-service time of 15 minutes) and agreed that the relativity of both codes in terms of time and physician work further supports the recommended work RVU of 2.00 for CPT code 75630. **The RUC recommends a work RVU of 2.00 for CPT code 75630.**

Practice Expense

The RUC reviewed and approved the direct practice expense inputs as approved by the Practice Expense (PE) Subcommittee.

Angiography (Tab 20)

Michael Hall, MD (SIR); Curtis Anderson, MD (SIR); Matthew Sideman, MD (SVS); Francesco Aiello, MD (SVS)

In October 2017, the RAW requested that AMA staff compile a list of CMS/Other codes with Medicare utilization of 30,000 or more. In January 2018, the RUC recommended to survey these services for October 2018.

Compelling Evidence

The specialty society presented compelling evidence for CPT codes 75726 and 75774 based on a flawed methodology and a change in patient population. Code 75726 has not been previously surveyed and is the result of CMS/ Other inputs. There is no existing vignette or description of work to assess the specific physician activities or patient population that support current valuation. The patient population has also changed. In decades past, this code would have been used for atherosclerotic disorders. In current use, code 75726 used to evaluate bleeding visceral disorders and gastrointestinal neoplasms. Trans-arterial interventional oncologic treatments were not widely in use at the time of previous valuation. Additionally, code 75774 has not previously been surveyed and is the result of CMS/ Other inputs. There is no existing vignette or description of work to assess the specific physician activities or patient population that support current valuation. The patient population has also changed. Corresponding physician knowledge regarding the conditions being evaluated has changed. In decades past, this code would have been used for atherosclerotic disorders. In current use, code 75774 is performed to evaluate bleeding visceral disorders and gastrointestinal neoplasms. Trans-arterial interventional oncologic treatments were not widely in use at the time of previous valuation. New microcatheter construction has allowed access to arteries that were previously inaccessible. The RUC agreed with the societies' compelling evidence based primarily on flawed methodology and a change in patient population.

75726 Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation

The RUC reviewed the survey results from 107 physicians and agreed on the following physician time components: 15 minutes of pre-service time, 45 minutes of intra-service time, and 15 minutes of immediate post-service time. The RUC thoroughly reviewed the recommended work and agreed that the survey 25th percentile correctly estimates the amount of physician work involved. To justify a work RVU of 2.05, the RUC compared the survey code to CPT code 70554 *Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration* (RVU= 2.11, pre-service time of 15 minutes, intra-service time of 35 minutes, and post-service time of 10 minutes) and noted that the survey code contains 10 minutes of additional intra-service time and 5 minutes of additional post-service time, justifying the higher work RVU for the survey code. The RUC also agreed that there is consistency within the family of codes and that the recommended work RVU for the survey code appropriately accounts for the amount of physician work that is involved, further warranting a recommended work RVU of 2.05 for the survey code. **The RUC recommends a work RVU of 2.05 for CPT code 75726.**

75774 Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 107 physicians and agreed on the following physician time components: 30 minutes of intra-service time. The RUC thoroughly reviewed the recommended work RVU of 1.01 and agreed that the survey 25th percentile value correctly estimates the amount of physician work involved. To justify a work RVU of 1.01, the RUC compared the survey code to code 99359 *Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)* (work RVU= 1.00, intra-service time of 30 minutes) and noted that the survey code and reference code have identical intra-service times and comparable work values, warranting a recommended work RVU of 1.01 for the survey code. **The RUC recommends a work RVU of 1.01 for CPT code 75774.**

Practice Expense

The RUC reviewed and approved the direct practice expense inputs as approved by the Practice Expense (PE) Subcommittee.

X-Ray Exam Specimen (Tab 21)

Kurt Schoppe, MD (ACR); Lauren Golding, MD (ACR)

At the April 2018 meeting, the RUC inquired whether this service is typically performed with a placement of localization device service (i.e., CPT codes 19281-19288) on the same patient, same date of service and by the same provider, noting that any overlapping work that is typically performed with another service should be removed from the survey code. The specialty expert panel asserted that the survey code was typically performed alone — the RUC wanted to confirm this by reviewing the Medicare claims data. There are different localization device CPT codes for each imaging modality. As reviewing the relationship between a single code and multiple codes is a relatively more complex and nuanced scenario, the specialty requested and the RUC agreed that more time was necessary to properly summarize and interpret the data. The RUC agreed that AMA staff will research the current reported together data for this code and will be brought back at the October 2018 RUC meeting.

Compelling Evidence

The specialty society presented compelling evidence for CPT code 76098 based on a flawed methodology with inadequate time assigned to the code under the CMS/Other value and a change in population due to the bundling with biopsy code 19081 in 2014. It is now typical for the survey code to be performed in patients undergoing lumpectomy, mastectomy, or surgical excision in the operating room. 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, comparisons with the key reference services, and to maintain relativity with other diagnostic imaging services. The RUC reaffirmed the societies' compelling evidence based on previously unknown and flawed methodology.

76098 Radiological examination, surgical specimen

The RUC reviewed the survey results from 49 physicians and agreed on the following physician time components: 3 minutes of pre-service time, 5 minutes of intra-service time, and 3 minutes of immediate post-service time. When this code was originally presented in April 2018, there were concerns regarding whether this service is typically performed with a needle localization procedure by the same radiologist on the same day. After review of reported together data, CPT code 76098 is typically performed 63% of the time with one type of needle localization on the same day (CPT codes 19281-19288). The RUC agreed to reduce 4 minutes from the original pre-service time of 7 minutes presented at the April 2018 RUC meeting, totaling to 3 minutes of pre-service time for an accurate representation of the work performed for code 76098 and to be consistent with the specialty's recommended crosswalk.

The RUC thoroughly reviewed the physician work required to perform CPT code 76098 and determined to crosswalk the physician work value to 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=0.31, pre-service time of 1 minute, intra-service time of 6 minutes, post-service time of 1 minute, and total time of 8 minutes). The RUC agreed with the recommended crosswalk code 72082 and work RVU of 0.31, which falls between the survey 25th percentile work RVU of 0.17 and the survey median work RVU of 0.40. Additionally, the RUC referenced the key MPC comparator codes 76857 *Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)* (work RVU= 0.50, pre-service time of 5 minutes, intra-service time of 7 minutes, and post-service time of 5 minutes) and 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, pre-service time of 3 minutes, intra-service time of 5 minutes, and post-service time of 2 minutes) and noted that both MPC codes bracket the recommended work RVU for the survey code. Code 76098 has 1 additional minute of post-service time than MPC code 93922 and a higher intensity, warranting the recommended work RVU of 0.31 for code 76098. **The RUC recommends a work RVU of 0.31 for CPT code 76098.**

Practice Expense

The RUC affirmed the direct practice expense inputs as submitted by the specialty society at the April 2018 RUC Meeting.

Remote Interrogation Device Evaluation(s) (PE Only) (Tab 22)

Ed Tuohy, MD (ACC); Richard Wright, MD (ACC); David Slotwiner, MD (HRS)

The RUC reviewed the Cardiac Electrophysiology Device Monitoring Services in January 2017. The specialty society submitted practice expense inputs for CPT code 93299 and the PE Subcommittee and RUC accepted the society recommendations. CMS proposed to implement the RUC recommendation for 2018 in the July 2017 Proposed Rule. CMS received comments from the RUC and national specialty societies supporting the CMS proposal. Another commenter supported national pricing and noted the

significant variation in contractor pricing and unfair variation in patient co-pays throughout the country. CMS received a comment from Medtronic that complained that implementation of resource-based relative values would lead to a significant reduction in payment in some geographic areas. The average allowed charge for CPT code 99299 was \$88 in 2017, while the resource-based practice expense would lead to a \$27 national payment rate. In the Final Rule, CMS chose to continue contractor pricing, noting the Medtronic rationale as the reason (resource based inputs lead to lower payment than contractor pricing). It is highly unusual for a code with significant volume (2017 = 468,596) to be contractor priced. AMA staff contacted CMS stating that if CMS believes that there are inaccuracies in the direct practice expense inputs submitted in February 2017, the RUC would be willing to re-examine this code in October 2018.

CMS initially proposed to accept the RUC's recommended practice expense inputs for CPT 93299, and to price the code nationally under the PFS. However, after receiving several comments expressing concern about the payment rate of approximately \$27 for this code. As stated in the Final Rule, the Agency was persuaded by these commenters that this payment rate might not sufficiently address the needs of local populations, supply costs, and practice patterns. At least one other commenter expressed support for national pricing of CPT code 93299, but urged additional research so that the code can be adequately valued. The practice expense inputs for CPT code 93299, as stated by the RUC, were based on a crosswalk from CPT 93296, but CMS questioned the appropriateness of this crosswalk, especially because 93299 is a service for up to 30 days and CPT code 93296 is for up to 90 days of remote monitoring.

The specialty societies requested and the RUC agreed to add family codes 93297 and 93298 to be reviewed for practice expense only. These codes are currently work only codes and 93299 is meant to serve as the catch-all for both types of 30-day remote monitoring services. The RUC is unclear why the code family was designed this way, it may have been a way to allow for the possibility that the technical work would be provided by vendors, but that is not how the service is being provided. In the decade since these codes were created, it has become clear that implantable cardiovascular monitor (ICM) and implantable loop recorder (ILR) services are very different services and the PE cannot be appropriately captured for both services in a single technical code. CPT code 93297 is related to the remote monitoring of physiological measures obtained from implantable pacemakers and defibrillators related to heart failure that come at an interval of every 30 days. CPT code 93298 refers to subcutaneous wireless remote monitors that provide data at more frequent interval, requiring more clinical staff work. The specialty society provided recommendations for direct PE inputs for both 93297 and 93298 that align with each of the services.

Compelling Evidence

PE inputs for 93297-93299 were last evaluated by the RUC in 2017 when work and PE for the large family of cardiac device monitoring services were all revalued. Updating the family of 21 codes with work, PE or both was a daunting task. At that time, the specialty societies identified code 93296 that also describes the technical component of remote monitoring services as a comparison code for PE and recommended it be used as a crosswalk. Stakeholder comments and CMS's decision to maintain contractor pricing for the service suggested that a value for 93299 based on 93296 was incorrect and based on incorrect assumptions. With the ability to focus on this single code rather than a large family, the specialty has been able to better quantify the clinical staff time necessary to perform the technical components of the services. The specialty explained and the PE Subcommittee agreed that compelling evidence had been met based on a flawed crosswalk and that additional data is available.

To better scrutinize the inputs that were a straight crosswalk when these codes were reviewed in January 2017 the specialty society engaged industry and obtained data from one manufacturer that sells the vast majority of ILR devices. It was important to engage industry for these services because there is no single product or electronic record that all practices use, however one consistent work item is that the

technologists at each practice log onto the industry server to do their clinical work. Each night the device equipment in the office communicates wirelessly with the patient's device and the data gets uploaded to the industry server. The staff are notified if there is an abnormality and staff would log onto the server to check the abnormality. The data collected on the server includes the number of device-generated event notifications per month, the number of patient-generated manual event transmissions per month, and the amount of time a technologist is logged into the system and engaging with the monitoring reports. That data indicates that over the course of a month, a technologist interacts with patient monitoring reports 1.63 times a month to process device-generated notifications for 17 minutes, 1.74 times a month to process patient-generated notifications for 19 minutes, and once a month to generate a monthly report for 14 minutes. That is 50 minutes per month for alerts and report work. Additionally, the clinical staff engages with the patient throughout the month to perform education about the device and re-education protocols after the initial enrollment (11 minutes), troubleshoot non-connective monitoring hardware (4 minutes), and request manual transmission(s) to incorporate additional device data into reports (11 minutes). That is 26 minutes per month for patient interaction. The table below outlines this time:

Activity	93298/93299	93297
Automated alert transmissions	17	
Technician requested transmissions	11	
Patient-initiated transmissions	19	11
Monthly report	14	14
Education/re-education	11	11
Troubleshooting	4	4
Sum	76	40

While acknowledging that extant data is often used to determine practice expense, some PE Subcommittee members expressed concern about data obtained from industry sources. There is concern that the goal of industry to sell the product does not align with the interests of the RUC process. RUC members wanted assurance that when industry data is used it is the full data set and not a favorable subset. The specialty society assured the Subcommittee and the RUC that the data obtained is unbiased and not used for sales purposes. The industry server collects data to assist in the monitoring process and is representative of many more patients in various regions of the country than an expert panel could be

The PE Subcommittee reviewed and approved the direct practice expense inputs as submitted by the specialty society without modification.

New Technology/New Services

CPT codes 93297-93299 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.

Referral to CPT

The specialty society intends to submit a coding proposal to the CPT Editorial Panel to delete CPT code 93299, as it will no longer be necessary to have a separate code for practice expense once CPT codes 93297 and 93298 are allocated direct practice expense inputs in 2020. **The RUC recommends that CPT code 93299 be referred to CPT for deletion.**

Open Wound Debridement (Tab 23)

Brooke A. Bisbee, DPM (APMA); Lloyd Smith, DPM (APMA); Charles Mabry, MD (ACS); Nader Massarweb, MD (ACS); Megan Adamson, MD (AAFP)

In October 2017, the RUC identified CPT code 97598 as originally surveyed by one specialty (podiatry and physical therapy) but now performed by a different specialty (general surgery, family medicine, internal medicine). In January 2018, the RUC recommended to survey CPT code 97598 and added CPT code 97597 as a family code.

Compelling Evidence

The specialty societies presented compelling evidence based on a flawed survey methodology and a change in both the provider and typical patient population. The first point of compelling evidence was a flawed survey method. When CPT code 97597 was surveyed in 2010, it was an XXX code and the Reference Service List (RSL) included both XXX and ZZZ codes, including physical therapy modality services not requiring constant patient contact and E/M and other services not familiar to physical therapists. It was not until after the survey that the HCPAC recommended and the CMS agreed to assign this service a 000-day global period. It is possible that survey respondents were not clear about the components of work in a 000-day global procedure code, because the XXX survey template did not capture the preservice evaluation, positioning, and scrub/dress/wait times and only asked for total pre-service time. For these reasons, the RUC agreed that the survey method was flawed.

The second point of compelling evidence was based on different patient population and different providers. For CPT 2011, codes 11040 and 11041 were deleted, and the descriptors for codes 97597 and 97598 were revised to add "open wound" and delete "without anesthesia." Prior to these code deletions and revisions, CPT codes 97597 and 97598 were *wound cleansing* codes performed by physical therapists. But once the code descriptors changed, patients who would have previously been reported with *excisional debridement* codes now became part of the code 97597 and 97598 population. Hence, the dramatic increase in utilization in 2011 for codes 97597 and 97598 (ie, shift of work from 11040 and 11041). In addition, since the procedure is now for an *open wound*, the descriptor changes resulted in a dramatic decrease in physical therapist utilization (from 40% to 2%). Therefore, the specialties believe, and RUC agrees, there was a change in the typical patient for CPT codes 97597 and 97598 to include patients that previously would have undergone excisional debridement of partial and full thickness skin (ie., former CPT codes 11040 and 11041).

Finally, utilization estimates and work neutrality calculations were flawed, because the values developed for the revised CPT codes 97597 and 97598 in 2010 were based on the surveying specialty estimates of utilization for deleted CPT codes 11040 and 11041 that would be reported with revised codes 97597 and 97598. However, the surveying specialties and the HCPAC did not anticipate the dramatic shift in reporting for the revised codes. Thus, the calculations that reduced the HCPAC-facilitated work RVUs were flawed, and these values were then further reduced by CMS. The RUC approved compelling evidence based on change in provider and patient population and flawed survey methodology.

97597 Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less

The RUC reviewed the survey results from 139 family physicians, general surgeons, and podiatrists and determined that the survey 25th percentile work RVU of 0.88 appropriately accounts for the physician work involved to perform this service. The specialties selected pre-service time package 5, *Procedure with minimal anesthesia care*, which is consistent with the patient and procedure and was deemed to be

typical. The RUC recommends the following physician time components: 9 minutes of pre-service time (7 minutes evaluation time, 1 minute positioning time, 1 minute scrub/dress/wait), 15 minutes of intra-service time, and 5 minutes of immediate post-service time. The RUC noted that the survey code is a 000-day global and not typically reported with an E/M on the same day.

To justify a work RVU of 0.88, the RUC compared the survey code to the following 000-day global codes: CPT code 11305 *Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less* (work RVU = 0.80 and 14 minutes intra-service time), CPT code 11301 *Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm* (work RVU = 0.90 and 15 minutes intra-service time), and CPT code 36470 *Injection of sclerosant; single incompetent vein (other than telangiectasia)* (work RVU = 0.75 and 15 minutes intra-service time). The RUC also noted that the IWPOT for the survey code (0.039) is similar to other debridement codes (eg, 11000, 11042). The RUC concluded that CPT code 97597 should be valued at the 25th percentile work RVU as supported by the survey, similar 000-day global codes, and similar debridement codes. **The RUC recommends a work RVU of 0.88 for CPT code 97597.**

97598 Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 58 family physicians and general surgeons and determined that the survey 25th percentile work RVU of 0.50 accurately reflects the physician work necessary for this service. CPT code 97598 is an add-on code used for patients requiring debridement of more than 20 sq cm; typically involving multiple wounds. The RUC recommends 20 minutes of intra-service time. This additional time represents the additional documentation, repositioning, re-draping, and anesthetic with larger and multiple wounds. The RUC agreed that, the total time for the additional 20 sq cm (20 minutes) will be greater than the intra-time for the typical patient with a single, initial 20 sq cm or less wound (15 minutes) that is reported with code 97597.

The RUC compared CPT code 97598 to the top key reference service CPT 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 the survey code has an identical value but an additional 5 minutes of intra-service time than the reference code. Conversely, the RUC compared CPT code 97598 to the second highest key reference service CPT code 11046 *Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 1.03 and 20 minutes intra-service time) and noted the survey code has identical intra-service time but a lower work value than the reference code. Most survey respondents found the intensity/complexity to be identical if not more complex than the top key reference service. Overall, the RUC determined that the recommendation of the survey 25th percentile was well supported by the key reference services.

The RUC also reviewed MPC code 15003 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)* (work RVU= 0.80 and 15 minutes intra-service time) and noted that the survey code was less intense and complex and therefore should be valued less. As further support, the RUC reviewed data for all ZZZ-day global codes with 15-20 minutes of intra-time that were recently reviewed by the RUC and finalized by CMS and noted these codes further supported the work RVU of 0.50 for 97598. The RUC concluded that CPT code

97598 should be valued at the 25th percentile work RVU as supported by the survey and other recently reviewed add-on codes. **The RUC recommends a work RVU of 0.50 for CPT code 97598.**

Practice Expense

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

Transitional Care Management Services (Tab 24)

Audrey Chun, MD (AGS); Amy Aronsky, DO (AOA); Megan Adamson, MD (AAFP); Mary Newman, MD (ACP); Kevin Kerber, MD (AAN)

In October 2017, the RUC reviewed codes that were flagged as new technology or services at the October 2012-April 2013 meetings, with three years of available Medicare claims data (2014, 2015 and preliminary 2016 data). The specialty societies requested and the RUC agreed that CPT codes 99495 and 99496 be resurveyed for physician work and practice expense.

Compelling Evidence

The specialty societies indicated there has been a change in physician work required to perform these services due to a diffusion of technology in which physicians now have the infrastructure and work flow established to provide these services. When the codes were initially surveyed, there was no standard infrastructure and work flow associated with transitional care management. There also has been a change in the patient population as this transitional care management intervention now starts within two days of the patients' hospital discharge and the time required to perform these services has increased.

Accordingly, the number of days in which the service is provided is between 28 and 30, as opposed to before the codes when initial contact typically did not take place until 5-7 days after discharge, therefore the service was provided over 23-25 days. The time required to perform these services has increased because the patients' clinical conditions are more serious at two days after discharge (e.g., the likelihood of readmission is greatest in the first few days after discharge). The RUC accepted the compelling evidence that these services include new technology, a change in patient population and a change in physician time.

99495 Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge

The RUC reviewed the survey results from 206 physicians and determined that the survey median of 2.36 work RVU accurately accounts for the work required to perform this service. The RUC recommends 47 minutes of physician time. The RUC noted that the physician time has increased 7 minutes, which is reflected by the increase in physician work required. This service starts when the patient is discharged. The physician reporting this service does not typically report the hospital discharge day management service. The qualified health care provider or clinical staff contacts the patient two days from discharge, meets with the patient face-to-face within fourteen days of discharge and the duration of this service is for 30 days.

The RUC compared the surveyed code to the top key reference service chosen by the survey respondents, code 99214 *Office or other outpatient visit for the evaluation and management of an established patient*, (work RVU = 1.50, 25 minutes intra-service time, and 40 minutes total time) and agreed that the physician work, time and all intensity and complexity measures are higher for code 99495 than code 99214. The RUC compared code 99495 to second key reference service 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 2.11 and 35 minutes intra-service time) and noted that the survey respondents indicated that CPT code 99495 is overall

somewhat more intense than code 99215. For additional support the RUC referenced MPC codes 99310 *Subsequent nursing facility care, per day, for the evaluation and management of a patient* (work RVU = 2.35 and 35 minutes intra-service time, 70 minutes total time) and 99204 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 2.43 and 30 minutes intra-service, 45 minutes total time). Because hospitalized patients typically have new problems and medications upon discharge, they are more like new patients than established patients. This is reflected by the need to review the lengthy discharge summary with multiple new conditions and data, making the work more comparable to the work entailed with seeing a new patient (code 99204), rather than an established patient (code 99214). **The RUC recommends a work RVU of 2.36 for CPT code 99495.**

99496 Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge

The RUC reviewed the survey results from 201 physicians and determined that the survey median of 3.10 work RVU accurately accounts for the work required to perform this service. The RUC recommends 60 minutes of physician time. The RUC noted that the physician time has increased 10 minutes, which is reflected by the slight increase in physician work required. This service starts when the patient is discharged; the physician reporting this service does not typically report the hospital discharge day management service. The qualified health care provider or clinical staff contacts the patient within two days of discharge, sees the patient face-to-face within seven days of discharge and the duration of this service is for 30 days.

The RUC compared the surveyed code to the top key reference service chosen by the survey respondents, 99215 *Office or other outpatient visit for the evaluation and management of an established patient*, (work RVU = 2.11 and 35 minutes intra-service time, 55 minutes total time) and agreed that the physician work, time and all intensity and complexity measures are higher for code 99496 than code 99215, justifying a higher valuation for the survey code. The RUC also compared the surveyed code to the second key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 3.17 and 45 minutes intra-service time, 67 minutes total time) and noted that the survey respondents indicated that CPT code 99496 is overall the same or somewhat more intense than code 99205, thus should be valued similarly. Reviewing the lengthy discharge summary, with multiple unexpected conditions and new data, is more comparable to the work entailed with seeing a new patient (CPT code 99205), rather than an established patient (CPT code 99215). For additional support the RUC referenced MPC code 99306 *Initial nursing facility care, per day, for the evaluation and management of a patient* (work RVU = 3.06 and 45 minutes intra-service time, 80 minutes total time) and code 90962 *End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month* (work RVU = 3.15 and 63 minutes intra/total time), which maintains the appropriate relativity among similar services. **The RUC recommends a work RVU of 3.10 for CPT code 99496.**

Based on the 2016 Medicare 5% file, 14% of TCM services were billed by the same NPI as the matching discharge.

Practice Expense

The Practice Expense Subcommittee reviewed the direct practice expense inputs, accepted compelling evidence and modified a clinical staff activity to a more appropriate line. The PE Subcommittee removed 15 minutes of clinical staff time from the equipment time because the time for staff to perform clinical activity, CA035 *Review home care instructions, coordinate visits/prescriptions* was inappropriately included in the equipment time formula. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

IX. Practice Expense Subcommittee (Tab 25)

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

- **Power Table Workgroup**

The PE Subcommittee convened a Workgroup to review the consistency or inconsistency regarding the type of table (power table (EF031) versus exam table (EF023)) allocated to the direct practice expense inputs for a service. The PE Subcommittee discussed the CMS repricing proposal from the CY 2019 proposed rule, which if implemented would result in narrowing the equipment cost between the two items, with EF031, power table being priced at \$5,438.12 and EF023, exam table being priced at \$4,737.73 after the four-year transition period. After several conference calls the Workgroup determined that they did not want to make any decisions based on the narrowing of the cost. The Workgroup discussed that the effect of the cost is relatively small and it is very difficult to assess which specialties have power tables exclusively and which do not. Most members of the Practice Expense Subcommittee Power Table Workgroup agreed that for most services, the allocation of the type of table should be based on the service under review. However, there was significant concern that this change would negatively impact specialties that only have power tables in the office setting and the Workgroup requested a full discussion of the issue at the PE Subcommittee meeting prior to making a recommendation to the RUC. The PE Subcommittee discussed the issue and voted with the Workgroup majority opinion. The Practice Expense Subcommittee recommends that for most services, the allocation of the type of table should be based on what is needed for the service under review.

- **Computed Radiography (CR) and Digital Radiography (DR) Imaging Services**

The Consolidated Appropriations Act of 2016 imposes a 20% reduction on payment for imaging services using analog radiography (film) beginning in 2017 and a 7% reduction on imaging services using computed radiography (CR) beginning in 2018 to provide an incentive for the adoption of digital radiography (DR) imaging. The PE Subcommittee expressed concern about the policy as most imaging services recommendations are based on the direct practice expense inputs for CR imaging, which remains the typical way to provide most imaging services. Given that the legislation has already passed, the PE Subcommittee is not able to influence this reduction in payment. After reading the informational staff note, the PE Subcommittee decided that no further action is necessary.

- **Invoice Process**

The CMS repricing proposal from the CY 2019 proposed rule, prompted a review of all the prior work discussions and considerations regarding invoices and equipment pricing. The PE Subcommittee recognizes that there are a variety of information sources available and has requested that CMS reprice the supplies and equipment on a more frequent basis. After reading the informational staff note, the PE Subcommittee decided that no further action is necessary.

- **Use of Vendor Data in PE Recommendations**

During the PE Subcommittee meeting the Subcommittee reviewed remote interrogation device evaluation services where the clinical staff times were developed using data from a large vendor owned database. The specialty society attested that they reviewed the data and found it to be sound as part of their preparation to present to the PE Subcommittee. Some PE Subcommittee members were concerned that there may not be enough clarity around the rules and policies regarding using data obtained from vendors. RUC staff clarified that there are extensive policies already in place and

that the PE Subcommittee and the RUC rely on the specialty societies to attest to any data, including data obtained from industry, that they use in developing their recommendation. The PE Subcommittee acknowledged that the specialty society is responsible for any data that they may obtain, however, the Subcommittee would like clearly defined requirements for data obtained from industry that the specialty societies would need to ensure the data meets prior to using it in their practice expense recommendations. The PE Subcommittee recommended referral to the Administrative Subcommittee to consider developing requirements around vendor data used for PE recommendations.

The RUC approved the Practice Expense Subcommittee Report.

X. Research Subcommittee (Tab 26)

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

- **The Subcommittee reviewed and accepted the June 2018 Research Subcommittee report**

The Research Subcommittee report from the June 6 conference call and separate electronic review included in Tab 26 of the October 2018 agenda materials was approved without modification.

- **RUC Service Performance Rate Question**

At the January 2018 RUC meeting, a RUC member proposed updating the survey instrument to inquire for low volume services whether survey respondents have performed the survey code in the past few years instead of only the past 12 months. They noted that knowing this additional information may be beneficial when a survey code has a median performance rate of zero for the past 12 months. This item was referred to the Research Subcommittee for consideration. At the April 2018 meeting, the Research Subcommittee agreed to continue discussing this topic at the fall meeting and requested for AMA staff and the Chair to provide alternate language for consideration. Two options were provided and each version would only display for survey respondents that answer zero for a survey code for question 5.

The Subcommittee discussed the merits of both options and decided that determining if providers had ever performed or if they had performed more than 5 years ago was not helpful. Also, the Subcommittee reiterated that just because a survey respondent has not performed the service before or recently does not mean that their survey responses should be dismissed. AMA staff noted that the instructions in the RUC survey state “IMPORTANT: Please only respond to questions for survey codes that you either have experience performing or are familiar with.”

The Research Subcommittee approved the following standard survey language changes for all RUC survey instruments:

[This page would only display for respondents that put zero for 12 month question for survey code:]
How many times have you personally performed the following service(s) in the past 5 years?
Survey Code _____

The RUC approved the Research Subcommittee Report.

XI. Relativity Assessment Workgroup (Tab 27)

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

- **NPRM for 2019 Nominations for Potentially Misvalued Services**

CMS received two public nominations for nine codes. The first nomination included seven codes (27130, 27447, 43239, 45385, 70450, 93000 and 93306) in which the nominator stated that they are overvalued and that previous RUC reviews of these services did not result in reductions in valuation that adequately reflected reductions in surveyed times. CMS staff indicated that this nomination was not received during the *Proposed Rule* comment period and therefore is not publicly available in the **Federal Docket Management System**. The nomination was sent directly to CMS by the February 10th deadline.

In the RUC comment letter on the NPRM for 2019, the RUC requested that CMS publicly provide the source of comment and entire comment letter submitted to provide transparency and aide the RUC's discussion of these services. The RUC requested that CMS provide greater transparency and publicly provide all public nomination requests identifying potentially misvalued services.

The Workgroup noted that this is a process issue and without more information on how these services were identified and rationale to review these services, the Workgroup will wait until the Final Rule for more information to determine whether review these services.

The *Society for Cardiovascular Angiography and Interventions (SCAI)* submitted the second nomination for two services, CPT code 92992 *Atrial septectomy or septostomy; transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization)* and 92993 *Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization)*. These services are typically performed on children, a non-Medicare population, and are contractor-priced. The specialty society requests that these services be surveyed through the RUC process. **The Workgroup agreed with the specialty recommend survey for January 2019.**

- **PE Screen – High Cost Supplies**

At the January 2018 RUC meeting, the Practice Expense (PE) Subcommittee discussed potential screens that would identify misvalued services and recommended a high cost supply items screen to the Relativity Assessment Workgroup (RAW). There are 58 supply items with a purchase price greater than \$500. The PE Subcommittee recommended that the RAW identify services that include supply items greater than \$500 and based upon utilization, dominant specialty and date of last review, determine if there is reason for RUC review.

The only family identified with non-facility Medicare utilization over 10,000 that has not been recently reviewed (in the last five years), with high cost supply items are CPT codes 37225, 37227 and 37229.

CPT code 37227 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed* has three high cost supply items:

- SD253 atherectomy device (Spectronetics laser or Fox Hollow) (\$4,979.67)
- SD254 covered stent (VIABAHN, Gore) (\$3,768)
- SD256 Embolic Protection Device Spider FX (EV3, documentation available) (\$1,365)

CPT code 37225 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed* and 37229 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed* each contain two high cost supply items:

- SD253 atherectomy device (Spectronetics laser or Fox Hollow) (\$4,979.67)
- SD256 Embolic Protection Device Spider FX (EV3, documentation available) (\$1,365)

Inclusion of a high cost supply does not necessarily indicate that a service is potentially misvalued. Although the RUC has requested, CMS has not indicated that they will re-price high cost supply items every year.

The Workgroup reviewed the high-priced supply items CPT codes 37225, 37227 and 37229 and recommends an action plan be submitted for January 2019 on how to address these services.

- **Review Modifier -51 Exempt List (Appendix E)**

In January 2018, a Workgroup member suggested to review codes on the Modifier -51 *Multiple Procedures* exempt list to make sure there is no duplication on pre- and post- work related to the services it is typically reported. AMA Staff examined list of 25 codes from the CPT Modifier-51 Exempt list and identified seven (7) services with 2017 estimated Medicare utilization over 10,000 (CPT codes 17004, 31500, 36620, 93451, 93456, 93503 and 95992).

In April 2018, the Workgroup examined the data provided on the percentage reported alone, physician pre- and intra time and determined that this is an appropriate screen. The Workgroup requested action plans for the October 2018 RAW meeting and for specialty societies to indicate whether these services should stay on the Modifier -51 exempt list.

The Workgroup reviewed the action plans and agrees with the specialty societies that CPT codes 17004, 93451, 93456 and 95992 be removed from the Modifier -51 exempt list. Noting the three latter codes were placed on the list in error. The Workgroup agreed that CPT code 31500, 36620 and 93503 are separate and distinct procedures and should remain on the list. The Workgroup noted that the CPT Editorial Panel may be reviewing Appendix E at the February 2019 meeting. The specialty societies may need to provide CPT with clarification regarding when CPT code 93503 is provided by Anesthesiology as the dominant provider and reported with anesthesia services (ie, 00567 35 % of the time and 00562 33% of the time) can this still be reported with modifier -51?

- **Contractor Priced with High Volume**

In January 2018, a RUC member suggested to review high volume contractor priced codes. AMA Staff identified five (5) contractor-priced Category I CPT codes that have 2017 estimated Medicare utilization over 10,000 (CPT codes 77522, 77523, 90868, 93299 and 95943). In April 2018, the Workgroup determined that there are various reasons in which these codes have been recommended to be contractor priced and the specialty societies should submit action plans for the October 2018 meeting indicating whether these services should be reviewed for physician work/practice expense by the RUC.

In October 2018, the Workgroup reviewed the action plans and recommends the following:

CPT Code	Issue	Recommendation
77522 77523 77525 (f)	Proton Beam Treatment Delivery	The Workgroup determined that these TC only codes are still evolving and are not diffused enough to determine the typical practice expense resources. The Workgroup recommended to review again in 3 years, however when the full RUC discussed they determined that these services should be surveyed for practice expense.
95943	Heart Rate Test	The Workgroup determined that this service is performed by many specialties and the utilization is high enough to survey. Survey for January 2019.

90868 90867 (f) 90869 (f)	Transcranial Magnetic Stimulation	These services are also identified on the new technology list for review. The Workgroup agreed with the specialty that technology for these services is still evolving. Two FDA modifications were recently approved and the new coil will significantly reduce the time required to perform these services. Review again in 2 years (Oct 2020).
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Doctor Collins indicated that for the proton beam treatment delivery codes (77522, 77523 and 77525), during discussion the specialty societies indicated that the indications for usage are expanding drastically. There are new prostate indications that have come on-line just this year, to survey now it may require another survey in 2-3 years. Therefore, the Workgroup agreed that a survey in three years would yield a valid survey. RUC members noted that these services are expanding, starting in 2007 with Medicare claims of and rising sharply since 2011. The RUC also stated that having a value for these services for a couple years and re-valuing later if necessary is better than not having any value currently. Another RUC member indicated that proton beam therapy is primarily used to treat prostate cancer, but it is expanding to treat other illnesses to spare neuro injury to other parts of the body. **The RUC determined that the proton beam treatment delivery codes (77522, 77523 and 77525) should be surveyed for practice expense.**

- **New Technology/New Services – Review Action Plans**

In September 2005, the RUC began a process of flagging services that represent new technology as the codes were presented to the Committee. The RAW will review codes that were flagged October 2013-April 2014 with three years of available Medicare claims data (2015, 2016 and preliminary 2017 data).

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

The Workgroup indicated that specialty societies should expect that the Workgroup will typically extend the review of services to beyond the first 3 years of utilization data and should consider that when developing action plans for services on the new technology/new services list.

The Workgroup reviewed the action plans and recommends the following:

CPT Code	Issue	Recommendation
20983	Cryoablation Treatment of the Bone Tumors	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
21811 21812 21813	Internal Fixation of Rib Fracture	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.

CPT Code	Issue	Recommendation
22858	Total Disc Arthroplasty Additional Cervical Level Add-On Code	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
29584	Multi-Layer Compression System-HCPAC	The utilization is low but still growing. Review in 3 years (Oct 2021).
33270 33271 33272 33273 93260 93261 93644	Subcutaneous Implantable Defibrillator Procedures	The utilization is low but still growing. Review in 3 years (Oct 2021).
33418 33419	Transcatheter Mitral Valve Repair	The utilization is low but still growing. Review in 3 years (Oct 2021).
33946 - 33989	ECMO-ECLS	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
36475 36476 36478 36479	Endovenous Ablation	Review in 3 years (Oct 2021).
37218	Transcatheter Placement of Carotid Stents	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
43180	Endoscopic Hypopharyngeal Diverticulotomy	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
44705 G0445	Fecal Bacteriotherapy	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
46601 46607	High Resolution Anoscopy	Review in 3 years (Oct 2021) to determine who is performing these services.
47383	Cryoablation of Liver Tumor	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
52441 52442	Cystourethroscopy Insertion Transprostatic Implant	The Workgroup is concerned because the utilization is significantly increasing and questioned the time required to perform these services. Survey for January 2019.
77061 77062 77063	Breast Tomosynthesis	The Workgroup recommends that CMS delete G0279 and use codes 77061, 77062, and 77063 as created by CPT and valued by the RUC. Review again in 3 years (Oct 2021).

CPT Code	Issue	Recommendation
90867 90868 90869	Transcranial Magnetic Stimulation	These services are also identified on the contractor-priced with high volume screen for review. The Workgroup agreed with the specialty that technology for these services is still evolving. Two FDA modifications were recently approved and the new coil will significantly reduce the time required to perform these services. Review again in 2 years (Oct 2020).
92145	Corneal Hysteresis Determination	The utilization has continued to increase. Survey for January 2019.
97605 97606 97607 97608	Negative Pressure Wound Therapy	Review again in 3 years (Oct 2021).
97610	HCPAC - Ultrasonic Wound Assessment	Survey for January 2019.

• **Re-review of Flagged Services – Review Action Plans**

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

The Workgroup recommends the following:

CPT Code	Issue	Recommendation
75710	Angiography of Extremities	Review again in 2 years (October 2020).
75894	Transcatheter Procedure	Utilization decreased appropriately after code bundling solutions. However, this service is currently CMS/Other source and has never been RUC surveyed. The Workgroup requests an action plan for January 2019 to determine whether to survey what remains in this service currently or delete this service.
75898	Follow-up Angiography	Utilization decreased appropriately after code bundling solutions. However, this service is currently CMS/Other source and has never been RUC surveyed. The Workgroup requests an action plan for January 2019 to determine whether to survey what remains in this service currently or delete this service.
75984	Introduction of Catheter or Stent	Utilization decreased appropriately after code bundling solutions. However, this service is currently CMS/Other source and has never been RUC surveyed. The Workgroup requests an action plan for January 2019 to determine whether to survey what remains in this service currently or delete this service.
78070 78071 78072 78803	Parathyroid Imaging	Utilization may be appropriate however, CPT code 78803 is Harvard valued. The Workgroup requests an action plan if this service should be surveyed.

- **Re-iteration of Existing Screens – Review Data**

A. *Site of Service Anomalies*

Outpatient Setting but Includes Hospital Visits

AMA Staff reviewed services with anomalous sites of service when compared to Medicare utilization data. One service was identified, CPT code 63030 *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar*, in which the Medicare data from 2014-2017e indicated that it was performed less than 50% of the time in the inpatient setting, yet include inpatient hospital Evaluation and Management services within the global period. **The Workgroup requests an action plan for January 2019.**

Inpatient Hospital Setting but includes half discharge day management (99238)

Additionally, a RUC member requested a site-of-service anomaly screen based on the review of three years of data (2015, 2016 and 2017e) for services with utilization over 10,000 in which a service is typically performed in the inpatient hospital setting, yet only a half discharge day management (99238) is included. One service was identified 28820 *Amputation, toe; metatarsophalangeal joint*. When this service was reviewed in October 2010 the RUC made a recommendation as an inpatient service with 1- 99231 hospital visit and 1-99238. The data at that time indicated that this service was performed in the inpatient setting 48% of the time. CMS rejected the RUC recommendation of 7.00 work RVUs, instead finalized a 5.82 work RVU, removed the 99231 hospital visit and reduced the discharge day to half. The data now indicates that this service is performed 55% in the hospital setting. **The Workgroup requests an action plan for January 2019.**

B. *CMS Other Source Codes*

AMA staff identified the CMS/Other Source codes with 2017e Medicare utilization over 30,000. Seven (7) services were identified (74300, 74328, 93623, G0270*, G0297, G0452 and Q0091). **The Workgroup requests action plans January 2019.** *G0270 is on the CMS/Other source codes and the High Volume Growth screens.

C. *Harvard Valued*

AMA staff identified the Harvard Valued services with 2017e Medicare utilization over 30,000. One service was identified, CPT code 29823 *Arthroscopy, shoulder, surgical; debridement, extensive*. **The Workgroup requests an action plan January 2019.**

D. *High Volume Growth*

AMA staff identified services that with 2017e Medicare utilization of 10,000 or more that has increased by at least 100% from 2012 through 2017. Twelve (12) codes were identified (00534, 00560, 37229, 64566, 70496, 70498, 77401, 93662, 93750, 95012, G0270, G0399). **The Workgroup request an action plan January 2019.** *G0270 is on the CMS/Other source codes and the High Volume Growth screens.

E. *Surveyed by one specialty and now performed by a different specialty*

AMA staff reviewed the 2017e Medicare utilization over 10,000 where a service was performed by one specialty but is now performed by a different specialty. **No new codes were identified via this screen.**

- F. 000-Day Global reported with an E/M 75% or More (Research Subcommittee Request)**
AMA staff reviewed 000-day global period services, reported with E/M 75% or more, not reviewed in the last 5 years with more than 10,000 in 2017e Medicare utilization. **No new services were identified as all codes were previously addressed by CMS' similar screen in 2017 (000-day global period 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).**

- G. CPT Assistant Article Analysis**
AMA staff identified RUC referrals for CPT Assistant articles from 2013-2016. Seventeen (17) codes were identified (33620, 33621, 33622, 51784, 51792, 52234, 52240, 64555, 70371, 76513, 92287, 94060, 94400, 94640, 94668, 94770 and 95970). **The Workgroup requested action plans for January 2019. The Workgroup specifically requests that the specialty societies address the following in their action plans:**

2. Explain the issue and background of the code and why a CPT Assistant article was created.
3. What was the expected result?
4. Did the article address the issues identified with this service?
5. Is a re-review in a couple years or further action necessary?

- H. Multiple Units**
When reviewing the action plan for the health and behavior intervention CPT code 96154 *Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)*, the Workgroup indicated that there may be other timed codes reported in multiple units that may have excessive post time. When querying services with "minutes" identified in the descriptor, 2017e Medicare utilization over 10,000 and 1.5 more mean units reported, only the four health and behavior codes were identified (96150, 96152, 96153 and 96154). **Based on the identification of these codes at the last Workgroup meeting, the RUC recommended this family of services was referred to the September 2018 CPT meeting for revision.** Therefore, this will not go forward as a specific screen as no additional codes were identified.

- I. Work Neutrality CPT 2017**
All code families from the CPT 2017 cycle did not exceed the 10% threshold for work neutrality.

- **Other Business**

The Workgroup discussed future screens and recommends lowering the threshold and examining the list of CMS/Other source codes with Medicare utilization over 20,000 at the January 2019 meeting.

- **Informational Items**

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

The RUC approved the Relativity Assessment Workgroup Report.

XII. Anesthesia Workgroup (Tab 28)

Doctor Peter Hollman provided the Anesthesia Workgroup report:

- **Final Methodology**

The purpose of the Anesthesia Workgroup has been to create a rank order among services that will be used for the anesthesia reference service list in the future. The final methodology does not refer to base units, but proxy values to assess relativity. The methodology involves five steps using surveys for time and fixed intensity, as well as using time packages using straightforward and complex patients and straightforward and complex anesthesia.

The Workgroup reviewed the methodology and recommends the following:

Step 1: Pre-Service Evaluation

The Workgroup noted that the previous recommendation of selecting a proxy new/established Evaluation and Management (E/M) service may have incorrectly compared time and intensity for this step. Also, using the fixed intensity avoids the potential confounder that would occur were there changes in the E/M services as proposed for 2019. The Workgroup noted that the fixed intensity multiplied by time as determined by survey and verified by an expert panel would be consistent with other RUC methods for determining work values in the RBRVS. **The Workgroup recommends ASA survey the proposed reference service codes for pre-service evaluation time and multiply by the intensity of 0.0224 to compute the proxy value of this phase of anesthesia services.**

Step 2: Equipment, Drug and Supply Preparation (EDSP)

The Workgroup recommended that ASA develop time packages to apply to EDSP work. The Workgroup noted that these packages will eventually be part of the anesthesia base code survey process and be used in conjunction with the ASA expert panel to refine the survey results, just as the RUC analyzes survey pre-time with the pre-time packages with the review of services in the RBRVS. The Workgroup reviewed ASA's drafted time packages provided. The Workgroup agreed with the four levels of anesthesia complexity/patient complexity similar to other RUC pre-time packages. **The Workgroup recommends that ASA survey the reference service codes for EDSP time, review the surveyed time and adjust to reflect the time packages, and multiply by 0.0081 to determine the proxy value of this phase of the anesthesia services. The Workgroup further recommends, as in the standard RUC process, Anesthesia will not increase time beyond the survey total for any segment of this process.**

Step 3: Induction Period Procedure

The Workgroup reviewed ASA's drafted time packages for the induction period and agreed with the four levels of anesthesia/patient complexity and the detailed description of the work of the anesthesiologist for each level and for the induction period time to drill down to the individual task level. The Workgroup determined that two levels of intensity should be used. The Workgroup determined that the intensity of code 31575 *Laryngoscopy, flexible; diagnostic* (IWPUT = 0.1172) should be used for the complex patient packages and the intensity of code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (IWPUT = 0.0636) should be used for the straightforward patient packages. **The Workgroup recommends that ASA survey the proposed reference service codes for induction period time, review the surveyed time and adjust to reflect the time packages, and multiply the time by the appropriate level of intensity (straightforward patient, 0.0636 or complex patient, 0.1172).**

Step 4: Post- Induction Period Procedure Anesthesia (PIPPA)

The Workgroup discussed the PIPPA level descriptions. ASA noted that for time units beyond base units the anesthesiologist is paid the same amount per unit of time no matter what the complexity of the surgical service in which the anesthesia is being administered. ASA indicated that the PIPPA helps to understand the complexity of each case. The Workgroup noted that taking the total post-induction time, divided into each quintile and then multiplied by the PIPPA quintile intensities will produce distortions in relativity for very short or very long services. The Workgroup and ASA agreed that PIPPA should be a factor, but did not reach a conclusion on how it would be applied (e.g., to create value units using time, to use to move up or down an intensity scale based on expert panel or to be a set percent of the factor in creating value units). **Therefore, the Workgroup recommends surveying the proposed reference codes for post-induction anesthesia time first and then determine a way to incorporate a proxy value for the PIPPA phase after review of the survey data.**

Step 5: Post Anesthesia Evaluation

The Workgroup noted that the previous recommendation of selecting a proxy new/established Evaluation and Management (E/M) service may have incorrectly compared time and intensity for this step. Also, using the fixed intensity avoids the potential confounder that would occur were there changes in the E/M services as proposed for 2019. The Workgroup noted that the fixed intensity multiplied by time as determined by survey and verified by an expert panel would be consistent with other RUC methods for determining work values in the RBRVS. **The Workgroup recommends ASA survey the proposed reference service codes for post-anesthesia evaluation time and multiply by the intensity of 0.0224 to compute the proxy value of this phase of anesthesia services.**

The values from the five phases of anesthesia care will then be summed to create a proxy value for each of the proposed reference service codes. These proxy values will be used to establish relativity among the codes to set the stage for future valuation using anesthesia units.

This new methodology is independent and any circular logic that was in the previous methodology is excluded.

- **Anesthesia Reference Service List**

At the June 2018 Anesthesia Workgroup meeting, the Workgroup requested that the specialty society propose other highly utilized anesthesia codes that span the breath of the base units (3-30) in anticipation of using this methodology to develop an anesthesia reference service list.

The eight reference codes previously identified by this Workgroup are from the top 32 anesthesia codes that represent 75% of Anesthesia Medicare allowed charges, each code with \$20 million or more in Medicare allowed charges, that have a single top surgical code that is reported at least 50% of the time. These were codes 00142, 00350, 00567, 00731, 01214, 01402, 01630, and 01638. ASA presented six additional reference codes that span from 3-30 base units (Codes 00560, 00562, 00566, 00670, 00796 and 01810). The Workgroup agreed these additional codes demonstrated an appropriate range and granularity of anesthesia services. In October 2018, the Workgroup determined two additional anesthesia codes should be added to the reference code list for a total of 16 services (Codes 00790 and 00812).

The proposed methodology is to use the five-step method to compute proxy relative values for the 16 codes on the proposed RSL. The lowest valued proxy code will be arrayed to the lowest base units (3) and the highest valued proxy code to the highest base unit value (30). Linear regression will be used to confirm that the current anesthesia base units are in the correct rank order compared to the proxy values.

The Workgroup recommends using the 16 codes identified, and proposes to use the five-step methodology to develop an anesthesia reference service list.

- **Survey of Reference Services**

The Workgroup reviewed the current RUC Anesthesia survey for base units as a starting point to develop the proposed reference services list survey. **The Workgroup recommends maintaining the current typical patient intro question, Question 2 on anesthesia time and Question 5 on PIPPA intensity. See draft survey attached to this report.**

- **Next Steps**

- November 2018 – the Anesthesia Workgroup will have a conference call to finalize the survey instrument (review survey in Qualtrics), vignettes, educational materials, time packages document and format of the presentation of survey results.
- January 2019 – the Research Subcommittee will review all materials
- April 2019 – the Anesthesia Workgroup review the survey data of the 16 proposed anesthesia reference services to independently establish the relativity of the current anesthesia base codes The Workgroup will verify or identify any need for change across the relativity of these 16 services. **The Workgroup will determine how PIPPA will be used in establishing relativity and asks ASA to propose a methodology upon review of the survey results.**

The RUC approved the Anesthesia Workgroup Report.

XIII. Multi-Specialty Points of Comparison (MPC) Workgroup (Tab 29)

The MPC Workgroup's agenda was deferred to the January 2019 meeting.

XIV. RUC HCPAC Review Board (Tab 30)

Doctor Dee Adams Nikjeh, Co-Chair, provided a summary of the report of the Health Care Professionals Advisory Committee Review (HCPAC) Review Board:

- **HCPAC Multi Points of Comparison (MPC) List Review**

Although the HCPAC can use the RUC MPC list, the HCPAC also has its own MPC list. HCPAC members reviewed the list and HCPAC specialty societies nominated codes for deletion and addition. The HCPAC discussed the nominations and the full list of final additions and deletions can be found in the HCPAC Review Board report.

- **Relative Value Recommendations for CPT 2020**

Auditory Function Evaluation (Tab 30)

Paul Pessis, AuD (AAA); Leisha Eiten, AuD, CCC-A (ASHA)

In October 2016, the Relativity Assessment Workgroup (RAW) identified CPT code 92626 through the High-Volume Growth screen and in October 2017 through the CMS Request - Audiology Services screen. CPT code 92627 was included in the CMS Request - Audiology Services screen as the add-on code for this service.

92626 Evaluation of auditory function for surgically implanted device(s) candidacy or post-operative status of a surgically implanted device(s); first hour

The HCPAC reviewed the survey results from 71 audiologists for CPT code 92626 and determined that the proposed work RVU of 1.40, which is the current work RVU and below the survey median, appropriately accounts for the work required to perform this service. The HCPAC recommends 7 minutes of pre-service time, 60 minutes intra-service time and 10 minutes post-service time.

The typical patient for this service is being tested to see if they are a candidate for implant surgery and the code can also be used after the device is implanted to test for efficacy. The specialty recommended and the HCPAC agreed that although the age of the patient population has changed from typically a child to typically an adult, the work associated with the service has not changed and maintaining the current time and work RVU is appropriate. The HCPAC compared the survey code to CPT code 92606 *Therapeutic service(s) for the use of non-speech-generating device, including programming and modification* (work RVU = 1.40, 7 minutes pre-service, 60 minutes intra-service and 10 minutes post-service time). Both codes are performed on patients with communication impairment. The times for both codes are identical and the work RVUs should be identical. The HCPAC also compared the service to the survey top key reference service 92620 *Evaluation of central auditory function, with report; initial 60 minutes* (work RVU = 1.50 and 60 minutes intra-service time) and agreed that the work involved is similar and the codes should be valued similarly. **The HCPAC recommends a work RVU of 1.40 for CPT code 92626.**

92627 Evaluation of auditory function for surgically implanted device(s) candidacy or post-operative status of a surgically implanted device(s); each additional 15 minutes (List separately in addition to code for primary procedure)

The HCPAC reviewed the survey results from 63 audiologists for CPT code 92627 and determined that the proposed work RVU of 0.33, the current work RVU and below the survey 25th percentile, appropriately accounts for the work required to perform this service. The HCPAC recommends 15 minutes intra-service time for this add-on code.

The typical patient for this service is being tested to see if they are a candidate for implant surgery and the code can also be used after the device is implanted to test for efficacy. Typically, the additional time is needed because the patient requires time for additional testing and the patient has severe communication impairments that require more complex testing elements. The specialty recommended and the HCPAC agreed that maintaining the current time and work RVU is appropriate. The HCPAC compared the survey code to top key reference service CPT code 92621 *Evaluation of central auditory function, with report; each additional 15 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.35, 15 minutes intra-service time) and agreed that the work involved is similar and the codes should be valued similarly. **The HCPAC recommends a work RVU of 0.33 for add-on code CPT code 92627.**

Practice Expense

The HCPAC approved the direct practice expense inputs as reviewed without modification by the Practice Expense Subcommittee.

The RUC filed the HCPAC Report.

XV. New Business/Other Issues (Tab 31)

• **Surveys conducted by more than one specialty**

A RUC member proposed for the Research Subcommittee to explore whether additional guidelines are necessary for surveys conducted by more than one specialty regarding how to align the specialty mix of the survey sample relative to how often each specialty performs the service. If the dominant provider specialty is not providing a sufficient number of surveys, then this could impact the validity of the survey.

A referral was made to the Research Subcommittee to ensure that when multiple specialties are surveyed, the survey is reasonably representative based on the mix of respondents. Also, the question arose as to whether it is appropriate to continue to leave it up to the surveying specialties whether they break out the survey data by specialty on their summary spreadsheets.

- **TCM Services**

Based on a request from a RUC member, staff reviewed claims reported with TCM services, using the 2016 5% carrier file, and found that TCM services are NOT typically reported by the same physician reporting the discharge management. 14% of TCM services (CPT codes 99495 and 99496) were billed by the same NPI as the matching discharge (CPT codes 99238 and 99239).

- **Pre- & Post-Service Packages**

A RUC member inquired whether having pre- & post-service packages for XXX codes had been considered. The chair of the Research Subcommittee explained that the subcommittee had just completed a review at the April 2018 meeting of potentially having packages for the XXX codes. The conclusion was that the variation in pre- and post-service times in general seemed appropriate and that XXX global packages should not be created at this time.

- **Practice Expense Survey**

A RUC member asked CMS representatives about the status of a new survey to capture practice costs. The RUC has encouraged CMS to use existing funds dedicated to refining the RBRVS to conduct a survey to better define the practice expense inputs. CMS representatives stated that it is under discussion.

- **SORs – Service performance rate**

A specialty society staff member asked that the RUC review the guideline that requires data to be broken out on the summary spreadsheet and that three separate SORS be submitted when median service performance rate is zero. He requested that the data continue to be broken out on the spreadsheet but only one combined SOR be required for submission. The RUC chair supported this idea and the **RUC voted in favor** of having societies submit a summary spreadsheet and one combined SOR when the median service performance rate is zero.

- **Use of Illustrations in RUC Presentations**

The chair of the Administrative Subcommittee reiterated that the issue of illustrations in RUC presentations will be under discussion at the January 2019 meeting. A specialty society had requested to submit illustrations with their recommendation for this meeting; however, the RUC determined that illustrations should not be distributed for presentation at the October 2018 RUC meeting until the Administrative Subcommittee has fully discussed this issue. The Subcommittee will have a formal discussion exploring the use of modern technology to enhance the RUC's understanding of complex and/or high intensity codes.

The RUC adjourned at 2:10 p.m. on Saturday, October 6, 2018.

Members Present: Scott Manaker, MD, PhD, (Chair), David C. Han, MD (Vice Chair), Kathy Krol, MD (CPT Resource), Gregory L. Barkley, MD, Eileen Brewer, MD, Joseph Cleveland, MD, Neal H. Cohen, MD, William Gee, MD, 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, Thomas Weida, MD, Adam Weinstein, MD

I. Power Table Workgroup

At the April 2018 Practice Expense (PE) Subcommittee meeting the Subcommittee discussed that in recent years the type of table (*power table* (EF031) versus the *exam table* (EF023)) allocated to the direct practice expense inputs for a service has been based on the type of table available in the office of the dominant specialty, rather than what is required for the service. The PE Subcommittee convened a Workgroup to analyze the issue and determine if a different approach is appropriate.

The Workgroup reviewed data analysis showing that every specialty provides both, services allocated an exam table, and services allocated a power table. This caused the Workgroup to question if the PE Subcommittee has been consistent in their decision making. A Workgroup member also pointed out that there are many CPT codes in the data that have a power table or exam table inconsistently allocated even within the same family of codes. Most members of the Practice Expense Subcommittee Power Table Workgroup agreed that for the majority of services, the allocation of the type of table should be based on the service under review, with the caveat that the post-op visits might use a different table than the procedure. However, there was significant concern that this change would negatively impact specialties that only have power tables in the office setting.

The Workgroup requested a full discussion of the issue prior to making a recommendation to the RUC. The PE Subcommittee discussed the CMS repricing proposal from the *CY 2019 proposed rule*, which if implemented would result in equipment item, EF031, *power table* being priced at \$5,438.12 and equipment item, EF023, *exam table* being priced at \$4,737.73 after the four-year transition period. PE Subcommittee members pointed out that the proposal may not be implemented and that many of the specialty societies oppose the CMS proposed pricing of these equipment items. Subcommittee members also discussed that determining the table based on the needs of the service does not consider the mobility of the patient. Other members thought considering the typical patient for the service in conjunction with the needs of the service would address this issue. The Chair of the Workgroup established that it is not the intention of the Workgroup to consider the type of table in all codes retrospectively, but rather only prospectively. **The Practice Expense Subcommittee recommends that for most services, the allocation of the type of table should be based on what is needed for the service under review.**

II. Computed Radiography (CR) and Digital Radiography (DR) Imaging Services.

The Consolidated Appropriations Act of 2016 imposes a 20% reduction on payment for imaging services using analog radiography (film) beginning in 2017 and a 7% reduction on imaging services using computed radiography (CR) beginning in 2018 to provide an incentive for the adoption of digital radiography (DR) imaging. At the April 2018 RUC meeting, the PE Subcommittee expressed concern about the policy as most imaging services recommendations are

based on the direct practice expense inputs for CR imaging, which remains the typical way to provide most imaging services. Given that the legislation has already passed, the PE Subcommittee is not able to influence this reduction in payment. After reading the informational staff note, the PE Subcommittee decided that no further action is necessary.

III. Invoice Process

At the April 2018 PE Subcommittee meeting, the Subcommittee discussed concerns about the difficulty of obtaining paid invoices to submit to CMS for their reference in creating pricing for supplies and equipment. A PE Subcommittee member expressed concern that there are databases documenting supply and equipment pricing for the VA, GA, many large commercial providers and hospital cost reports that could be used rather than the current invoicing process. There has been extensive discussion of this issue throughout the history of the RBRVS. RUC staff developed informational materials on CMS proposals and the RUCs response regarding equipment and supply repricing efforts. Staff also included a summary of the current CMS equipment and supplies repricing proposal outlined in the *CY 2019 Proposed Rule*. After reading the informational staff note, the PE Subcommittee decided that no further action is necessary.

IV. Use of Vendor Data in PE Recommendations

During this PE Subcommittee meeting the Subcommittee reviewed a service where the clinical staff times were developed using data from a large vendor owned database. The specialty society attested that they reviewed the data and found it to be sound as part of their preparation to present to the PE Subcommittee. Some PE Subcommittee members are concerned that there may not be enough clarity around the rules and policies regarding using data obtained from vendors. RUC staff clarified that there are extensive policies already in place and that the PE Subcommittee and the RUC rely on the specialty societies to attest to any data, including data obtained from industry, that they use in developing their recommendation. The PE Subcommittee acknowledged that the specialty society is responsible for any data that they may obtain, however, the Subcommittee would like clearly defined requirements for data obtained from industry that the specialty societies would need to ensure the data meets prior to using it in their practice expense recommendations. **The PE Subcommittee recommends referral to the Administrative Subcommittee to consider developing requirements around vendor data.**

V. Practice Expense Recommendations for CPT 2020:

Tab	Title	PE Input Changes
4	Tissue Grafting Procedures	Modifications
5	Drug Delivery Implant Procedures	Modifications
6	Aortic Graft Procedures	No Change

Tab	Title	PE Input Changes
7	Transanal Hemorrhoidal Dearterialization	No Change
8	Preperitoneal Pelvic Packing	No Change
9	Somatic Nerve Injection	Modifications
10	Genicular Injection and RFA	Modifications
11	Lower Gastrointestinal Tract Imaging	Modifications
12	Myocardial PET	Modifications
13	Long-Term EEG Monitoring	Modifications
14	Intravascular Ultrasound	Modifications
15	X-Ray Exam-Neck (PE Only)	Affirm recommendation from May 2018
16	CT-Orbit-Ear-Fossa	No Change
17	X-Ray Exam -Clavicle-Shoulder (PE Only)	Modifications
18	Urography	Modifications
19	Abdominal Aortography	Modifications
20	Angiography	Modifications
21	X-Ray Exam Specimen	Affirm recommendation from May 2018
22	Remote Interrogation Device Evaluation (PE Only)	No Change

Tab	Title	PE Input Changes
23	Open Wound Debridement	No Change
24	Transitional Care Management Services	Modifications

Members Present: Margie Andreae, MD (Chair), Jimmy Clark, MD (Vice Chair), Allan Anderson, MD, Robert Dale Blasier, MD, Michael Gerardi, MD, Peter Hollmann, MD, Katie Jordan, OTD, OTR/L, Alan Lazaroff, MD, Bradley Marple, MD, Daniel McQuillen, MD, Timothy Tillo, DPM, Christopher Senkowski, MD, Stanley W. Stead, MD, MBA, Robert Zwolak, MD

I. Minutes, June 6, 2018 RSC Specialty Requests Conference Call and Separate Electronic Review

The Research Subcommittee report from the June 6 conference call and separate electronic review included in Tab 26 of the October 2018 agenda materials was approved without modification.

II. RUC Service Performance Rate Question

At the January 2018 RUC meeting, a RUC member proposed updating the survey instrument to inquire for low volume services whether survey respondents have performed the survey code in the past few years instead of only the past 12 months. They noted that knowing this additional information may be beneficial when a survey code has a median performance rate of zero for the past 12 months. This item was referred to the Research Subcommittee for consideration. At the April 2018 meeting, the Research Subcommittee agreed to continue discussing this topic at the fall meeting and requested for AMA staff and the Chair to provide alternate language for consideration. Two options were provided and each version would only display for survey respondents that answer zero for a survey code for question 5.

The Subcommittee discussed the merits of both options and decided that determining if providers had ever performed or if they had performed more than 5 years ago was not helpful. Also, the Subcommittee reiterated that just because a survey respondent has not performed the service before or recently does not mean that their survey responses should be dismissed. AMA staff noted that the instructions in the RUC survey state “IMPORTANT: Please only respond to questions for survey codes that you either have experience performing or are familiar with.”

The Research Subcommittee approved the following standard survey language changes for all RUC survey instruments:

[This page would only display for respondents that put zero for 12 month question for survey code:]

How many times have you personally performed the following service(s) in the past 5 years?

Survey Code _____

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

I. NPRM for 2019 Nominations for Potentially Misvalued Services

CMS received two public nominations for nine codes. The first nomination included seven codes (27130, 27447, 43239, 45385, 70450, 93000 and 93306) in which the nominator stated that they are overvalued and that previous RUC reviews of these services did not result in reductions in valuation that adequately reflected reductions in surveyed times. CMS staff indicated that this nomination was not received during the *Proposed Rule* comment period and therefore is not publicly available in the Federal Docket Management System. The nomination was sent directly to CMS by the February 10th deadline.

In the RUC comment letter on the NPRM for 2019, the RUC requested that CMS publicly provide the source of comment and entire comment letter submitted to provide transparency and aide the RUC's discussion of these services. The RUC requested that CMS provide greater transparency and publicly provide all public nomination requests identifying potentially misvalued services.

The Workgroup noted that this is a process issue and without more information on how these services were identified and rationale to review these services, the Workgroup will wait until the Final Rule for more information to determine whether review these services.

The *Society for Cardiovascular Angiography and Interventions* (SCAI) submitted the second nomination for two services, CPT code 92992 *Atrial septectomy or septostomy; transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization* and 92993 *Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization)*. These services are typically performed on children, a non-Medicare population, and are contractor-priced. The specialty society requests that these services be surveyed through the RUC process. **The Workgroup agreed with the specialty recommend survey for January 2019.**

II. PE Screen – High Cost Supplies

At the January 2018 RUC meeting, the Practice Expense (PE) Subcommittee discussed potential screens that would identify misvalued services and recommended a high cost supply items screen to the Relativity Assessment Workgroup (RAW). There are 58 supply items with a purchase price greater than \$500. The PE Subcommittee recommended that the RAW identify services that include supply items greater than \$500 and based upon utilization, dominant specialty and date of last review, determine if there is reason for RUC review.

The only family identified with non-facility Medicare utilization over 10,000 that has not been recently reviewed (in the last five years), with high cost supply items are CPT codes 37225, 37227 and 37229.

CPT code 37227 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed* has three high cost supply items:

- SD253 atherectomy device (Spectronetics laser or Fox Hollow) (\$4,979.67)
- SD254 covered stent (VIABAHN, Gore) (\$3,768)
- SD256 Embolic Protection Device Spider FX (EV3, documentation available) (\$1,365)

CPT code 37225 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed* and 37229 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed* each contain two high cost supply items:

- SD253 atherectomy device (Spectronetics laser or Fox Hollow) (\$4,979.67)
- SD256 Embolic Protection Device Spider FX (EV3, documentation available) (\$1,365)

Inclusion of a high cost supply does not necessarily indicate that a service is potentially misvalued. Although the RUC has requested, CMS has not indicated that they will re-price high cost supply items every year.

In April 2018, the Relativity Assessment Workgroup determined that this is an appropriate screen, however did not have enough time to discuss this issue in detail. The Workgroup deferred this issue until the October 2018 meeting.

The Workgroup noted it should identify CMS' process regarding the review of high priced supply items and how J codes are constructed to determine how to proceed with this screen. AMA staff contacted CMS staff and confirmed that there is no current process outside of the submission of invoices to review high priced supply items. As recent as the August 31, 2017, RUC comment letter to CMS on the Proposed Rule for 2018, "The RUC has repeatedly called on CMS to separately identify and pay for high cost disposable supplies using distinct J codes, rather than bundle into the service described by CPT so that these expenses may be monitored closely and paid appropriately. There are 33 supply items that CMS has priced more than \$1,000 and bundled into the practice expense RVU for various CPT codes. The RUC urged CMS to establish J codes for high cost supplies. The pricing of these supplies should be based on a transparent process, where items are annually reviewed and updated."

The Workgroup reviewed the high-priced supply items CPT codes 37225, 37227 and 37229 and recommends an action plan be submitted for January 2019 on how to address these services.

III. Review Modifier -51 Exempt List (Appendix E)

In January 2018, a Workgroup member suggested to review codes on the Modifier -51 *Multiple Procedures* exempt list to make sure there is no duplication on pre- and post- work related to the services it is typically reported. AMA Staff examined list of 25 codes from the CPT Modifier-51 Exempt list and identified seven (7) services with 2017 estimated Medicare utilization over 10,000 (CPT codes 17004, 31500, 36620, 93451, 93456, 93503 and 95992).

In April 2018, the Workgroup examined the data provided on the percentage reported alone, physician pre- and intra time and determined that this is an appropriate screen. The Workgroup requested action plans for the October 2018 RAW meeting and for specialty societies to indicate whether these services should stay on the Modifier -51 exempt list.

The Workgroup reviewed the action plans and agrees with the specialty societies that CPT codes 17004, 93451, 93456 and 95992 be removed from the Modifier -51 exempt list. Noting the three latter codes were placed on the list in error. The Workgroup agreed that CPT code 31500, 36620 and 93503 are separate and distinct procedures and should remain on the list. The Workgroup noted that the CPT Editorial Panel may be reviewing

Appendix E at the February 2019 meeting. The specialty societies may need to provide CPT with clarification regarding when CPT code 93503 is provided by Anesthesiology as the dominant provider and reported with anesthesia services (ie, 00567 35 % of the time and 00562 33% of the time) can this still be reported with modifier -51?

IV. Contractor Priced with High Volume

In January 2018, a RUC member suggested to review high volume contractor priced codes. AMA Staff identified five (5) contractor-priced Category I CPT codes that have 2017 estimated Medicare utilization over 10,000 (CPT codes 77522, 77523, 90868, 93299 and 95943). In April 2018, the Workgroup determined that there are various reasons in which these codes have been recommended to be contractor priced and the specialty societies should submit action plans for the October 2018 meeting indicating whether these services should be reviewed for physician work/practice expense by the RUC.

In October 2018, the Workgroup reviewed the action plans and recommends the following:

CPT Code	Issue	Recommendation
77522 77523 77525 (f)	Proton Beam Treatment Delivery	The Workgroup determined that these TC only codes are still evolving and are not diffused enough to determine the typical practice expense resources. The Workgroup recommended to review again in 3 years, however when the full RUC discussed they determined that these services should be surveyed for practice expense.
95943	Heart Rate Test	The Workgroup determined that this service is performed by many specialties and the utilization is high enough to survey. Survey for January 2019.
90868 90867 (f) 90869 (f)	Transcranial Magnetic Stimulation	These services are also identified on the new technology list for review. The Workgroup agreed with the specialty that technology for these services is still evolving. Two FDA modifications were recently approved and the new coil will significantly reduce the time required to perform these services. Review again in 2 years (Oct 2020).

V. New Technology/New Services – Review Action Plans

In September 2005, the RUC began a process of flagging services that represent new technology as the codes were presented to the Committee. The RAW will review codes that were flagged October 2013-April 2014 with three years of available Medicare claims data (2015, 2016 and preliminary 2017 data).

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

The Workgroup indicated that specialty societies should expect that the Workgroup will typically extend the review of services to beyond the first 3 years of utilization data and should consider that when developing action plans for services on the new technology/new services list.

The Workgroup reviewed the action plans and recommends the following:

CPT Code	Issue	Recommendation
20983	Cryoablation Treatment of the Bone Tumors	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
21811 21812 21813	Internal Fixation of Rib Fracture	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
22858	Total Disc Arthroplasty Additional Cervical Level Add-On Code	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
29584	Multi-Layer Compression System-HCPAC	The utilization is low but still growing. Review in 3 years (Oct 2021).
33270 33271 33272 33273 93260 93261 93644	Subcutaneous Implantable Defibrillator Procedures	The utilization is low but still growing. Review in 3 years (Oct 2021).
33418 33419	Transcatheter Mitral Valve Repair	The utilization is low but still growing. Review in 3 years (Oct 2021).
33946 - 33989	ECMO-ECLS	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
36475 36476 36478 36479	Endovenous Ablation	Review in 3 years (Oct 2021).
37218	Transcatheter Placement of Carotid Stents	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
43180	Endoscopic Hypopharyngeal Diverticulotomy	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
44705 G0445	Fecal Bacteriotherapy	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
46601 46607	High Resolution Anoscopy	Review in 3 years (Oct 2021) to determine who is performing these services.
47383	Cryoablation of Liver Tumor	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.

52441 52442	Cystourethroscopy Insertion Transprostatic Implant	The Workgroup is concerned because the utilization is significantly increasing and questioned the time required to perform these services. Survey for January 2019.
77061 77062 77063	Breast Tomosynthesis	The Workgroup recommends that CMS delete G0279 and use codes 77061, 77062, and 77063 as created by CPT and valued by the RUC. Review again in 3 years (Oct 2021).
90867 90868 90869	Transcranial Magnetic Stimulation	These services are also identified on the contractor-priced with high volume screen for review. The Workgroup agreed with the specialty that technology for these services is still evolving. Two FDA modifications were recently approved and the new coil will significantly reduce the time required to perform these services. Review again in 2 years (Oct 2020).
92145	Corneal Hysteresis Determination	The utilization has continued to increase. Survey for January 2019.
97605 97606 97607 97608	Negative Pressure Wound Therapy	Review again in 3 years (Oct 2021).
97610	HCPAC - Ultrasonic Wound Assessment	Survey for January 2019.

VI. Re-review of Flagged Services – Review Action Plans

Throughout the RUC's review of potentially misvalued services, codes have been flagged for review at later date after additional utilization was available, CPT assistant articles were published or additional information was gathered. Five code families were flagged and action plans were submitted for review. **The Workgroup recommends the following:**

CPT Code	Issue	Recommendation
75710	Angiography of Extremities	Review again in 2 years (October 2020).
75894	Transcatheter Procedure	Utilization decreased appropriately after code bundling solutions. However, this service is currently CMS/Other source and has never been RUC surveyed. The Workgroup requests an action plan for January 2019 to determine whether to survey what remains in this service currently or delete this service.
75898	Follow-up Angiography	Utilization decreased appropriately after code bundling solutions. However, this service is currently CMS/Other source and has never been RUC surveyed. The Workgroup requests an action plan for January 2019 to determine whether to survey what remains in this service currently or delete this service.
75984	Introduction of Catheter or Stent	Utilization decreased appropriately after code bundling solutions. However, this service is currently CMS/Other source and has never been RUC surveyed. The Workgroup requests an action plan for January 2019 to determine whether to survey what remains in this service currently or delete this service.
78070 78071 78072 78803	Parathyroid Imaging	Utilization may be appropriate however, CPT code 78803 is Harvard valued. The Workgroup requests an action plan if this service should be surveyed.

VII. Re-iteration of Existing Screens – Review Data

A. *Site of Service Anomalies*

Outpatient Setting but Includes Hospital Visits

AMA Staff reviewed services with anomalous sites of service when compared to Medicare utilization data. One service was identified, CPT code 63030 *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar*, in which the Medicare data from 2014-2017e indicated that it was performed less than 50% of the time in the inpatient setting, yet include inpatient hospital Evaluation and Management services within the global period. **The Workgroup requests an action plan for January 2019.**

Inpatient Hospital Setting but includes half discharge day management (99238)

Additionally, a RUC member requested a site-of-service anomaly screen based on the review of three years of data (2015, 2016 and 2017e) for services with utilization over 10,000 in which a service is typically performed in the inpatient hospital setting, yet only a half discharge day management (99238) is included. One service was identified 28820 *Amputation, toe; metatarsophalangeal joint*. When this service was reviewed in October 2010 the RUC made a recommendation as an inpatient service with 1- 99231 hospital visit and 1-99238. The data at that time indicated that this service was performed in the inpatient setting 48% of the time. CMS rejected the RUC recommendation of 7.00 work RVUs, instead finalized a 5.82 work RVU, removed the 99231 hospital visit and reduced the discharge day to half. The data now indicates that this service is performed 55% in the hospital setting. **The Workgroup requests an action plan for January 2019.**

B. *CMS Other Source Codes*

AMA staff identified the CMS/Other Source codes with 2017e Medicare utilization over 30,000. Seven (7) services were identified (74300, 74328, 93623, G0270*, G0297, G0452 and Q0091). **The Workgroup requests action plans January 2019.** *G0270 is on the CMS/Other source codes and the High Volume Growth screens.

C. *Harvard Valued*

AMA staff identified the Harvard Valued services with 2017e Medicare utilization over 30,000. One service was identified, CPT code 29823 *Arthroscopy, shoulder, surgical; debridement, extensive*. **The Workgroup requests an action plan January 2019.**

D. *High Volume Growth*

AMA staff identified services that with 2017e Medicare utilization of 10,000 or more that has increased by at least 100% from 2012 through 2017. Twelve (12) codes were identified (00534, 00560, 37229, 64566, 70496, 70498, 77401, 93662, 93750, 95012, G0270, G0399). **The Workgroup request an action plan January 2019.** *G0270 is on the CMS/Other source codes and the High Volume Growth screens.

E. *Surveyed by one specialty and now performed by a different specialty*

AMA staff reviewed the 2017e Medicare utilization over 10,000 where a service was performed by one specialty but is now performed by a different specialty. **No new codes were identified via this screen.**

F. *000-Day Global reported with an E/M 75% or More (Research Subcommittee Request)*

AMA staff reviewed 000-day global period services, reported with E/M 75% or more, not reviewed in the last 5 years with more than 10,000 in 2017e Medicare utilization. **No new**

services were identified as all codes were previously addressed by CMS' similar screen in 2017 (000-day global period 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).

G. CPT Assistant Article Analysis

AMA staff identified RUC referrals for CPT Assistant articles from 2013-2016, to review utilization data after article published. Seventeen (17) codes were identified (33620, 33621, 33622, 51784, 51792, 52234, 52240, 64555, 70371, 76513, 92287, 94060, 94400, 94640, 94668, 94770 and 95970). **The Workgroup requested action plans for January 2019. The Workgroup specifically requests that the specialty societies address the following in their action plans:**

1. Explain the issue and background of the code and why a CPT Assistant article was created.
2. What was the expected result?
3. Did the article address the issues identified with this service?
4. Is a re-review in a couple years or further action necessary?

H. Multiple Units

When reviewing the action plan for the health and behavior intervention CPT code 96154 *Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)*, the Workgroup indicated that there may be other timed codes reported in multiple units that may have excessive post time. When querying services with “minutes” identified in the descriptor, 2017e Medicare utilization over 10,000 and 1.5 more mean units reported, only the four health and behavior codes were identified (96150, 96152, 96153 and 96154). **Based on the identification of these codes at the last Workgroup meeting, the RUC recommended this family of services was referred to the September 2018 CPT meeting for revision.** Therefore, this will not go forward as a specific screen as no additional codes were identified.

I. Work Neutrality CPT 2017

All code families from the CPT 2017 cycle did not exceed the 10% threshold for work neutrality.

VIII. Other Business

The Workgroup discussed future screens and recommends lowering the threshold and examining the list of CMS/Other source codes with Medicare utilization over 20,000 at the January 2019 meeting.

IX. Informational Items

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

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

I. Review Final Methodology

In April 2017, the Anesthesia Workgroup began examining the methodology for valuing anesthesia services, since the RUC had not validated this methodology since 2007. The Workgroup examined the 2007 anesthesia methodology and analyzed the physician work component of anesthesia base units as they relate to work RVUs. Although these reviews allowed the Workgroup to understand the history and correlations between the span of anesthesia services, it was clear that it was not an independent methodology to validate anesthesia services. The previous method incorporated a circular flawed assumption to validate base units by incorporating the base unit of each code in the methodology itself.

The Workgroup notes that the proposed methodology is to assign proxy units to create a rank order. Though the process should utilize familiar RUC methods and does use familiar terms (e.g., IWPUT as converted to RVU/min), work relative value units are not being created. Additionally, the process will utilize a survey without reference services as there are no reference services with this process to create rank order.

The Workgroup met in April 2018, twice via conference call over the summer and at this meeting to create a new methodology to establish the relativity of base values for anesthesia services. **The Workgroup reviewed the methodology and recommends the following:**

Step 1: Pre-Service Evaluation

The Workgroup noted that the previous recommendation of selecting a proxy new/established Evaluation and Management (E/M) service may have incorrectly compared time and intensity for this step. Also, using the fixed intensity avoids the potential confounder that would occur were there changes in the E/M services as proposed for 2019. The Workgroup noted that the fixed intensity multiplied by time as determined by survey and verified by an expert panel would be consistent with other RUC methods for determining work values in the RBRVS. **The Workgroup recommends ASA survey the proposed reference service codes for pre-service evaluation time and multiply by the intensity of 0.0224 to compute the proxy value of this phase of anesthesia services.**

Step 2: Equipment, Drug and Supply Preparation (EDSP)

The Workgroup recommended that ASA develop time packages to apply to EDSP work. The Workgroup noted that these packages will eventually be part of the anesthesia base code survey process and be used in conjunction with the ASA expert panel to refine the survey results, just as the RUC analyzes survey pre-time with the pre-time packages with the review of services in the RBRVS. The Workgroup reviewed ASA's drafted time packages provided. The Workgroup agreed with the four levels of anesthesia complexity/patient complexity similar to other RUC pre-time packages. **The Workgroup recommends that ASA survey the reference service codes for EDSP time, review the surveyed time and adjust to reflect the time packages, and multiply by 0.0081 to determine the proxy value of this phase of the anesthesia services. The Workgroup further recommends, as in the standard RUC process, Anesthesia will not increase time beyond the survey total for any segment of this process.**

Step 3: Induction Period Procedure

The Workgroup reviewed ASA's drafted time packages for the induction period and agreed with the four levels of anesthesia/patient complexity and the detailed description of the work of the anesthesiologist for each level and for the induction period time to drill down to the individual task level. The Workgroup determined that two levels of intensity should be used. The Workgroup determined that the intensity of code 31575 *Laryngoscopy, flexible; diagnostic* (IWPUT = 0.1172) should be used for the complex patient packages and the intensity of code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (IWPUT = 0.0636) should be used for the straightforward patient packages. **The Workgroup recommends that ASA survey the proposed reference service codes for induction period time, review the surveyed time and adjust to reflect the time packages, and multiply the time by the appropriate level of intensity (straightforward patient, 0.0636 or complex patient, 0.1172).**

Step 4: Post- Induction Period Procedure Anesthesia (PIPPA)

The Workgroup discussed the PIPPA level descriptions. ASA noted that for time units beyond base units the anesthesiologist is paid the same amount per unit of time no matter what the complexity of the surgical service in which the anesthesia is being administered. ASA indicated that the PIPPA helps to understand the complexity of each case. The Workgroup noted that taking the total post-induction time, divided into each quintile and then multiplied by the PIPPA quintile intensities will produce distortions in relativity for very short or very long services. The Workgroup and ASA agreed that PIPPA should be a factor, but did not reach a conclusion on how it would be applied (e.g., to create value units using time, to use to move up or down an intensity scale based on expert panel or to be a set percent of the factor in creating value units), **Therefore, the Workgroup recommends surveying the proposed reference codes for post-induction anesthesia time first and then determine a way to incorporate a proxy value for the PIPPA phase after review of the survey data.**

Step 5: Post Anesthesia Evaluation

The Workgroup noted that the previous recommendation of selecting a proxy new/established Evaluation and Management (E/M) service may have incorrectly compared time and intensity for this step. Also, using the fixed intensity avoids the potential confounder that would occur were there changes in the E/M services as proposed for 2019. The Workgroup noted that the fixed intensity multiplied by time as determined by survey and verified by an expert panel would be consistent with other RUC methods for determining work values in the RBRVS. **The Workgroup recommends ASA survey the proposed reference service codes for post-anesthesia evaluation time and multiply by the intensity of 0.0224 to compute the proxy value of this phase of anesthesia services.**

The values from the five phases of anesthesia care will then be summed to create a proxy value for each of the proposed reference service codes. These proxy values will be used to establish relativity among the codes to set the stage for future valuation using anesthesia units.

This new methodology is independent and any circular logic that was in the previous methodology is excluded.

II. Anesthesia Reference Service List

At the June 2018 Anesthesia Workgroup meeting, the Workgroup requested that the specialty society propose other highly utilized anesthesia codes that span the breath of the base units (3-30) in anticipation of using this methodology to develop an anesthesia reference service list.

The eight reference codes previously identified by this Workgroup are from the top 32 anesthesia codes that represent 75% of Anesthesia Medicare allowed charges, each code with \$20 million or more in

Medicare allowed charges, that have a single top surgical code that is reported at least 50% of the time. These were codes 00142, 00350, 00567, 00731, 01214, 01402, 01630, and 01638. ASA presented six additional reference codes that span from 3-30 base units (Codes 00560, 00562, 00566, 00670, 00796 and 01810). The Workgroup agreed these additional codes demonstrated an appropriate range and granularity of anesthesia services. In October 2018, the Workgroup determined two additional anesthesia codes should be added to the reference code list for a total of 16 services (Codes 00790 and 00812).

The proposed methodology is to use the five-step method to compute proxy relative values for the 16 codes on the proposed RSL. The lowest valued proxy code will be arrayed to the lowest base units (3) and the highest valued proxy code to the highest base unit value (30). Linear regression will be used to confirm that the current anesthesia base units are in the correct rank order compared to the proxy values.

The Workgroup recommends using the 16 codes identified, and proposes to use the five-step methodology to develop an anesthesia reference service list.

III. Survey of Reference Services

The Workgroup reviewed the current RUC Anesthesia survey for base units as a starting point to develop the proposed reference services list survey. **The Workgroup recommends maintaining the current typical patient intro question, Question 2 on anesthesia time and Question 5 on PIPPA intensity. See draft survey attached to this report.**

Next Steps

- November 2018 – the Anesthesia Workgroup will have a conference call to finalize the survey instrument (review survey in Qualtrics), vignettes, educational materials, time packages document and format of the presentation of survey results.
- January 2019 – the Research Subcommittee will review all materials
- April 2019 – the Anesthesia Workgroup review the survey data of the 16 proposed anesthesia reference services to independently establish the relativity of the current anesthesia base codes The Workgroup will verify or identify any need for change across the relativity of these 16 services. **The Workgroup will determine how PIPPA will be used in establishing relativity and asks ASA to propose a methodology upon review of the survey results.**



The American Medical
Association/Specialty Society
RVS Update Committee

Anesthesia Services Survey

Survey CPT Code: _____

CPT Code Descriptor: _____

Typical Patient/Service: _____

START HERE

IMPORTANT: Please only respond to questions for survey codes that you either have experience performing or are familiar with.

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

1) Complete the survey using the typical patient/vignette described below

AND

2) Explain in the following section how your typical patient differs from the typical patient described in this survey

TYPICAL PATIENT

Is your typical patient for this procedure similar to the typical patient described on the cover?

Yes ☐ No ☐

If no, please describe your typical patient for this procedure:

INTRODUCTION

Why should I complete this survey?

The AMA/Specialty Society RVS Update Committee (RUC) and the American Society of Anesthesiologists needs your help to assure values will be accurately and fairly presented to CMS during this revision process.

What if I have a question?

Contact: Sharon Merrick, CCS-P

(202) 289-2222

s.merrick@asahq.org

How is this survey organized?

Each new/revised code must be surveyed (i.e., **there is one questionnaire per code**), so you may have several questionnaires to complete. Each questionnaire is organized the same and is comprised of questions relating to physician work.

The following information must be provided by the physician responsible for completing the questionnaire.

Physician name: _____

Business name: _____

Business phone: _____

E-mail address: _____

Physician specialty: _____

Primary geographic practice setting: ☐ Rural ☐ Suburban ☐ Urban

Primary type of practice: ☐Solo practice
☐Single specialty group
☐Multispecialty group
☐Medical school faculty practice plan

Financial Disclosure:

Please answer the following questions by checking yes or no.

Do you or a family member* have a direct financial interest in this procedure, other than providing these services in the course of patient care? For purposes of this Survey “direct financial interest” means:

- A financial ownership interest in an organization** of 5% or more:

Yes ☐ / No ☐

- A financial ownership interest in an organization** which contributes materially*** to your income:

Yes ☐ / No ☐

- Ownership of stock options in an organization**: Yes ☐ / No ☐

- A position as proprietor, director, managing partner, or key employee in an organization**: Yes ☐ / No ☐

- Serve as a consultant, researcher, expert witness (excluding professional liability testimony), speaker or writer for an organization** or participate in a clinical trial that involves the services being reviewed, where payment contributes materially*** to your income: Yes ☐ / No ☐

*Family member means spouse, domestic partner, parent, child brother or sister. Disclosure of family member’s interest applies to the extent known by the survey respondent.

** Organization means any entity that makes or distributes the product that is utilized in performing the service, and not the physician group or facility in which you work or perform the service.

***Materially means \$10,000 or more in income (excluding any reimbursement for expenses) for the past twenty-four months.

If you have answered yes to any of the above questions, do not complete this survey.

Additional Disclosure:

Have you been contacted by anyone other than your specialty society, other specialty societies sponsoring this survey (or any of their representatives) or the American Medical Association with respect to this survey? Yes ☐ / No ☐

If you have answered yes to the above question, do not complete this survey.

PHYSICIAN WORK

“Physician work” includes the following elements:

- Physician time it takes to perform the service
- Physician mental effort and judgment
- Physician technical skill and physical effort, and
- Physician psychological stress that occurs when an adverse outcome has serious consequences

All of these elements will be explained in greater detail as you complete this survey.

“Physician work” does not include the services provided by support staff who are employed by your practice and cannot bill separately, including registered nurses, licensed practical nurses, medical secretaries, receptionists, and technicians; these services are included in the practice cost component, a different part of the anesthesia conversion factor.

Background for Question 1: Anesthesia services

You should assume that you are **personally providing** the anesthetic care during each of the service periods described, rather than medically directing residents or non-physician providers. Do not report time or work of technicians or OR staff. **Do not report time or work related to separately billable services such as postoperative pain management procedures or invasive monitoring procedures. Do not report time or work of separately billable critical care services or evaluation and management services.**

Reportable anesthesia time is defined in CPT as beginning “when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision.”

Pre-anesthesia period

This period includes several distinct physician activities:

1. Patient evaluation -
 - a. The evaluation of the patient for anesthesia prior to the beginning of reportable anesthesia time, which includes service prior to the day of surgery (not separately billed) as well as time on the day of surgery prior to reportable anesthesia time.
 - b. Time spent reviewing records, communicating with other professionals, obtaining the patient’s history, performing an examination, formulating the anesthesia plan, obtaining consent, ordering studies, reviewing results of diagnostic studies and communicating with the patient’s family when needed.
2. Equipment and supply preparation –

The period in which you acquire, prepare and check anesthetic drugs, supplies and equipment prior to the beginning of reportable anesthesia time, which includes acquiring, preparing and labeling anesthetic and/or cardiovascular drugs, assembling and checking airway management equipment connecting and calibrating monitoring equipment, preparing infusion pumps, and performing the anesthesia machine checkout routine. Do not report time spent by technicians or other staff.

Intra-anesthesia period

This period corresponds to reportable anesthesia time and includes preparation of the patient for anesthesia, induction, maintenance and emergence from anesthesia and transfer of the patient to postoperative care until you are no longer continuously present and caring for the patient.

The intra-anesthesia period consists of two distinct elements:

1. Induction period: The time from the initiation of reportable anesthesia time until induction of general anesthesia, establishment of adequate regional anesthesia (spinal, epidural or peripheral neural blockade), or completing establishment of sedation in conjunction with a monitored anesthetic care case. One can consider the end of the induction period as the “anesthesia ready time” or the time when the surgical team may begin to prepare the patient for the planned procedure after initiation of anesthesia.
2. Post-induction period: The time from the end of the induction period until the end of reportable anesthesia time.

Post-anesthesia period

This is the period (after the end of reportable anesthesia time) in which you manage pain, respiratory, cardiovascular or other clinical issues in the post-anesthesia care unit, critical care unit or ward. It includes the time spent assessing the patient’s postanesthetic course and any necessary visits, documentation, follow-up or communication with other professionals. Do not report time associated with separately billable visits or services.

Question 1

How much of your time is required per patient for each of the following steps in patient care related to this procedure? It is important to be as precise as possible. For example, indicate 3 or 6 minutes instead of rounding to 5 minutes or indicate 14 or 17 minutes instead of rounding to 15 minutes. Indicate your time for the survey code on the front cover. (Refer to definitions.) Indicate your time for the survey code on the front cover. Do not report time or work related to separately billable services such as postoperative pain management procedures or invasive monitoring procedures. Do not report time or work of separately billable critical care services or evaluation and management services. (Refer to definitions.)

Pre-Anesthesia	
1A. Evaluation of the patient prior to the beginning of reportable anesthesia time	_____ minutes
1B. Equipment and Supply preparation	_____ minutes
Intra-Op Anesthesia	
1C. Induction period	_____ minutes
1D. Post-induction period	_____ minutes
1E. Post-Anesthesia Time	_____ minutes

Question 2

Post induction anesthesia time has varying levels of physician work intensity. In this portion of the survey, you are asked to allocate the post-induction anesthesia

time to five different intensity groups. The post-induction intensity levels represent activities characterized by a level of physician work intensity (mental effort, technical skill, psychological stress) similar to the example of activities listed below. Assign the appropriate percentage of post-induction time to each of the five intensity levels so the the total equals 100%. Do not include time spent on the induction procedure

	Percentage of Time (%)
<p>Level 1: Presenting Problems are self-limited or minor; Straightforward medical decision making and treatment Examples include but are not limited to:</p> <ul style="list-style-type: none"> • <i>Monitoring and recording standard physiologic monitors (EKG, ETCO₂, SpO₂, BP, respiratory parameters) in a stable patient</i> • <i>Positioning a patient for surgery (ie, supine)</i> • <i>Titrating anesthetic level to achieve optimal surgical condition</i> 	
<p>Level 2: Presenting Problems are of low severity; Medical decision making and treatment of low complexity Examples include but are not limited to:</p> <ul style="list-style-type: none"> • <i>Evaluating and managing transient aberrations in hemodynamic or respiratory status such as moderate tachycardia or hypotension</i> • <i>Responding to abrupt changes in surgical activity (eg, visceral traction, orthopedic cement application, abdominal insufflation)</i> • <i>Positioning an unconscious patient (ie, prone, sitting, decubitus) for surgery</i> • <i>Maintenance of cardiopulmonary bypass</i> 	
<p>Level 3: Presenting Problems are of moderate severity; Medical decision making and treatment of moderate complexity Examples include but are not limited to:</p> <ul style="list-style-type: none"> • <i>Inducing intentional hypotension (eg, starting a vasodilator)</i> • <i>Evaluation and management of sustained hypertension using vasoactive agents</i> • <i>Preparing and evaluating a patient for anesthetic emergence and tracheal extubation</i> • <i>Initiation of cardiopulmonary bypass</i> • <i>Maintenance of single-lung ventilation</i> 	
<p>Level 4: Presenting Problems are of moderate to high severity; Medical decision making of moderate to high complexity and treatment of high complexity Critically ill or critically injured patient Examples include but are not limited to:</p> <ul style="list-style-type: none"> • <i>Evaluating and managing intraoperative myocardial ischemia, sustained hypotension, serious cardiac arrhythmias</i> • <i>Maintenance of hypotension and associated fluid, drug and transfusion requirements during cerebral aneurysm clipping</i> • <i>Initiating single lung ventilation</i> 	
<p>Level 5: Presenting Problems are of high severity; Medical decision making and treatment of high complexity Critically ill or critically injured patient Examples include but are not limited to:</p> <ul style="list-style-type: none"> • <i>Managing separation from cardiopulmonary bypass</i> • <i>Managing clamping or unclamping of abdominal aorta</i> • <i>Managing massive transfusion for resuscitation of hemorrhagic shock</i> 	
Total (must equal 100%)	

Question 3

How many times have you personally performed these procedures in the past 12 months?

Survey Code _____

**AMA/Specialty Society RVS Update Committee
MPC Workgroup
October 4, 2018**

Tab 29

Workgroup members in attendance: Doctors Alan Lazaroff (Chair), Allan Anderson (Vice Chair), Amr Abouleish, Gregory Barkley, Jimmy Clark, Jeffrey Edelstein, Alnoor Malick, Bradley Marple, Nader Massarweh, Daniel McQuillen, M. Eugene Sherman, Norman Smith, James Waldorf

Review of Specialty Code Recommendations

The MPC Workgroup's agenda is deferred to the January 2019 meeting.

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

I. Introductions

Doctor Bishop called the meeting to order at 5:20 pm and let the Review Board know that Dr. Nikjeh will be chairing the meeting.

II. CMS Update

Doctor Edith Hambrick from CMS attended the HCPAC meeting and introduced CMS staff. The Agency is planning to release the final rule on November 1st. If any specialty societies or individuals plan to meet with CMS regarding the final rule please do so as soon as possible.

III. Relative Value Recommendations for CPT 2020

Auditory Function Evaluation

In October 2016, the Relativity Assessment Workgroup (RAW) identified CPT code 92626 through the High-Volume Growth screen and in October 2017 through the CMS Request - Audiology Services screen. CPT code 92627 was included in the CMS Request - Audiology Services screen as the add-on code for this service.

92626 Evaluation of auditory function for surgically implanted device(s) candidacy or post-operative status of a surgically implanted device(s); first hour

The HCPAC reviewed the survey results from 71 Audiologists for CPT code 92626 and determined that the proposed work RVU of 1.40, the current work RVU and below the survey median, appropriately accounts for the work required to perform this service. The HCPAC recommends 7 minutes of pre-evaluation time, 60 minutes intra-service time and 10 minutes immediate post-service time.

The typical patient for this service is being tested to see if they are a candidate for implant surgery and the code can also be used after the device is implanted to test for efficacy. The specialty recommended and the HCPAC agreed that although the age of the patient population has changed from typically a child to typically an adult, the work associated with the service has not changed and maintaining the current time and work RVU is appropriate. The HCPAC compared the survey code to CPT code 92606 *Therapeutic service(s) for the use of non-speech-generating device, including programming and modification* (work RVU = 1.40 7 minutes pre-service, 60 minutes intra-service and 10 minutes post-service time). Both codes are performed on patients with communication impairment. The times for both codes are identical and the work RVUs should be identical. The HCPAC also compared the service to the survey key reference service 92620 *Evaluation of central auditory function, with report; initial 60 minutes* (work RVU = 1.50 and 60 minutes intra-service time). **The HCPAC recommends a work RVU of 1.40 for CPT code 92626.**

92627 *Evaluation of auditory function for surgically implanted device(s) candidacy or post-operative status of a surgically implanted device(s); each additional 15 minutes (List separately in addition to code for primary procedure)*

The HCPAC reviewed the survey results from 63 Audiologists for CPT code 92627 and determined that the proposed work RVU of 0.33, the current work RVU and below the survey 25th percentile, appropriately accounts for the work required to perform this service. The HCPAC recommends 15 minutes intra-service time.

The typical patient for this service is being tested to see if they are a candidate for implant surgery and the code can also be used after the device is implanted to test for efficacy. Typically, the additional time is needed because the patient requires time for additional testing and the patient has severe communication impairments that require more complex testing elements. The specialty recommended and the HCPAC agreed that maintaining the current time and work RVU is appropriate. The HCPAC compared the survey code to 1st key reference service CPT code 92621 *Evaluation of central auditory function, with report; each additional 15 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.33, 15 minutes intra-service time). **The HCPAC recommends a work RVU of 0.33 for add-on code CPT code 92627.**

The HCPAC approved the direct practice expense inputs as reviewed without modification by the Practice Expense Subcommittee.

IV. Edits to HCPAC MPC List

The following CPT codes will be added to the HCPAC MPC list:

- 11732 *Avulsion of nail plate, partial or complete, simple; each additional nail plate (List separately in addition to code for primary procedure)*
- 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)*
- 29580 *Strapping; Unna boot*
- 90845 *Psychoanalysis*
- 92609 *Therapeutic services for the use of speech-generating device, including programming and modification*
- 92611 *Motion fluoroscopic evaluation of swallowing function by cine or video recording*
- 97032 *Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes*
- 97112 *Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities*
- 97162 *Physical therapy evaluation – mod complexity*
- 97166 *Occupational therapy evaluation – mod complexity*
- 97530 *Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes*
- 97533 *Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes*
- 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*
- 97537 *Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task*

analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes

- 97760 *Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes*
- 97763 *Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes*

The following CPT codes will be deleted from the HCPAC MPC list:

- 22505 *Manipulation of spine requiring anesthesia, any region*
- 31720 *Catheter aspiration (separate procedure); nasotracheal*
- 36510 *Catheterization of umbilical vein for diagnosis or therapy, newborn*
- 64450 *Injection, anesthetic agent; other peripheral nerve or branch*
- 92225 *Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial*
- 92568 *Acoustic reflex testing, threshold*
- 93040 *Rhythm ECG, 1-3 leads; with interpretation and report*
- 96116 *Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report*
- 96150 *Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment*
- 96152 *Health and behavior intervention, each 15 minutes, face-to-face; individual*
- 97597 *Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less*

The following CPT codes will be deleted from the HCPAC MPC list because they have not been reviewed by the HCPAC or RUC in more than 15 years:

- 20551 *Injection(s); single tendon origin/insertion*
- 65205 *Removal of foreign body, external eye; conjunctival superficial*
- 92020 *Gonioscopy (separate procedure)*
- 92225 *Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial*
- 97804 *Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes*

The HCPAC discussed that staff will note any services that were removed because they are currently under review and add the codes to the HCPAC MPC list the next time it is reviewed.

V. HCPAC Work RVUs Rate of Acceptance by CMS

The HCPAC briefly discussed information provided by staff, tracking the CPT codes that the HCPAC has reviewed to date and if the HCPAC recommended values were accepted by CMS. The HCPAC is pleased with the participation of society advisors in the comprehensive review of surveys and feels that the implementation of pre-meeting review process is beneficial to presenters and HCPAC members.

AMA/Specialty Society RVS Update Committee
Somatic Nerve Injection (Tab 9) and Genicular Injection and RFA (Tab 10)
Facilitation Committee #2

Tabs 9 and 10

Members Present: Allan Anderson, MD (Chair), Margie Andreae, MD, James Blankenship, MD, David Hitzeman, DO, Doug Leahy, MD, Christopher Senkowski, MD, Ezequiel Silva, III, MD, Robert Zwolak, MD

Tab 9 Somatic Nerve Injection Recommendations:

The Facilitation Committee reviewed the somatic nerve injection family of services. The services which had not yet been discussed in detail by the RUC are shaded in the table below. The Facilitation Committee also confirmed that the physician times and work values would maintain appropriate rank order within the code family. The Committee agreed on the following recommendations:

CPT Code	Global	wRVU	Total Time	Pre Eval	Pre Pos	Pre SDW	Intra time	Immd Post	Rationale
64400	000	1.00	20	7	1	1	6	5	Intra-time reduced to 6 minutes, post-time reduced to 5 minutes, Work RVU of 1.00 from AAN 25 th percentile
64405	000	0.94	16	5	1		5	5	Affirmed April 2017 RUC Recommendation
64408	000	0.90	20	7	3		5	5	25 th percentile; Post- time reduced to 5 min
64415	000	1.42	40	13	1	4	12	10	25 th percentile; S/D/W reduced to 4 min
64416	000	1.81	49	13	1	5	20	10	25 th percentile
64417	000	1.27	38	13	1	4	10	10	25 th percentile; S/D/W reduced to 4 min
64418	000	1.10	32	6	3	3	10	10	Affirmed April 2016 RUC Recommendation; flag in RUC database for do not use
64420	000	1.18	39	13	1	5	10	5	Current value; Post-service time reduced to 5 min
64421	ZZZ	0.60	10				10		Direct work RVU crosswalk to 77063 <i>Screening breast tomosynthesis</i> (work RVU 0.60, intra-time 8)
64425	000	1.19	25	7	1	1	11	5	25 th percentile; Post- time reduced to 5 min
64430	000	1.15	43	13	5	5	10	10	25 th percentile
64435	000	0.75	20	7	3		5	5	25 th percentile
64445	000	1.18	29	7	1	1	10	10	Direct work RVU crosswalk to 67810 <i>Biopsy of Eyelid</i> (intra-time of 13, total time of 27)
64446	000	1.54	40	13	1	5	15	6	Direct work RVU crosswalk to 30903 <i>Control of Nose Bleed</i> (intra-time of 15, total of 39)
64447	000	1.10	27	12	1	3	6	5	Direct work RVU crosswalk to 31231 <i>Diagnostic Nasal Endoscopy</i> (intra-time 7, total time of 21).
64448	000	1.55	38	13	1	5	13	6	Direct work RVU crosswalk to 62322 <i>Interlaminar Lumbar or Sacral Injection w/o image guidance</i> (intra-time of 11, total of 39); ref code 57452 <i>Exam of cervix</i> (wRVU 1.50, intra 15, total 40)
64449	000	1.55	38	13	1	5	14	5	Direct work RVU crosswalk to 62322 <i>Interlaminar Lumbar or Sacral Injection w/o image guidance</i> (intra-time of 11, total of 39)
64450	000	0.75	19	7	1	1	5	5	Maintain current work RVU and maintain current intra-time and post-time

The Facilitation Committee also discussed the practice expense and noted that the change in intra-service time for codes 64400 and 64450 would need to also be made to the clinical labor time.

Tab 10 Genicular Injection and RFA Recommendations:

The advisory committee for tab 10 requested for codes 644X0, 64640 and 644X1 to receive interim valuation to enable them to resurvey these services. The specialties noted their concern that many survey respondents appeared to be confused about the number of nerve branch injections involved with these three codes. The Facilitation Committee supports the advisory committee request for these services to be valued as interim and for them to be resurveyed and presented at the January 2019 RUC meeting. The Committee agreed on the following recommendations:

CPT Code	Global	wRVU	Total Time	Pre Eval	Pre Pos	Pre SDW	Intra time	Immd Post	Post-Op Visits	Rationale
64450	000	0.75	19	7	1	1	5	5		Maintain current work RVU and maintain current intra-time and post-time
644X0	000	1.40	33	7	1	1	15	9		Interim Recommendation of 25th percentile work RVU and reduce the post-time to 9 min
64640	010	1.22	65	13	1	5	20	10	1 x 99212	Interim Recommendation; direct work RVU crosswalk to 17261 Destruction of Skin Lesions (wRVU 1.22, intra-time of 17, total time of 47)
644X1	010	2.10	65	13	1	5	20	10	1 x 99212	Interim Recommendation of 25th percentile work RVU

The Facilitation Committee also discussed the practice expense and noted that the change in intra-service time for codes 64450 would need to also be made to the clinical labor time.