

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2020
October 2018 Meeting**

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October 24, 2018

Seema Verma, MPH
Administrator
Center for Medicare
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: RUC Recommendations

Dear Administrator Verma:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) submits the enclosed recommendations for work relative values and direct practice expense inputs to the Centers for Medicare and Medicaid Services (CMS). These recommendations relate to new and revised codes for *CPT 2020*, as well as to existing services identified by the RUC's Relativity Assessment Workgroup and CMS.

Enclosed are the RUC recommendations for all the CPT codes reviewed at the October 3-6, 2018, RUC meeting.

CPT 2020 New and Revised Codes – October 2018 RUC Submission

The enclosed binder contains RUC recommendations, including those for new and revised CPT codes. The RUC considered 85 new/revised/related family CPT codes at the October 2018 meeting. The RUC submits work value and/or practice expense inputs for 72 new/revised/related family CPT codes from the October meeting.

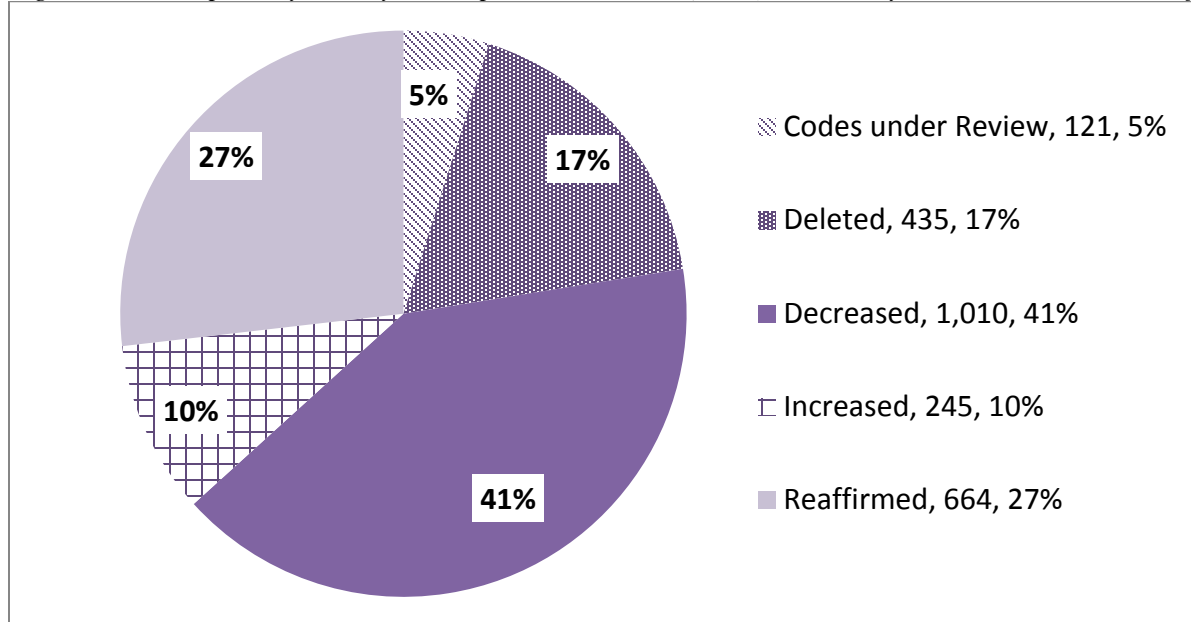
Existing Services Identified by RUC and CMS for Review

In addition to the new/revised CPT code submission, the RUC submits recommendations for 24 services identified by the RUC or CMS as potentially misvalued and reviewed at the October 2018 RUC meeting. The RUC recommends work relative values for 21 codes and direct practice expense inputs only for 3 codes. The HCPAC submits recommendations for 2 CPT codes identified by the *CMS Request - Audiology Services / High Volume Growth* screens.

RUC Progress in Identifying and Reviewing Potentially Misvalued Codes

Since 2006, the RUC has identified 2,475 potentially misvalued services through objective screening criteria and has completed review of 2,354 of these services. The RUC has recommended that over half of the services identified be decreased or deleted (Figure 1). The RUC has worked vigorously over the past several years to identify and address misvaluations in the RBRVS through provision of revised physician time data and resource recommendations to CMS. The RUC looks forward to working with CMS on a concerted effort to address potentially misvalued services. *A detailed report of the RUC's progress is appended to this letter.*

Figure 1: AMA/Specialty Society RVS Update Committee (RUC) Potentially Misvalued Services Project



Enclosed Recommendations and Supporting Materials:

Included in these binders and on the enclosed USB drive are:

- RUC Recommendation Status Report for New and Revised Codes
- RUC Recommendation Status Report for 2,475 services identified to date by the Relativity Assessment Workgroup and CMS as potentially misvalued. In addition, a spreadsheet containing the codes specific to this submission is included.
- RUC Referrals to the CPT Editorial Panel – both for CPT nomenclature revisions and *CPT Assistant* articles.
- Physician Time File: A list of the physician time data for each of the CPT codes reviewed at the October 2018 RUC meeting.
- Pre-Service and Post-Service Time Packages Definitions: The RUC developed physician pre-service and post-service time packages which have been incorporated into these recommendations. The intent of these packages is to streamline the RUC review process as well as create standard pre-service and post-service time data for all codes reviewed by the RUC.
- PLI Crosswalk Table: The RUC has committed to selecting appropriate professional liability insurance crosswalks for new and revised codes and existing codes under review. We have provided a PLI Crosswalk Table listing the reviewed code and its crosswalk code for easy reference. We hope that the provision of this table will assist CMS in reviewing and implementing the RUC recommendations.

- **BETOS Assignment Table:** The RUC, for each meeting, provides CMS with suggested BETOS classification assignments for new/revised codes. Furthermore, if an existing service is reviewed and the specialty believes the current assignment is incorrect, this table will reflect the desired change.
- **Source Code Utilization Crosswalk Table:** A table estimating the flow of claims data from existing codes to the new/revised codes. This information is used to project the work relative value savings to be included in the 2020 conversion factor increase.
- **New Technology List and Flow Chart:** In April 2006, the RUC adopted a process to identify and review codes that represent new technology or services that have the potential to change in value. To date, the RUC has identified 609 of these procedures through the review of new CPT codes. A table of these codes identified as new technology services and the date of review is enclosed, as well as a flow chart providing a detailed description of the process to be utilized to review these services.

We appreciate your consideration of these RUC recommendations. If you have any questions regarding the attached materials, please contact Sherry Smith at (312) 464-5604.

Sincerely,



Peter K. Smith, MD

Enclosures

cc: Nisha Bhat
Edith Hambrick, MD
Karen Nakano, MD
Marge Watchorn
Michael Soracoe
RUC Participants

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2020**

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CPT 2020 RUC and HCPAC Recommendations - October 2018

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
0002M	XXX	R	Sept 2018	31	Admin MAAA Liver Disease		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
0003M	XXX	R	Sept 2018	31	Admin MAAA Liver Disease		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
0011M	XXX	R	Sept 2018	32	Admin MAAA Prostate Cancer		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
00X0T	XXX	N	Sept 2018	57	CatIII Biomechanical Computed Tomography		CatIII						<input type="checkbox"/>		<input type="checkbox"/>
00X0T	XXX	N	Sept 2018	57	CatIII Biomechanical Computed Tomography		CatIII						<input type="checkbox"/>		<input type="checkbox"/>
00X0T	XXX	N	Sept 2018	57	CatIII Biomechanical Computed Tomography		CatIII						<input type="checkbox"/>		<input type="checkbox"/>
00X0T	XXX	N	Sept 2018	57	CatIII Biomechanical Computed Tomography		CatIII						<input type="checkbox"/>		<input type="checkbox"/>
00X0T	XXX	N	Sept 2018	57	CatIII Biomechanical Computed Tomography		CatIII						<input type="checkbox"/>		<input type="checkbox"/>
01X0T	XXX	N	Sept 2018	21	Continenence Device Procedures		January 2019						<input type="checkbox"/>		<input type="checkbox"/>
01X1T	XXX	N	Sept 2018	21	Continenence Device Procedures		January 2019						<input type="checkbox"/>		<input type="checkbox"/>
01X2T	XXX	N	Sept 2018	21	Continenence Device Procedures		January 2019						<input type="checkbox"/>		<input type="checkbox"/>
01X3T	XXX	N	Sept 2018	21	Continenence Device Procedures		January 2019						<input type="checkbox"/>		<input type="checkbox"/>
0249T	YYY	D	May 2018	19	Transanal Hemorrhoidal Dearterialization		October 2018	07					<input type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
0254T	YYY	D	Sept 2018	16	Iliac Branched Endograft Placement		January 2019						<input type="checkbox"/>		<input type="checkbox"/>
0358T	XXX	R	Sept 2018	50	Bioelectrical Impedance Analysis		CatIII						<input type="checkbox"/>		<input type="checkbox"/>
0399T	XXX	D	Sept 2018	52	Myocardial Strain Imaging		January 2019						<input type="checkbox"/>		<input type="checkbox"/>
0402T	XXX	R	Sept 2018	53	CatIII Collagen Cross-Linking of Cornea		Editorial						<input type="checkbox"/>		<input type="checkbox"/>
0482T	ZZZ	D	May 2018	28	Myocardial PET		January 2019	12					<input type="checkbox"/>		<input type="checkbox"/>
0X00T	XXX	N	Sept 2018	59	CatIII Transapical Mitral Valve Repair		CatIII						<input type="checkbox"/>		<input type="checkbox"/>
0X03T	XXX	N	Sept 2018	42	Low-Level Laser Therapy		CatIII						<input type="checkbox"/>		<input type="checkbox"/>
0X0XT	XXX	N	Sept 2018	60	CatIII Transcatheter Mitral and Tricuspid Valve Annulus Reconstruction		CatIII						<input type="checkbox"/>		<input type="checkbox"/>
0X1XT	XXX	N	Sept 2018	60	CatIII Transcatheter Mitral and Tricuspid Valve Annulus Reconstruction		CatIII						<input type="checkbox"/>		<input type="checkbox"/>
0XX0T	XXX	N	Sept 2018	56	CatIII Arteriovenous Anastomosis Implant Placement		CatIII						<input type="checkbox"/>		<input type="checkbox"/>
0XXXT	XXX	N	Sept 2018	11	Cat III Touch Biopsy, Bone		CatIII						<input type="checkbox"/>		<input type="checkbox"/>
0XXXT	XXX	N	Sept 2018	10	Radiofrequency Spectroscopy Mastectomy Margin Assessment		CatIII						<input type="checkbox"/>		<input type="checkbox"/>
11980	000	F	May 2018	10	Drug Delivery Implant Procedures	C1	October 2018	05	AUA, ACOG	1.10	1.10	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
11981	XXX	F	May 2018	10	Drug Delivery Implant Procedures	C2	October 2018	05	AUA, ACOG	1.30	1.30		<input checked="" type="checkbox"/>		<input type="checkbox"/>
11982	XXX	F	May 2018	10	Drug Delivery Implant Procedures	C3	October 2018	05	AUA, ACOG	1.70	1.70		<input checked="" type="checkbox"/>		<input type="checkbox"/>
11983	XXX	F	May 2018	10	Drug Delivery Implant Procedures	C4	October 2018	05	AUA, ACOG	2.10	2.10		<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
15X00	090	N	May 2018	12	Tissue Grafting Procedures	B1	October 2018	04	AAOHNS, ASPS	6.68	6.68		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
15X01	090	N	May 2018	12	Tissue Grafting Procedures	B2	October 2018	04	ASPS	6.73	6.73		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
15X02	ZZZ	N	May 2018	12	Tissue Grafting Procedures	B3	October 2018	04	ASPS	2.50	2.50		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
15X03	090	N	May 2018	12	Tissue Grafting Procedures	B4	October 2018	04	ASPS	6.83	6.83		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
15X04	ZZZ	N	May 2018	12	Tissue Grafting Procedures	B5	October 2018	04	ASPS	2.41	2.41		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
19260	090	D	May 2018	08	Breast and Chest Wall Procedures		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
19271	090	D	May 2018	08	Breast and Chest Wall Procedures		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
19272	090	D	May 2018	08	Breast and Chest Wall Procedures		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
19304	090	D	May 2018	08	Breast and Chest Wall Procedures		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
1XXXT	XXX	N	Sept 2018	61	CatIII Anatomic Modeling-3D Printing		CatIII						<input type="checkbox"/>		<input type="checkbox"/>
205X1	XXX	N	Sept 2018	44/45	Trigger Point Acupuncture/ Dry Needling	N1	January 2019		ACA, AAPM&R, APTA, NASS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
205X2	XXX	N	Sept 2018	44/45	Trigger Point Acupuncture/ Dry Needling	N2	January 2019		ACA, AAPM&R, APTA, NASS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
206X0	ZZZ	N	May 2018	10	Drug Delivery Implant Procedures	C5	October 2018	05	AAOS	2.00	1.50		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
206X1	ZZZ	N	May 2018	10	Drug Delivery Implant Procedures	C7	October 2018	05	AAOS	3.25	2.50		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
206X2	ZZZ	N	May 2018	10	Drug Delivery Implant Procedures	C9	October 2018	05	AAOS	4.00	2.60		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
206X3	ZZZ	N	May 2018	10	Drug Delivery Implant Procedures	C6	October 2018	05	AAOS	1.13	1.13		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
206X4	ZZZ	N	May 2018	10	Drug Delivery Implant Procedures	C8	October 2018	05	AAOS	1.80	1.80		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
206X5	ZZZ	N	May 2018	10	Drug Delivery Implant Procedures	C10	October 2018	05	AAOS	2.15	2.15		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
20926	090	D	May 2018	12	Tissue Grafting Procedures		October 2018	04					<input checked="" type="checkbox"/>		<input type="checkbox"/>
2XXX0	090	N	May 2018	08	Breast and Chest Wall Procedures		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
2XXX1	090	N	May 2018	08	Breast and Chest Wall Procedures		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
2XXX2	090	N	May 2018	08	Breast and Chest Wall Procedures		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
2XXXT	ZZZ	N	Sept 2018	61	CatIII Anatomic Modeling-3D Printing		CatIII						<input type="checkbox"/>		<input type="checkbox"/>
31233	000	R	May 2018	13	Nasal Sinus Endoscopy		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
31235	000	R	May 2018	13	Nasal Sinus Endoscopy		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
31292	010	R	May 2018	13	Nasal Sinus Endoscopy		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
31293	010	R	May 2018	13	Nasal Sinus Endoscopy		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
31294	010	R	May 2018	13	Nasal Sinus Endoscopy		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
31295	000	R	May 2018	13	Nasal Sinus Endoscopy		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
31296	000	R	May 2018	13	Nasal Sinus Endoscopy		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
31297	000	R	May 2018	13	Nasal Sinus Endoscopy		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
31298	000	R	May 2018	13	Nasal Sinus Endoscopy		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
33010	000	D	Sept 2018	14	Pericardiocentesis and Pericardial Drainage		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>
33011	000	D	Sept 2018	14	Pericardiocentesis and Pericardial Drainage		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>
33015	000	D	Sept 2018	14	Pericardiocentesis and Pericardial Drainage		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>
33860	090	D	May 2018	17	Aortic Graft Procedures		October 2018	06					<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
33863	090	F	May 2018	17	Aortic Graft Procedures	D3	October 2018	06	STS, AATS	59.00	59.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
33864	090	F	May 2018	17	Aortic Graft Procedures	D4	October 2018	06	STS, AATS	63.00	63.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
33870	090	D	May 2018	17	Aortic Graft Procedures		October 2018	06					<input checked="" type="checkbox"/>		<input type="checkbox"/>
338X1	090	N	May 2018	17	Aortic Graft Procedures	D2	October 2018	06	STS, AATS	50.00	50.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
338X2	090	N	May 2018	17	Aortic Graft Procedures	D6	October 2018	06	STS, AATS	65.75	65.75		<input checked="" type="checkbox"/>		<input type="checkbox"/>
338XX	090	N	May 2018	17	Aortic Graft Procedures	D1	October 2018	06	STS, AATS	65.00	65.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
33X01	ZZZ	F	May 2018	17	Aortic Graft Procedures	D5	October 2018	06	STS, AATS	19.74	17.75		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
33X06	XXX	R	Sept 2018	13	Leadless Pacemaker		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
34X00	ZZZ	N	Sept 2018	16	Iliac Branched Endograft Placement	P1	January 2019		SIR, SVS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
34X01	090	N	Sept 2018	16	Iliac Branched Endograft Placement	P2	January 2019		SIR, SVS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
35701	090	R	Sept 2018	17	Exploration of Major Artery	Q1	January 2019		SVS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
35721	090	D	Sept 2018	17	Exploration of Major Artery		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>
35741	090	D	Sept 2018	17	Exploration of Major Artery		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>
35761	090	D	Sept 2018	17	Exploration of Major Artery		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>
35X00	090	N	Sept 2018	17	Exploration of Major Artery	Q2	January 2019		SVS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
35X01	090	N	Sept 2018	17	Exploration of Major Artery	Q3	January 2019		SVS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
3X000	000	N	Sept 2018	14	Pericardiocentesis and Pericardial Drainage	O1	January 2019		ACC, SCAI				<input checked="" type="checkbox"/>		<input type="checkbox"/>
3X001	000	N	Sept 2018	14	Pericardiocentesis and Pericardial Drainage	O2	January 2019		ACC, SCAI				<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
3X002	000	N	Sept 2018	14	Pericardiocentesis and Pericardial Drainage	O3	January 2019		ACC, SCAI				<input checked="" type="checkbox"/>		<input type="checkbox"/>
3X003	000	N	Sept 2018	14	Pericardiocentesis and Pericardial Drainage	O4	January 2019		ACC, ACR, SIR, SCAI				<input checked="" type="checkbox"/>		<input type="checkbox"/>
3XXX	XXX	N	Sept 2018	61	CatIII Anatomic Modeling-3D Printing		CatIII						<input type="checkbox"/>		<input type="checkbox"/>
46945	090	R	May 2018	19	Transanal Hemorrhoidal Dearterialization	E1	October 2018	07	ACS, ASCRS	3.69	3.69		<input checked="" type="checkbox"/>		<input type="checkbox"/>
46946	090	R	May 2018	19	Transanal Hemorrhoidal Dearterialization	E2	October 2018	07	ACS, ASCRS	4.50	4.50		<input checked="" type="checkbox"/>		<input type="checkbox"/>
46X48	090	N	May 2018	19	Transanal Hemorrhoidal Dearterialization	E3	October 2018	07	ACS, ASCRS	5.57	5.57		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
490X1	000	N	May 2018	20	Preperitoneal Pelvic Packing	F1	October 2018	08	ACS	8.35	8.35		<input checked="" type="checkbox"/>		<input type="checkbox"/>
490X2	000	N	May 2018	20	Preperitoneal Pelvic Packing	F2	October 2018	08	ACS	6.73	6.73		<input checked="" type="checkbox"/>		<input type="checkbox"/>
4XXX	ZZZ	N	Sept 2018	61	CatIII Anatomic Modeling-3D Printing		CatIII						<input type="checkbox"/>		<input type="checkbox"/>
54640	090	R	Sept 2018	22	Orchiopexy, Inguinal Approach	R1	January 2019		AUA, APSA				<input checked="" type="checkbox"/>		<input type="checkbox"/>
62270	000	R	Sept 2018	24	Lumbar Puncture	T1	January 2019		ACR, ASNR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
62272	000	R	Sept 2018	24	Lumbar Puncture	T3	January 2019		ACR, ASNR, AANS/CNS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
622X0	000	N	Sept 2018	24	Lumbar Puncture	T2	January 2019		ACR, ASNR, SIR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
622X1	000	N	Sept 2018	24	Lumbar Puncture	T4	January 2019		ACR, ASNR, SIR, AANS/CNS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
64400	000	R	May 2018	24	Somatic Nerve Injection	H1	October 2018	9	AAN, ASA	1.14	1.00		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64402	000	D	May 2018	24	Somatic Nerve Injection		October 2018	9					<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
64405	000	R	May 2018	24	Somatic Nerve Injection	H2	October 2018	9	AAN, AAPM&R, AAPM, ASA	0.94	0.94	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
64408	000	R	May 2018	24	Somatic Nerve Injection	H3	October 2018	9	AAOHNS	0.94	0.90		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64410	000	D	May 2018	24	Somatic Nerve Injection		October 2018	9					<input checked="" type="checkbox"/>		<input type="checkbox"/>
64413	000	D	May 2018	24	Somatic Nerve Injection		October 2018	9					<input checked="" type="checkbox"/>		<input type="checkbox"/>
64415	000	R	May 2018	24	Somatic Nerve Injection	H4	October 2018	9	ASA	1.42	1.42		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64416	000	R	May 2018	24	Somatic Nerve Injection	H5	October 2018	9	ASA	1.81	1.81	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
64417	000	R	May 2018	24	Somatic Nerve Injection	H6	October 2018	9	ASA	1.27	1.27		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64418	000	R	May 2018	24	Somatic Nerve Injection	H7	October 2018	9	AAPM&R, ASA	1.20	1.10	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
64420	000	R	May 2018	24	Somatic Nerve Injection	H8	October 2018	9	AAPM&R, AAPM, ASA	1.24	1.18		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64421	ZZZ	R	May 2018	24	Somatic Nerve Injection	H9	October 2018	9	AAPM&R, AAPM, ASA	0.60	0.60		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64425	000	R	May 2018	24	Somatic Nerve Injection	H10	October 2018	9	AAPM&R, AAPM, ASA	1.19	1.19		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64430	000	R	May 2018	24	Somatic Nerve Injection	H11	October 2018	9	ACOG, AAPM, ASA	1.15	1.15		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64435	000	R	May 2018	24	Somatic Nerve Injection	H12	October 2018	9	ACOG	0.75	0.75		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64445	000	R	May 2018	24	Somatic Nerve Injection	H13	October 2018	9	AAPM&R, ASA	1.47	1.30		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64446	000	R	May 2018	24	Somatic Nerve Injection	H14	October 2018	9	ASA	1.80	1.54		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64447	000	R	May 2018	24	Somatic Nerve Injection	H15	October 2018	9	ASA	1.40	1.10		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64448	000	R	May 2018	24	Somatic Nerve Injection	H16	October 2018	9	ASA	1.78	1.55		<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
64449	000	R	May 2018	24	Somatic Nerve Injection	H17	October 2018	9	ASA	1.80	1.55		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64450	000	F	May 2018	23	Genicular Injection and RFA	H18	January 2019	10	AAPM&R, AAPM, SIS, ASA				<input checked="" type="checkbox"/>		<input type="checkbox"/>
64450	000	R	May 2018	24	Somatic Nerve Injection	H18	October 2018	9	AAN, AAPM&R, AAPM, ASA	0.84	0.75		<input checked="" type="checkbox"/>		<input type="checkbox"/>
64640	010	F	May 2018	23	Genicular Injection and RFA	G2	January 2019	10	AAPM&R, AAPM, SIS, ASA				<input checked="" type="checkbox"/>		<input type="checkbox"/>
64XX0	000	N	May 2018	23	Genicular Injection and RFA	G1	January 2019	10	AAPM&R, AAPM, SIS, ASA				<input checked="" type="checkbox"/>		<input type="checkbox"/>
64XX1	010	N	May 2018	23	Genicular Injection and RFA	G3	January 2019	10	AAPM&R, AAPM, SIS, ASA				<input checked="" type="checkbox"/>		<input type="checkbox"/>
66711	090	R	May 2018	26	Cyclophotocoagulation	I1	January 2019		AAO, ASCRS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
66982	090	R	May 2018	26	Cyclophotocoagulation	I2	January 2019		AAO, ASCRS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
66983	090	F	May 2018	26	Cyclophotocoagulation	I4	January 2019		AAO, ASCRS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
66984	090	R	May 2018	26	Cyclophotocoagulation	I5	January 2019		AAO, ASCRS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
66X01	090	N	May 2018	26	Cyclophotocoagulation	I3	January 2019		AAO, ASCRS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
66X02	090	N	May 2018	26	Cyclophotocoagulation	I6	January 2019		AAO, ASCRS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
6XX00	000	N	Sept 2018	25	Radiofrequency Neurotomy Sacrioliac Joint	S1	January 2019		ASA, ASIPP, AAPM, NANS, AAPM&R, SIS, NASS				<input checked="" type="checkbox"/>		<input type="checkbox"/>
6XX01	010	N	Sept 2018	25	Radiofrequency Neurotomy Sacrioliac Joint	S2	January 2019		ASA, ASIPP, AAPM, NANS, AAPM&R, SIS, NASS				<input checked="" type="checkbox"/>		<input type="checkbox"/>

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74210	XXX	R	May 2018	27	Gastrointestinal Tract Imaging	J1	January 2019		ACR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
74220	XXX	R	May 2018	27	Gastrointestinal Tract Imaging	J2	January 2019		ACR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
74230	XXX	R	May 2018	27	Gastrointestinal Tract Imaging	J4	January 2019		ACR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
74240	XXX	R	May 2018	27	Gastrointestinal Tract Imaging	J5	January 2019		ACR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
74241	XXX	D	May 2018	27	Gastrointestinal Tract Imaging		October 2018	11					<input checked="" type="checkbox"/>		<input type="checkbox"/>
74245	XXX	D	May 2018	27	Gastrointestinal Tract Imaging		October 2018	11					<input checked="" type="checkbox"/>		<input type="checkbox"/>
74246	XXX	R	May 2018	27	Gastrointestinal Tract Imaging	J6	January 2019		ACR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
74247	XXX	D	May 2018	27	Gastrointestinal Tract Imaging		October 2018	11					<input checked="" type="checkbox"/>		<input type="checkbox"/>
74249	XXX	D	May 2018	27	Gastrointestinal Tract Imaging		October 2018	11					<input checked="" type="checkbox"/>		<input type="checkbox"/>
74250	XXX	R	May 2018	27	Gastrointestinal Tract Imaging	J8	October 2018	11	ACR	0.81	0.81		<input checked="" type="checkbox"/>		<input type="checkbox"/>
74251	XXX	R	May 2018	27	Gastrointestinal Tract Imaging	J9	October 2018	11	ACR	1.17	1.17		<input checked="" type="checkbox"/>		<input type="checkbox"/>
74260	XXX	D	May 2018	27	Gastrointestinal Tract Imaging		October 2018	11					<input checked="" type="checkbox"/>		<input type="checkbox"/>
74270	XXX	R	May 2018	27	Gastrointestinal Tract Imaging	J10	October 2018	11	ACR	1.04	1.04		<input checked="" type="checkbox"/>		<input type="checkbox"/>
74280	XXX	R	May 2018	27	Gastrointestinal Tract Imaging	J11	October 2018	11	ACR	1.26	1.26		<input checked="" type="checkbox"/>		<input type="checkbox"/>
74X00	XXX	N	May 2018	27	Gastrointestinal Tract Imaging	J3	January 2019		ACR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
74X01	ZZZ	N	May 2018	27	Gastrointestinal Tract Imaging	J7	January 2019		ACR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
76930	XXX	D	Sept 2018	14	Pericardiocentesis and Pericardial Drainage		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>
77061	XXX	R	Sept 2018	EC-I	Breast Tomosynthesis		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
77062	XXX	R	Sept 2018	EC-I	Breast Tomosynthesis		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>

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78205	XXX	D	Sept 2018	26	SPECT-CT Procedures		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>
78206	XXX	D	Sept 2018	26	SPECT-CT Procedures		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>
78320	XXX	D	Sept 2018	26	SPECT-CT Procedures		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>
78459	XXX	R	May 2018	28	Myocardial PET	K1	January 2019	12	SNMMI, ACNM, ACC, ACR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
78491	XXX	R	May 2018	28	Myocardial PET	K3	January 2019	12	SNMMI, ACNM, ACC, ACR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
78492	XXX	R	May 2018	28	Myocardial PET	K5	January 2019	12	SNMMI, ACNM, ACC, ACR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
78607	XXX	D	Sept 2018	26	SPECT-CT Procedures		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>
78647	XXX	D	Sept 2018	26	SPECT-CT Procedures		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>
78710	XXX	D	Sept 2018	26	SPECT-CT Procedures		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>
78800	XXX	R	Sept 2018	26	SPECT-CT Procedures	U1	January 2019		ACR, SNMMI, ACNM				<input checked="" type="checkbox"/>		<input type="checkbox"/>
78801	XXX	R	Sept 2018	26	SPECT-CT Procedures	U2	January 2019		ACR, SNMMI, ACNM				<input checked="" type="checkbox"/>		<input type="checkbox"/>
78802	XXX	R	Sept 2018	26	SPECT-CT Procedures	U3	January 2019		ACR, SNMMI, ACNM				<input checked="" type="checkbox"/>		<input type="checkbox"/>
78803	XXX	R	Sept 2018	26	SPECT-CT Procedures	U4	January 2019		ACR, SNMMI, ACNM				<input checked="" type="checkbox"/>		<input type="checkbox"/>
78804	XXX	R	Sept 2018	26	SPECT-CT Procedures	U5	January 2019		ACR, SNMMI, ACNM				<input checked="" type="checkbox"/>		<input type="checkbox"/>
78805	XXX	D	Sept 2018	26	SPECT-CT Procedures		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>
78806	XXX	D	Sept 2018	26	SPECT-CT Procedures		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
78807	XXX	D	Sept 2018	26	SPECT-CT Procedures		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>
788X0	XXX	N	Sept 2018	26	SPECT-CT Procedures	U6	January 2019		ACR, SNMMI, ACNM				<input checked="" type="checkbox"/>		<input type="checkbox"/>
788X1	XXX	N	Sept 2018	26	SPECT-CT Procedures	U7	January 2019		ACR, SNMMI, ACNM				<input checked="" type="checkbox"/>		<input type="checkbox"/>
788X2	XXX	N	Sept 2018	26	SPECT-CT Procedures	U8	January 2019		ACR, SNMMI, ACNM				<input checked="" type="checkbox"/>		<input type="checkbox"/>
788X3	ZZZ	N	Sept 2018	26	SPECT-CT Procedures	U9	January 2019		ACR, SNMMI, ACNM				<input checked="" type="checkbox"/>		<input type="checkbox"/>
78X29	XXX	N	May 2018	28	Myocardial PET	K2	January 2019	12	SNMMI, ACNM, ACC, ACR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
78X31	XXX	N	May 2018	28	Myocardial PET	K4	January 2019	12	SNMMI, ACNM, ACC, ACR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
78X32	XXX	N	May 2018	28	Myocardial PET	K6	January 2019	12	SNMMI, ACNM, ACC, ACR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
78X33	XXX	N	May 2018	28	Myocardial PET	K7	January 2019	12	SNMMI, ACNM, ACC, ACR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
78X34	XXX	N	May 2018	28	Myocardial PET	K8	January 2019	12	SNMMI, ACNM, ACC, ACR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
78X35	ZZZ	N	May 2018	28	Myocardial PET	K9	January 2019	12	SNMMI, ACNM, ACC, ACR				<input checked="" type="checkbox"/>		<input type="checkbox"/>
8XX03	XXX	N	Sept 2018	30	MAAA-Uveal Melanoma		CLFS						<input type="checkbox"/>		<input type="checkbox"/>
90734	XXX	R	Sept 2018	33	Meningococcal Vaccine		Vaccine						<input type="checkbox"/>		<input type="checkbox"/>
907XX	XXX	N	Sept 2018	33	Meningococcal Vaccine		Vaccine						<input type="checkbox"/>		<input type="checkbox"/>
908XX	000	N	Sept 2018	34	Biofeedback Training	V1	January 2019		AUA, ACOG				<input checked="" type="checkbox"/>		<input type="checkbox"/>
90911	000	D	Sept 2018	34	Biofeedback Training		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>

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909XX	ZZZ	N	Sept 2018	34	Biofeedback Training	V2	January 2019		AUA, ACOG				<input checked="" type="checkbox"/>		<input type="checkbox"/>
92225	XXX	D	Feb 2018	22	Ophthalmoscopy		April 2018	05					<input checked="" type="checkbox"/>		<input type="checkbox"/>
92226	XXX	D	Feb 2018	22	Ophthalmoscopy		April 2018	05					<input checked="" type="checkbox"/>		<input type="checkbox"/>
92548	XXX	R	Sept 2018	35	Computerized Dynamic Posturography	W1	January 2019		AAOHNS, ASHA, AAA, ACP, AAN				<input checked="" type="checkbox"/>		<input type="checkbox"/>
92626	XXX	R	May 2018	34	Auditory Function Evaluation	L1	October 2018	HCPAC	AAA, ASHA	1.40	1.40	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
92627	ZZZ	R	May 2018	34	Auditory Function Evaluation	L2	October 2018	HCPAC	AAA, ASHA	0.33	0.33	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
92X18	XXX	N	Feb 2018	22	Ophthalmoscopy	A1	April 2018	05	AAO, AOA, ASRS	0.40	0.40		<input checked="" type="checkbox"/>		<input type="checkbox"/>
92X19	XXX	N	Feb 2018	22	Ophthalmoscopy	A2	April 2018	05	AAO, AOA, ASRS	0.26	0.26		<input checked="" type="checkbox"/>		<input type="checkbox"/>
92XX0	XXX	N	Sept 2018	35	Computerized Dynamic Posturography	W2	January 2019		AAOHNS, ASHA, AAA, ACP				<input checked="" type="checkbox"/>		<input type="checkbox"/>
933X0	ZZZ	N	Sept 2018	52	Myocardial Strain Imaging	Y1	January 2019		ASE, ACC				<input checked="" type="checkbox"/>		<input type="checkbox"/>
93784	XXX	R	Sept 2018	07	Self-Measured Blood Pressure Monitoring	BB3	January 2019		AGS, ACC, ACP				<input checked="" type="checkbox"/>		<input type="checkbox"/>
93786	XXX	R	Sept 2018	07	Self-Measured Blood Pressure Monitoring	BB4	January 2019		AGS, ACC, ACP				<input checked="" type="checkbox"/>		<input type="checkbox"/>
93788	XXX	R	Sept 2018	07	Self-Measured Blood Pressure Monitoring	BB5	January 2019		AGS, ACC, ACP				<input checked="" type="checkbox"/>		<input type="checkbox"/>
93790	XXX	R	Sept 2018	07	Self-Measured Blood Pressure Monitoring	BB6	January 2019		AGS, ACC, ACP				<input checked="" type="checkbox"/>		<input type="checkbox"/>
93X00	XXX	N	Sept 2018	36	Duplex Scan Arterial Inflow-Venous Outflow Upper Extremity	X1	January 2019		ACR, SVS, RPA				<input checked="" type="checkbox"/>		<input type="checkbox"/>

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93X01	XXX	N	Sept 2018	36	Duplex Scan Arterial Inflow-Venous Outflow Upper Extremity	X2	January 2019		ACR, SVS, RPA				<input checked="" type="checkbox"/>		<input type="checkbox"/>
94728	XXX	R	Sept 2018	37	Airway Resistance		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
95812	XXX	F	May 2018	35	Long-Term EEG Monitoring	M1	October 2018	13	ACNS, AAN	1.08	1.08	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
95813	XXX	R	May 2018	35	Long-Term EEG Monitoring	M2	October 2018	13	ACNS, AAN	1.63	1.63	Yes	<input checked="" type="checkbox"/>		<input type="checkbox"/>
95827	XXX	D	May 2018	35	Long-Term EEG Monitoring		October 2018	13					<input checked="" type="checkbox"/>		<input type="checkbox"/>
95831	XXX	D	Sept 2018	39	Manual Muscle Testing		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>
95832	XXX	D	Sept 2018	39	Manual Muscle Testing		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>
95833	XXX	D	Sept 2018	39	Manual Muscle Testing		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>
95834	XXX	D	Sept 2018	39	Manual Muscle Testing		January 2019						<input checked="" type="checkbox"/>		<input type="checkbox"/>
95950	XXX	D	May 2018	35	Long-Term EEG Monitoring		October 2018	13					<input checked="" type="checkbox"/>		<input type="checkbox"/>
95951	XXX	D	May 2018	35	Long-Term EEG Monitoring		October 2018	13					<input checked="" type="checkbox"/>		<input type="checkbox"/>
95953	XXX	D	May 2018	35	Long-Term EEG Monitoring		October 2018	13					<input checked="" type="checkbox"/>		<input type="checkbox"/>
95956	XXX	D	May 2018	35	Long-Term EEG Monitoring		October 2018	13					<input checked="" type="checkbox"/>		<input type="checkbox"/>
95X01	XXX	N	May 2018	35	Long-Term EEG Monitoring	M3	October 2018	13	ACNS, AAN				<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X02	XXX	N	May 2018	35	Long-Term EEG Monitoring	M4	October 2018	13	ACNS, AAN				<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X03	XXX	N	May 2018	35	Long-Term EEG Monitoring	M5	October 2018	13	ACNS, AAN				<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X04	XXX	N	May 2018	35	Long-Term EEG Monitoring	M6	October 2018	13	ACNS, AAN				<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X05	XXX	N	May 2018	35	Long-Term EEG Monitoring	M7	October 2018	13	ACNS, AAN				<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X06	XXX	N	May 2018	35	Long-Term EEG Monitoring	M8	October 2018	13	ACNS, AAN				<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>

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95X07	XXX	N	May 2018	35	Long-Term EEG Monitoring	M9	October 2018	13	ACNS, AAN				<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X08	XXX	N	May 2018	35	Long-Term EEG Monitoring	M10	October 2018	13	ACNS, AAN				<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X09	XXX	N	May 2018	35	Long-Term EEG Monitoring	M11	October 2018	13	ACNS, AAN				<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X10	XXX	N	May 2018	35	Long-Term EEG Monitoring	M12	October 2018	13	ACNS, AAN				<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X11	XXX	N	May 2018	35	Long-Term EEG Monitoring	M13	October 2018	13	ACNS, AAN				<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X12	XXX	N	May 2018	35	Long-Term EEG Monitoring	M14	October 2018	13	ACNS, AAN				<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X13	XXX	N	May 2018	35	Long-Term EEG Monitoring	M15	October 2018	13	ACNS, AAN				<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X14	XXX	N	May 2018	35	Long-Term EEG Monitoring	M16	October 2018	13	ACNS, AAN	2.00	2.00		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X15	XXX	N	May 2018	35	Long-Term EEG Monitoring	M17	October 2018	13	ACNS, AAN	3.00	2.50		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X16	XXX	N	May 2018	35	Long-Term EEG Monitoring	M18	October 2018	13	ACNS, AAN	3.00	3.00		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X17	XXX	N	May 2018	35	Long-Term EEG Monitoring	M19	October 2018	13	ACNS, AAN	4.50	3.86		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X18	XXX	N	May 2018	35	Long-Term EEG Monitoring	M20	October 2018	13	ACNS, AAN	3.86	3.86		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X19	XXX	N	May 2018	35	Long-Term EEG Monitoring	M21	October 2018	13	ACNS, AAN	4.70	4.70		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X20	XXX	N	May 2018	35	Long-Term EEG Monitoring	M22	October 2018	13	ACNS, AAN	4.75	4.75		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X21	XXX	N	May 2018	35	Long-Term EEG Monitoring	M23	October 2018	13	ACNS, AAN	6.00	6.00		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X22	XXX	N	May 2018	35	Long-Term EEG Monitoring	M24	October 2018	13	ACNS, AAN	6.50	5.40		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
95X23	XXX	N	May 2018	35	Long-Term EEG Monitoring	M25	October 2018	13	ACNS, AAN	7.58	7.58		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
96150	XXX	D	Sept 2018	40	Health and Behavior Assessment Intervention		January 2019	HCPAC					<input checked="" type="checkbox"/>		<input type="checkbox"/>
96151	XXX	D	Sept 2018	40	Health and Behavior Assessment Intervention		January 2019	HCPAC					<input checked="" type="checkbox"/>		<input type="checkbox"/>

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96152	XXX	D	Sept 2018	40	Health and Behavior Assessment Intervention		January 2019	HCPAC					<input checked="" type="checkbox"/>		<input type="checkbox"/>
96153	XXX	D	Sept 2018	40	Health and Behavior Assessment Intervention		January 2019	HCPAC					<input checked="" type="checkbox"/>		<input type="checkbox"/>
96154	XXX	D	Sept 2018	40	Health and Behavior Assessment Intervention		January 2019	HCPAC					<input checked="" type="checkbox"/>		<input type="checkbox"/>
96155	XXX	D	Sept 2018	40	Health and Behavior Assessment Intervention		January 2019	HCPAC					<input checked="" type="checkbox"/>		<input type="checkbox"/>
961X0	XXX	N	Sept 2018	40	Health and Behavior Assessment Intervention	Z1	January 2019	HCPAC	APA				<input checked="" type="checkbox"/>		<input type="checkbox"/>
961X1	XXX	N	Sept 2018	40	Health and Behavior Assessment Intervention	Z2	January 2019	HCPAC	APA				<input checked="" type="checkbox"/>		<input type="checkbox"/>
961X2	ZZZ	N	Sept 2018	40	Health and Behavior Assessment Intervention	Z3	January 2019	HCPAC	APA				<input checked="" type="checkbox"/>		<input type="checkbox"/>
961X3	XXX	N	Sept 2018	40	Health and Behavior Assessment Intervention	Z4	January 2019	HCPAC	APA				<input checked="" type="checkbox"/>		<input type="checkbox"/>
961X4	ZZZ	N	Sept 2018	40	Health and Behavior Assessment Intervention	Z5	January 2019	HCPAC	APA				<input checked="" type="checkbox"/>		<input type="checkbox"/>
961X5	XXX	N	Sept 2018	40	Health and Behavior Assessment Intervention	Z6	January 2019	HCPAC	APA				<input checked="" type="checkbox"/>		<input type="checkbox"/>
961X6	ZZZ	N	Sept 2018	40	Health and Behavior Assessment Intervention	Z7	January 2019	HCPAC	APA				<input checked="" type="checkbox"/>		<input type="checkbox"/>
961X7	XXX	N	Sept 2018	40	Health and Behavior Assessment Intervention	Z8	January 2019	HCPAC	APA				<input checked="" type="checkbox"/>		<input type="checkbox"/>
961X8	ZZZ	N	Sept 2018	40	Health and Behavior Assessment Intervention	Z9	January 2019	HCPAC	APA				<input checked="" type="checkbox"/>		<input type="checkbox"/>
97127	XXX	R	Sept 2018	43	Cognitive Function Intervention	AA1	January 2019	HCPAC	APA, ASHA				<input checked="" type="checkbox"/>		<input type="checkbox"/>

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97153	XXX	R	Sept 2018	EC-H	Adaptive Behavior Treatment		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
97155	XXX	R	Sept 2018	EC-H	Adaptive Behavior Treatment		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
98969	XXX	D	Sept 2018	06	Online Digital Evaluation Service (e-Visit)		January 2019						<input type="checkbox"/>		<input type="checkbox"/>
98X00	XXX	N	Sept 2018	06	Online Digital Evaluation Service (e-Visit)	DD4	January 2019		AGS, AAP, AND, ACP				<input checked="" type="checkbox"/>		<input type="checkbox"/>
98X01	XXX	N	Sept 2018	06	Online Digital Evaluation Service (e-Visit)	DD5	January 2019		AGS, AAP, AND, ACP				<input checked="" type="checkbox"/>		<input type="checkbox"/>
98X02	XXX	N	Sept 2018	06	Online Digital Evaluation Service (e-Visit)	DD6	January 2019		AGS, AAP, AND, ACP				<input checked="" type="checkbox"/>		<input type="checkbox"/>
99444	XXX	D	Sept 2018	06	Online Digital Evaluation Service (e-Visit)		January 2019						<input type="checkbox"/>		<input type="checkbox"/>
99483	XXX	R	Sept 2018	EC-G	Psychological and Neuropsychological Test Administration		Editorial						<input checked="" type="checkbox"/>		<input type="checkbox"/>
994X0	ZZZ	N	Sept 2018	08	Remote Physiologic Monitoring	CC2	January 2019		AGS, ACC, ACP				<input checked="" type="checkbox"/>		<input type="checkbox"/>
994X9	XXX	R	Sept 2018	08	Remote Physiologic Monitoring	CC1	January 2019		AGS, ACC, ACP				<input checked="" type="checkbox"/>		<input type="checkbox"/>
99X01	XXX	N	Sept 2018	07	Self-Measured Blood Pressure Monitoring	BB1	January 2019		AGS, ACC, ACP				<input checked="" type="checkbox"/>		<input type="checkbox"/>
99X02	XXX	N	Sept 2018	07	Self-Measured Blood Pressure Monitoring	BB2	January 2019		AGS, ACC, ACP				<input checked="" type="checkbox"/>		<input type="checkbox"/>
9X0X1	XXX	N	Sept 2018	06	Online Digital Evaluation Service (e-Visit)	DD1	January 2019		AGS, AAP, AND, ACP, AAFF				<input checked="" type="checkbox"/>		<input type="checkbox"/>
9X0X2	XXX	N	Sept 2018	06	Online Digital Evaluation Service (e-Visit)	DD2	January 2019		AGS, AAP, AND, ACP				<input checked="" type="checkbox"/>		<input type="checkbox"/>
9X0X3	XXX	N	Sept 2018	06	Online Digital Evaluation Service (e-Visit)	DD3	January 2019		AGS, AAP, AND, ACP, AAFF				<input checked="" type="checkbox"/>		<input type="checkbox"/>

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
9XXX0	ZZZ	N	Sept 2018	43	Cognitive Function Intervention	AA2	January 2019	HCPAC	APA, ASHA				<input checked="" type="checkbox"/>		<input type="checkbox"/>
G0365	XXX	D	Sept 2018	36	Duplex Scan Arterial Inflow-Venous Outflow Upper Extremity		January 2019						<input type="checkbox"/>		<input type="checkbox"/>

RUC Recommendations for CMS Requests & Relativity Assessment Identified Codes October 2018

CPT Code	2018 Long Descriptor	Issue	RUC Recommendation	Codes Reported Together 75% or More	Contractor-Priced High Volume	CMS/Other Source Utilization Over 30,000	Different Performing Specialty from Survey	New Technology New Services	Work Neutrality (CPT 2016)
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)	Intravascular Ultrasound	1.80						X
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)	Intravascular Ultrasound	1.44						X
70360	Radiologic examination; neck, soft tissue	X-Ray Exam – Neck	New PE Inputs. 0.17			X			
70480	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material	CT – Orbit/Ear/Fossa	1.28			X			
70481	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)	CT – Orbit/Ear/Fossa	1.13			X			
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	CT – Orbit/Ear/Fossa	1.27			X			
73000	Radiologic examination; clavicle, complete	X-Ray – Clavicle/Shoulder	0.16			X			

RUC Recommendations for CMS Requests & Relativity Assessment Identified Codes October 2018									
CPT Code	2018 Long Descriptor	Issue	RUC Recommendation	Codes Reported Together 75% or More	Contractor-Priced High Volume	CMS/Other Source Utilization Over 30,000	Different Performing Specialty from Survey	New Technology New Services	Work Neutrality (CPT 2016)
73010	Radiologic examination; scapula, complete	X-Ray – Clavicle/Shoulder	0.17			X			
73020	Radiologic examination, shoulder; 1 view	X-Ray – Clavicle/Shoulder	0.15			X			
73030	Radiologic examination, shoulder; complete, minimum of 2 views	X-Ray – Clavicle/Shoulder	0.18			X			
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	X-Ray – Clavicle/Shoulder	0.18			X			
74425	Urography, antegrade (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation	Urography	0.51 and Referred to CPT for editorial changes	X					
75625	Aortography, abdominal, by serialography, radiological supervision and interpretation	Abdominal Aortography	1.75			X			
75630	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation	Abdominal Aortography	2.00			X			
75726	Angiography, visceral, selective or supraseductive (with or without flush aortogram), radiological supervision and interpretation	Angiography	2.05			X			
75774	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)	Angiography	1.01			X			
76098	Radiological examination, surgical specimen	X-Ray Exam Specimen	0.31			X			

RUC Recommendations for CMS Requests & Relativity Assessment Identified Codes October 2018									
CPT Code	2018 Long Descriptor	Issue	RUC Recommendation	Codes Reported Together 75% or More	Contractor-Priced High Volume	CMS/Other Source Utilization Over 30,000	Different Performing Specialty from Survey	New Technology New Services	Work Neutrality (CPT 2016)
93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional	Cardiac Electrophysiology Device Monitoring Services	New PE Inputs		Reviewed as part of 93299 family				
93298	Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional	Cardiac Electrophysiology Device Monitoring Services	New PE Inputs		Reviewed as part of 93299 family				
93299	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Cardiac Electrophysiology Device Monitoring Services	New PE Inputs. Referred to CPT for deletion (2021)		X				

RUC Recommendations for CMS Requests & Relativity Assessment Identified Codes October 2018									
CPT Code	2018 Long Descriptor	Issue	RUC Recommendation	Codes Reported Together 75% or More	Contractor-Priced High Volume	CMS/Other Source Utilization Over 30,000	Different Performing Specialty from Survey	New Technology New Services	Work Neutrality (CPT 2016)
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	Open Wound Debridement	0.88				X		
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)	Open Wound Debridement	0.50				X		
99495	Transitional Care Management Services with the following	Transitional Care Management	2.36					X	

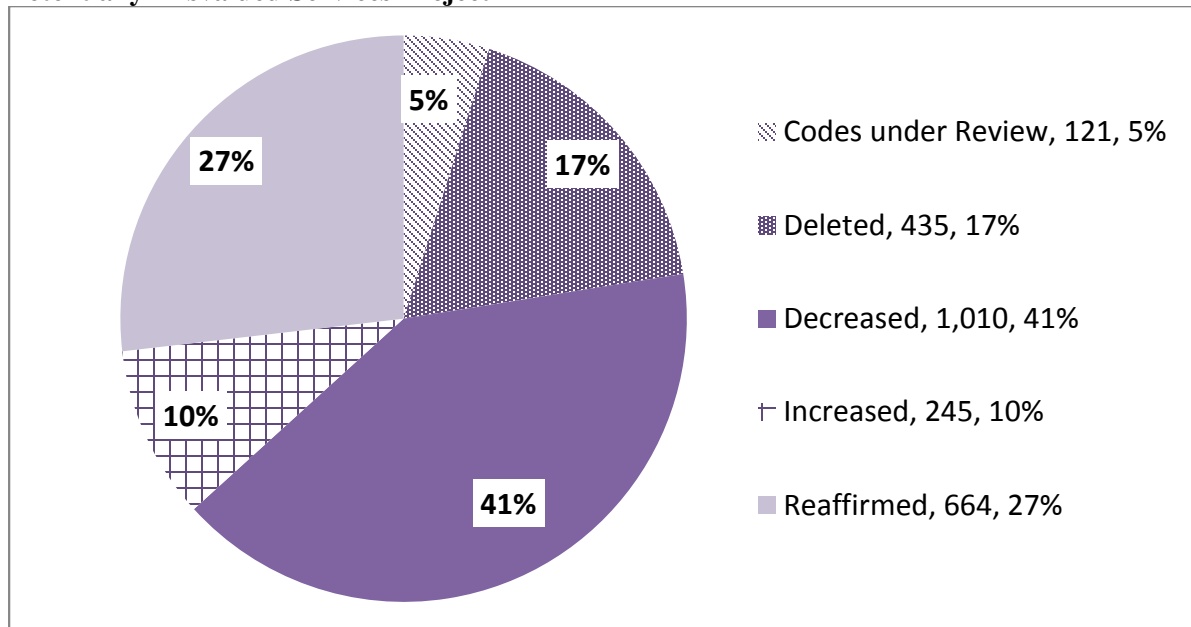
RUC Recommendations for CMS Requests & Relativity Assessment Identified Codes October 2018									
CPT Code	2018 Long Descriptor	Issue	RUC Recommendation	Codes Reported Together 75% or More	Contractor-Priced High Volume	CMS/Other Source Utilization Over 30,000	Different Performing Specialty from Survey	New Technology New Services	Work Neutrality (CPT 2016)
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	Transitional Care Management Services	3.10					X	

The RUC Relativity Assessment Workgroup Progress Report

In 2006, the AMA/Specialty Society RVS Update Committee (RUC) established the Five-Year Identification Workgroup (now referred to as the Relativity Assessment Workgroup) to identify potentially misvalued services using objective mechanisms for reevaluation prior to the next Five-Year Review. Since the inception of the Relativity Assessment Workgroup, the Workgroup and the Centers for Medicare and Medicaid Services (CMS) have identified 2,475 services through 20 different screening criteria for further review by the RUC. Additionally, the RUC charged the Workgroup with maintaining the “new technology” list of services that will be re-reviewed by the RUC as reporting and cost data become available.

To provide Medicare with reliable data on how physician work has changed over time, the RUC, with more than 300 experts in medicine and research, are examining over 2,400 potentially misvalued services accounting for \$45 billion in Medicare spending. The update committee has recommended reductions and deletions to 1,445 services, redistributing \$5 billion. Here are the outcomes for the committee’s review of 2,475 codes:

Potentially Misvalued Services Project



Source: American Medical Association

New Technology

As the RUC identifies new technology services that should be re-reviewed, a list of these services is maintained and forwarded to CMS. Currently, codes are identified as new technology based on recommendations from the appropriate specialty society and consensus among RUC members at the time of the RUC review for these services. RUC members consider several factors to evaluate potential new technology services, including: recent FDA-approval, newness or novelty of the service, use of an existing service in a new or novel way, and migration of the service from a Category III to Category I CPT® code. The Relativity Assessment Workgroup maintains and develops all standards and procedures associated with the list, which currently contains 609 services. In September 2010, the re-review cycle began and since then the RUC has recommended 47 services to be re-examined. The remaining services

are rarely performed (i.e., less than 500 times per year in the Medicare population) and will not be further examined. The Workgroup will continue to review the remaining 176 services every October after three years of Medicare claims data is available for each service.

Methodology Improvements

The RUC implemented process improvements to methodology following its October 2013 meeting. The process improvements are designed to strengthen the RUC's primary mission of providing the final RVS update recommendations to the Centers for Medicare and Medicaid Services.

In the area of methodology, the RUC is continuously improving its processes to ensure that it is best utilizing reliable, extant data. At its most recent meeting, the RUC increased the minimum number of respondents required for each survey of commonly performed codes:

- For services performed 1 million or more times per year in the Medicare population, at least 75 physicians must complete the survey.
- For services performed from 100,000 to 999,999 times annually, at least 50 physicians will be required.

Further strengthening its methodology, the RUC also announced that specialty societies will move to a centralized online survey process, which will be coordinated by the AMA and will utilize external expertise to ensure survey and reporting improvements.

Site of Service Anomalies

The Workgroup initiated its effort by reviewing services with anomalous sites of service when compared to Medicare utilization data. Specifically, these services are performed less than 50% of the time in the inpatient setting, yet include inpatient hospital Evaluation and Management services within their global period.

The RUC identified 194 services through the site of service anomaly screen. The RUC required the specialties to resurvey 129 services to capture the appropriate physician work involved. These services were reviewed by the RUC between April 2008 and February 2011. CMS implemented 124 of these recommendations in the 2009, 2010 and 2011 Medicare Physician Payment Schedules. The RUC submitted another five recommendations as well as re-reviewed and submitted 44 recommendations to previously reviewed site of service identified codes to CMS for the 2012 Medicare Physician Payment Schedule.

Of the remaining 65 services that were not re-surveyed, the RUC modified the discharge day management for 46 services, maintained three codes and removed two codes from the screen as the typical patient was not a Medicare beneficiary and would be an inpatient. The CPT® Editorial Panel deleted 14 codes. The RUC completed review of services under this initial screen.

During this review, the RUC uncovered several services that are reported in the outpatient setting, yet, according to several expert panels and survey data from physicians who perform the procedure, the service, typically requires a hospital stay of greater than 23 hours. The RUC maintains that physician work that is typically performed, such as visits on the date of service and discharge work the following day, should be included within the overall valuation. Subsequent observation day visits and discharge day management service are appropriate proxies for this work.

The RUC will reassess the data each year going forward to determine if any new site of service anomalies arise. In 2015, the RUC identified three services in which the Medicare data from 2011-2013 indicated it was performed less than 50% of the time in the inpatient setting, yet included inpatient hospital Evaluation and Management services within the global period. These services were referred to CPT and recommendations were submitted to CMS for the 2018 Medicare Physician Payment Schedule.

In 2016, the RUC identified one site of service anomaly CPT code and submitted the recommendation to CMS for the 2019 Medicare Physician Payment Schedule. In 2017, the RUC identified one site of service anomaly CPT code which was revised at the CPT Editorial Panel and the RUC submitted recommendations for the 2020 Medicare Physician Payment Schedule.

In 2018, the RUC also performed 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 via this screen and another identified for the outpatient site of service anomaly screen.

High Volume Growth

The Workgroup assembled a list of all services with a total Medicare utilization of 1,000 or more that have increased by at least 100% from 2004 through 2006. The query initially resulted in the identification of 81 services, but was expanded by 16 services to include the family of services, totaling 97 services. Specialty societies submitted comments to the Workgroup in April 2008 to provide rationales for the growth in reporting. Following this review, the RUC required the specialties to survey 35 services to capture the appropriate work effort and/or direct practice expense inputs. These services were reviewed by the RUC between February 2009 and April 2010.

The RUC recommended removing 15 services from the screen as the volume growth did not impact the resources required to provide these services. The CPT® Editorial Panel deleted 34 codes. The RUC submitted 44 recommendations to CMS for services for the 2012-2017 Medicare Physician Payment Schedules. In September 2011, the RUC began review of services after two years of utilization data were collected. The RUC will continue to review the remaining four services after additional utilization data is available.

In April 2013, the RUC assembled a list of all services with a total Medicare utilization of 10,000 or more that have increased by at least 100% from 2006 through 2011. The query resulted in the identification of 40 services and expanded to 62 services to include the appropriate family of services. The RUC recommended removing three services from the screen as the volume growth did not impact the resources required to provide these services. The RUC recommended review of two services after an additional two years of utilization data is collected. The CPT® Editorial Panel deleted ten codes and the RUC submitted recommendations for 47 services for the 2015-2019 Medicare Physician Payment Schedule.

In October 2015, the RUC ran this screen again for services based on Medicare utilization of 10,000 or more that have increased by at least 100% from 2008 through 2013. The query resulted in the identification of 19 services and expanded to 30 services to include the appropriate family of services. The RUC recommended removing one service from the screen as the volume growth did not impact the resources required to provide these services. The RUC will review three services after an additional two years of utilization data is collected. The CPT Editorial Panel deleted 12 codes and the RUC submitted recommendations for 14 services for the 2017-2020 Medicare Physician Payment Schedules.

In October 2016, the RUC ran this screen again and the query resulted in the identification of 12 services, which was expanded to 47 services. The RUC recommended removing three services from the screen as the volume growth did not impact the resources required to provide these services. The CPT Editorial Panel deleted three services. The RUC submitted recommendations for 29 services for the 2019-2020 Medicare Physician Payment Schedules. The RUC will review two services after additional utilization data is available and provide recommendations for the remaining 11 services for the 2020 Medicare Physician Payment Schedule.

In October 2018, the RUC ran this query again for services 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. The RUC will review action plans for the January 2019 meeting with specialty societies indicating whether these services should be reviewed for physician work/practice expense.

CMS Fastest Growing

In 2008, CMS developed the Fastest Growing Screen to identify all services with growth of at least 10% per year over the course of three years from 2005-2007. Through this screen, CMS identified 114 fastest growing services and the RUC added 69 services to include the family of services, totaling 183. The RUC required the specialties to survey 72 services to capture the appropriate work effort and/or direct practice expense inputs. These services were reviewed by the RUC from February 2008 through April 2010 and submitted to CMS for the Medicare Physician Payment Schedule.

The RUC recommended removing 27 services from the screen as the volume growth did not impact the resources required to provide the service. The CPT® Editorial Panel deleted 43 codes. The RUC submitted 41 recommendations to CMS for the 2012-2019 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

High IWP/UT

The Workgroup assembled a list of all services with a total Medicare utilization of 1,000 or more that have an intra-service work per unit of time (IWP/UT) calculation greater than 0.14, indicating an outlier intensity. The query resulted in identification of 32 services. Specialty societies submitted comments to the Workgroup in April 2008 for these services. As a result of this screen, the RUC has reviewed and submitted recommendations to CMS for 28 codes, removing four services from the screen as the IWP/UT was considered appropriate. The RUC completed review of services under this screen.

Services Surveyed by One Specialty – Now Performed by a Different Specialty

In October 2009, services that were originally surveyed by one specialty, but now performed predominantly by other specialties were identified and reviewed. The RUC identified 21 services by this screen, adding 19 services to address various families of codes. The majority of these services required clarification within CPT®. The CPT® Editorial Panel deleted 18 codes. The RUC submitted 22 recommendations for physician work and practice expense to CMS for the 2011-2014 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

In April 2013, the RUC queried the top two dominant specialties performing services based on Medicare utilization more than 1,000 and compared it to who originally surveyed the service. Two services were identified and the RUC recommended that one be removed from the screen since the specialty societies currently performing this service indicated that the service is appropriate and recommended that the other code be referred to CPT® to be revised. The RUC completed review of services under this screen.

Harvard Valued

Utilization over 1 Million

CMS requested that the RUC pay specific attention to Harvard valued codes that have a high utilization. The RUC identified nine Harvard valued services with high utilization (performed over 1 million times per year). The RUC also incorporated an additional 12 Harvard valued codes within the initial family of services identified. The CPT® Editorial Panel deleted one code. The RUC submitted 20 relative value work recommendations to CMS for the 2011 and 2012 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Utilization over 100,000

The RUC continued to review Harvard valued codes with significant utilization. The Relativity Assessment Workgroup expanded the review of Harvard codes to those with utilization over 100,000 which totaled 38 services. The RUC expanded this screen by 101 codes to include the family of services, totaling 139 services. The CPT® Editorial Panel deleted 27 codes. The RUC submitted 112 recommendations to CMS for the 2011-2014 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Utilization over 30,000

In April 2011, the RUC continued to identify Harvard valued codes with utilization over 30,000, based on 2009 Medicare claims data. The RUC determined that the specialty societies should survey the remaining 36 Harvard codes with utilization over 30,000 for September 2011. The RUC expanded the screen to include the family of services, totaling 65 services. The CPT® Editorial Panel deleted 12 codes. The RUC submitted recommendations for 53 services for the 2013-2014 Medicare Physician Payment Schedules.

In October 2018, the RUC reran this screen on Harvard valued services with 2017e Medicare utilization over 30,000. One service was identified. The RUC will review action plans for the January 2019 meeting with specialty societies indicating whether these services should be reviewed for physician work/practice expense.

Medicare Allowed Charges >\$10 million

In June 2012, CMS identified 16 services that were Harvard valued with annual allowed charges (2011 data) > \$10 million. The RUC expanded this screen to 33 services to include the proper family of services. The RUC removed two services from review as the allowed charges are approximately \$1 million and did not meet the screen criteria. The CPT® Editorial Panel deleted one service. The RUC submitted recommendations for 30 services for the 2013-2017 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

CMS/Other

Utilization over 500,000

In April 2011, the RUC identified 410 codes with a source of “CMS/Other.” CMS/Other codes are services which were not reviewed by the Harvard studies or the RUC and were either gap filled, most often via crosswalk by CMS or were part of a radiology fee schedule. “CMS/Other” source codes would not have been flagged in the Harvard only screens, therefore the RUC recommended that a list of all CMS/Other codes be developed and reviewed. The RUC established the threshold for CMS/Other source codes with Medicare utilization of 500,000 or more, which resulted in 19 codes. The RUC expanded this screen to 21 services to include the proper family of services. The CPT® Editorial Panel deleted three services. The RUC submitted recommendations for 16 services for the 2013-2015 Medicare Physician Payment Schedules. The RUC removed one service from the screen and will review one service for the 2020 Medicare Physician Payment Schedule.

Utilization over 250,000

In April 2013, the RUC lowered the threshold to the CMS/Other source codes with Medicare utilization of 250,000 or more, which resulted in 26 services and was expanded to 52 services to include the family of services. The CPT Editorial Panel deleted 11 codes identified under this screen. The RUC removed nine services and submitted 32 recommendations to CMS for the 2015-2019 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Utilization over 100,000

In October 2016, the RUC lowered the threshold to the CMS/Other source codes with Medicare utilization of 100,000 or more, which resulted in 27 services and was expanded to 41 services to include

the family of services. The RUC referred two codes to CPT for deletion and submitted recommendations for 39 services for the 2019 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

Utilization over 30,000

In October 2017, the RUC lowered the threshold to the CMS/Other source codes with Medicare utilization of 30,000 or more, which resulted in 34 services and was expanded to 55 services to include the family of services. The RUC referred 16 services to the CPT Editorial Panel for revision. The RUC submitted recommendations for 32 services for the 2019-2020 Medicare Physician Payment Schedules and will review the remaining services in the 2020 cycle.

In October 2018, the RUC reran this screen for CMS/Other Source codes with 2017e Medicare utilization over 30,000. Seven (7) services were identified. The RUC will review action plans for the January 2019 meeting with specialty societies indicating whether these services should be reviewed for physician work/practice expense.

Bundled CPT® Services

Reported 95% or More Together

The Relativity Assessment Workgroup solicited data from CMS regarding services inherently performed by the same physician on the same date of service (95% of the time) in an attempt to identify pairings of services that should be bundled together. The CPT® Editorial Panel deleted 31 individual component codes and replaced them with 53 new codes that describe bundles of services. The RUC then surveyed and reviewed work and practice costs associated with these services to account for any efficiencies achieved through the bundling. The RUC completed review of all services under this screen.

Reported 75% or More Together

In February 2010, the Workgroup continued review of services provided on the same day by the same provider, this time lowering the threshold to 75% or more together. The Relativity Assessment Workgroup again analyzed the Medicare claims data and found 151 code pairs which met the threshold. The Workgroup then collected these code pairs into similar “groups” to ensure that the entire family of services would be coordinated under one code bundling proposal. The grouping effort resulted in 20 code groups, totaling 80 codes, and were sent to specialty societies to solicit action plans for consideration at the April 2010 RUC meeting. Resulting from the Relativity Assessment Workgroup review, 81 additional codes were added for review as part of the family of services to ensure duplication of work and practice expense was mitigated throughout the entire set of services. Of the 161 total codes under review, the CPT® Editorial Panel deleted 35 individual component codes and replaced the component coding with 126 new and/or revised codes that described the bundles of services. The RUC will review two services after additional utilization data is available.

In August 2011, the Joint CPT®/RUC Workgroup on Codes Reported Together Frequently reconvened to perform its third cycle of analysis of code pairs reported together with 75% or greater frequency. The Workgroup reviewed 30 code pair groups and recommended code bundling for 64 individual codes. In October 2012, the CPT® Editorial Panel started the review of code bundling solutions. Of the 167 total codes under review, the CPT® Editorial Panel deleted 52 services. The RUC has submitted 113 code recommendations for the 2014-2019 Medicare Physician Payment Schedules and will review two services after additional utilization data is available.

In January and April 2015, the Joint CPT/RUC Workgroup on Codes Reported Together Frequently reconvened to perform its fourth cycle analysis of code pairs reported together with 75% or greater frequency. The Workgroup reviewed 8 code pair groups and recommended code bundling for 18 individual codes. In October 2015, the CPT Editorial Panel started review of the code bundling solutions.

Of the 75 total codes under review, the CPT Editorial Panel deleted 26 services. The RUC submitted 47 code recommendations for the 2017-2019 Medicare Physician Payment Schedules and will review the two services after additional utilization data is available.

In October 2017 the Relativity Assessment Workgroup performed the fifth cycle analysis of code pairs reported together with 75% or greater frequency. Only groups that totaled allowed charges of \$5 million or more were included. As with previous iterations, any code pairs in which one of the codes was either below 1,000 in Medicare claims data and/or contained at least one ZZZ global service were removed. Based on these criteria four groups or 8 codes were identified. The Relativity Assessment Workgroup determined two groups totaling four codes require code bundling solutions. The RUC referred four codes to CPT for code bundling solutions. The RUC submitted 2 code recommendations for the 2019 Medicare Physician Payment Schedule and will review the remaining codes for the 2020-2021 Medicare Physician Payment Schedule.

Low Value/Billed in Multiple Units

CMS has requested that services with low work RVUs that are commonly billed with multiple units in a single encounter be reviewed. CMS identified services that are reported in multiples of five or more per day, with work RVUs of less than or equal to 0.50 RVUs.

In October 2010, the Workgroup reviewed 12 CMS identified services and determined that six of the codes were improperly identified as the services were either not reported in multiple units or were reported in a few units and that was considered in the original valuation. The RUC submitted recommendations for the remaining six services for the 2012 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

Low Value/High Volume Codes

CMS has requested that services with low work RVUs and high utilization be reviewed. CMS has requested that the RUC review 24 services that have low work RVUs (less than or equal to 0.25) and high utilization. The RUC questioned the criteria CMS used to identify these services as it appeared some codes were missing from the screen criteria indicated. The RUC identified codes with a work RVU ranging from 0.01 - 0.50 and Medicare utilization greater than one million. In February 2011, the RUC reviewed the codes identified by this criteria and added 5 codes, totaling 29. The RUC submitted 24 recommendations to CMS for the 2012 Medicare Physician Payment Schedule and five recommendations to CMS for the 2013 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

Multi-Specialty Points of Comparison List

CMS requested that services on the Multi-Specialty Points of Comparison (MPC) list should be reviewed. CMS prioritized the review of the MPC list to 33 codes, ranking the codes by allowed service units and charges based on CY 2009 claims data as well as those services reviewed by the RUC more than six years ago. The RUC expanded the list to 182 services to include additional codes as part of a family (over 100 of these codes are part of the review of GI endoscopy codes). The CPT® Editorial Panel deleted 25 codes. The RUC submitted recommendations for 157 codes for the 2012-2015 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

CMS High Expenditure Procedural Codes

In the Proposed Rule for 2012, CMS requested that the RUC review a list of 70 high Medicare Physician Payment Schedule expenditure procedural codes representing services furnished by an array of specialties. CMS selected these codes since they have not been reviewed for at least 6 years, and in many cases the last review occurred more than 10 years ago.

The RUC reviewed the 70 services identified and expanded the list to 145 services to include additional codes as part of the family. The CPT® Editorial Panel deleted 20 codes. The RUC submitted 125 recommendations to CMS for the 2013-2019 Medicare Physician Payment Schedules. The RUC completed review of services under the first iteration of this screen.

In the Final Rule for 2016, CMS requested that the RUC review a list of 103 high Medicare Physician Payment Schedule high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010.

The RUC expanded the list of services to 238 services to include additional codes as part of the family. The CPT Editorial Panel deleted 30 codes. The RUC submitted 207 recommendations to CMS for the 2017-2019 Medicare Physician Payment Schedules and will review the remaining service after additional utilization data is available.

Services with Stand-Alone PE Procedure Time

In June 2012, CMS proposed adjustments to services with stand-alone procedure time assumptions used in developing non-facility PE RVUs. These assumptions are not based on physician time assumptions. CMS prioritized CPT® codes that have annual Medicare allowed charges of \$100,000 or more, include direct equipment inputs that amount to \$100 or more, and have PE procedure times greater than five minutes for review. The RUC reviewed 27 services identified through this screen and expanded to 29 services to include additional codes as part of the family. The CPT® Editorial Panel deleted 11 codes. The RUC submitted 18 recommendations for the 2014-2015 Medicare Physician Payment Schedules. The RUC completed review of services under this screen.

Pre-Time Analysis

In January 2014, the RUC reviewed codes that were RUC reviewed prior to April 2008, with pre-time greater than pre-time package 4 *Facility - Difficult Patient/Difficult Procedure* (63 minutes) for services with 2012 Medicare Utilization over 10,000. The screen identified 19 services with more pre-service time than the longest standardized pre-service package and was expanded to 24 to include additional codes as part of the family. The RUC reviewed these services and referred three services to the CPT® Editorial Panel for revision. The CPT Editorial Panel deleted one service and will review three services for CPT 2018. The RUC reviewed 18 services and noted that they were all originally valued by magnitude estimation and therefore readjustments in pre-service time categories did not alter the work values. Additionally, crosswalk references for each service were presented validating the pre-time adjustments. The RUC noted that this screen was useful, however did not reveal any large outliers and therefore the utilization threshold does not need to be lowered to identify more services. The RUC submitted 20 recommendations for the 2016 Medicare Physician Payment Schedule. The RUC completed review of services under this screen.

Post-Operative Visits

010-Day Global Codes

In January 2014, the RUC reviewed all 477, 010-day global codes to determine any outliers. Many 010-day global period services only include one post-operative office visit. The Relativity Assessment Workgroup pared down the list to 19 services with >1.5 office visits and 2012 Medicare utilization > 1,000. The RUC reviewed the 19 services, which was expanded to 21 services for additional codes in the family of services, identified via this screen. The RUC referred two codes to the CPT Editorial Panel for revision. The RUC submitted recommendations for 21 services for the 2015-2017 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

090-Day Global Codes

In January 2014, the RUC reviewed all 3,788, 090-day global codes to determine any outliers. Based on 2012 Medicare utilization data, 10 services were identified, that were reported at least 1,000 times per year and included more than six office visits. The RUC expanded the services identified in this screen to 38 to include additional codes as part of the family. The CPT® Editorial Panel deleted 8 services. The RUC submitted recommendations for 30 services for the 2015-2017 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

High Level E/M in Global Period

In October 2015, the RUC reviewed all services with Medicare utilization greater than 10,000 that have a level 4 (99214) or level 5 (99215) office visit included in the global period. There were no codes with volume greater than 10,000 that had a level 5 office visits included. Seven services were identified that have a level 4 office visit included. The RUC expanded the list of services to 11 services to include additional codes as part of the family. The RUC confirmed that the level 4 post-operative visits were appropriate and well-defined for four services. The CPT Editorial Panel deleted one code. The RUC submitted recommendations for 10 services for the 2017-2018 Medicare Physician Payment Schedules. The RUC noted that this screen will be complete after these services are reviewed because the RUC has more rigorously questioned level 4 office visits in the global period in recent years and will continue this process going forward. The RUC has completed review of the services under this screen.

000-Day Global Services Reported with an E/M with Modifier 25

In the NPRM for 2017 CMS identified 83 services with a 000-day global period billed 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.

The RUC commented that it appreciated CMS' identification of an objective screen and reasonable query. However, based on further analysis of the codes identified, it appears only 19 services met the criteria for this screen and have not been reviewed to specifically address an E/M performed on the same date. There were 38 codes that did not meet the screen criteria; they were either reviewed in the last 5 years and/or are not typically reported with an E/M. For 26 codes, the summary of recommendation (SOR), RUC rationale or practice expense inputs submitted specifically states that an E/M is typically reported with these services and the RUC accounted for this in its valuation.

The RUC requested that CMS remove 64 services that did not meet the screen criteria or which have already been valued as typically being reported with an E/M service. The RUC requested that CMS condense and finalize the list of services for this screen to the 19 remaining services.

In the Final Rule for 2017, CMS did finalize the list of 000-day global services reported with an E/M to the 19 services that truly met the criteria. The RUC recommended that two additional codes be removed from this screen as the specialty societies discovered that in fact an E/M as typical was considered in the survey process. Additional codes were added as part of the family of codes identified, totaling 22. The CPT Editorial Panel deleted one code and the RUC submitted 21 recommendations for the 2019 Medicare Physician Payment Schedule. The RUC has completed review of the services under this screen.

Negative IWPOT

In October 2017, the RUC identified 22 services with a negative IWPOT and Medicare utilization over 10,000 for all services or over 1,000 for Harvard valued and CMS/Other source codes. The RUC expanded the services identified in this screen to 56 services to include additional codes as part of the family. The CPT Editorial Panel deleted 15 services. The RUC submitted 41 recommendations for the 2019-2020 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Contractor Priced with High Volume

In April 2018, the RUC identified five contractor-priced Category I CPT codes that have 2017 estimated Medicare utilization over 10,000. The RUC expanded the services identified in this screen to seven to include additional codes as part of a family. The RUC will review 4 services for the 2019 and 2020 Medicare Physician Payment Schedule and the remaining three services after two years of additional data is available.

CPT Modifier -51 Exempt List

In April 2018, the RUC identified seven services on the CPT Modifier -51 *Multiple Procedures* exempt list with 2017 estimated Medicare utilization over 10,000. The RUC examined the data provided on the percentage reported alone, physician pre and intra time and determined that this is an appropriate screen. The RUC recommended that four services be removed from the Modifier – 51 exempt list and that three services remain on the list as they are separate and distinct services. The RUC notes that the CPT Editorial Panel will be reexamining this list in February 2019. The RUC has completed review of the services under this screen.

Public Comment Requests

In 2011, CMS announced that due to the ongoing identification of potentially misvalued services by CMS and the RUC, the Agency will no longer conduct a separate Five-Year Review. CMS will now call for public comments on an annual basis as part of the comment process on the Final Rule each year.

Final Rule for 2013

In the Final Rule for the 2013 Medicare Physician Payment Schedule, the public and CMS identified 35 potentially misvalued services, which was expanded to 39 services to include the entire code family. The RUC reviewed these services and recommended that eight services be removed from review as two G-codes lacked specialty society interest and six services are not potentially misvalued since there is no reliable way to determine an incremental difference from open thoracotomy to thoroscopic procedures. The CPT Editorial Panel deleted two services. The RUC submitted recommendations for 29 services for the 2014-2019 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Final Rule for 2014

CMS did not receive any publicly nominated potentially misvalued codes for inclusion in the Proposed Rule for 2014. To broaden participation in the process of identifying potentially misvalued codes, CMS sought the input of Medicare contractor medical directors (CMDs). The CMDs have identified over a dozen services which CMS is proposing as potentially misvalued. The RUC reviewed these services and appropriate families, totaling 90 services. The CPT® Editorial Panel deleted 11 services. The RUC submitted recommendations to CMS for 79 services for the 2015-2018 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Final Rule for 2015

In the Final Rule for 2015 the public and CMS nominated 26 services as potentially misvalued, which the RUC expanded to 53 services to include additional codes as part of this family. The CPT Editorial Panel deleted 16 services. The RUC submitted 37 recommendations for the 2016-2019 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Final Rule for 2016

In the Final Rule for 2016 the public and CMS nominated 25 services as potentially misvalued, which the RUC expanded to 53 services to include an additional code as part of the family. The CPT Editorial Panel deleted eight services. The RUC submitted 45 recommendations for the 2017-2019 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

Final Rule for 2017

In the Final Rule for 2017 there were no public nominations for services in which the RUC was not already addressing.

Final Rule for 2018

In the Final Rule for 2018 the public and CMS nominated six services as potentially misvalued, which the RUC expanded to nine services. The RUC submitted nine recommendations for the 2019-2020 Medicare Physician Payment Schedules. The RUC has completed review of the services under this screen.

NPRM for 2019

In the Proposed Rule for 2019 the public and CMS nominated two services as potentially misvalued. The RUC will review these services for the 2020 Medicare Physician Payment Schedule.

Other Issues

In addition to the above screening criteria, the Relativity Assessment Workgroup performed an exhaustive search of the RUC database for services indicated by the RUC to be re-reviewed at a later date. Three codes were found that had not yet been re-reviewed. The RUC recommended a work RVU decrease for two codes and to maintain the work RVU for another code.

CMS also identified 72 services that required further practice expense review. The RUC submitted practice expense recommendations on 67 services and the CPT® Editorial Panel deleted 5 services. The RUC also reviewed special requests for 19 audiology and speech-language pathology services. The RUC submitted recommendations for 10 services for the 2010 Medicare Physician Payment Schedule and the remaining nine services for the 2011 Medicare Physician Payment Schedule.

CMS Requests and RUC Relativity Assessment Workgroup Code Status

Total Number of Codes Identified*	2,475
<i>Codes Completed</i>	2,354
Work and PE Maintained	664
Work Increased	245
Work Decreased	838
Direct Practice Expense Revised (beyond work changes)	172
Deleted from CPT®	435
<i>Codes Under Review</i>	121
Referred to CPT® Editorial Panel	12
RUC to Review for <i>CPT 2020</i>	85
RUC to review future review after additional data obtained	24

**The total number of codes identified will not equal the number of codes from each screen as some codes have been identified in more than one screen.*

The RUC's efforts for 2009-2017 have resulted in \$5 billion for redistribution within the Medicare Physician Payment Schedule.

Status Report: CMS Requests and Relativity Assessment Issues

00534	Anesthesia for transvenous insertion or replacement of pacing cardioverter-defibrillator	Global: XXX	Issue:	Screen: High Volume Growth5	Complete? No
Most Recent RUC Meeting: October 2018	Tab 27 Specialty Developing Recommendation:	First Identified: October 2018	2017 Est. Medicare Utilization: 34,945	2007 Work RVU: 0.00 2007 NF PE RVU: 0 2007 Fac PE RVU 0	2018 Work RVU: 7.00 2018 NF PE RVU: 0 2018 Fac PE RVU: 0
RUC Recommendation: Review action plan		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result:	

00537	Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation	Global: XXX	Issue: RAW	Screen: High Volume Growth4	Complete? No
Most Recent RUC Meeting: January 2017	Tab 30 Specialty Developing Recommendation: ASA	First Identified: October 2016	2017 Est. Medicare Utilization: 77,361	2007 Work RVU: 0.00 2007 NF PE RVU: 0 2007 Fac PE RVU 0	2018 Work RVU: 7.00 2018 NF PE RVU: 0 2018 Fac PE RVU: 0
RUC Recommendation: Review action plan and additional utilization data (Oct 2019). Notify Anesthesia WG that this is a high growth service.		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result:	

00560	Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; without pump oxygenator	Global: XXX	Issue:	Screen: High Volume Growth5	Complete? No
Most Recent RUC Meeting: October 2018	Tab 27 Specialty Developing Recommendation:	First Identified: October 2018	2017 Est. Medicare Utilization: 47,571	2007 Work RVU: 0.00 2007 NF PE RVU: 0 2007 Fac PE RVU 0	2018 Work RVU: 15.00 2018 NF PE RVU: 0 2018 Fac PE RVU: 0
RUC Recommendation: Review action plan		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result:	

Status Report: CMS Requests and Relativity Assessment Issues

00731 Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified **Global:** XXX **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent **Tab** 04 **Specialty Developing** ASA
RUC Meeting: January 2017 **Recommendation:**

First Identified: September 2016 **2017 Est. Medicare Utilization:**

2007 Work RVU: **2018 Work RVU:** 5.00
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU **2018 Fac PE RVU:**
Result: Maintain

RUC Recommendation: 5 base units

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

00732 Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography (ERCP) **Global:** XXX **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent **Tab** 04 **Specialty Developing** ASA
RUC Meeting: January 2017 **Recommendation:**

First Identified: September 2016 **2017 Est. Medicare Utilization:**

2007 Work RVU: **2018 Work RVU:** 6.00
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU **2018 Fac PE RVU:**
Result: Increase

RUC Recommendation: 6 base units

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

00740 Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum **Global:** XXX **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent **Tab** 04 **Specialty Developing** ASA
RUC Meeting: January 2017 **Recommendation:**

First Identified: July 2015 **2017 Est. Medicare Utilization:** 1,424,130

2007 Work RVU: 0.00 **2018 Work RVU:**
2007 NF PE RVU: 0 **2018 NF PE RVU:** 0
2007 Fac PE RVU 0 **2018 Fac PE RVU:** 0
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

00810 Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum **Global:** XXX **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent **Tab** 04 **Specialty Developing** ASA
RUC Meeting: January 2017 **Recommendation:**

First **2017 Est.**
Identified: July 2015 **Medicare**
 Utilization: 1,980,405

2007 Work RVU: 0.00 **2018 Work RVU:**
2007 NF PE RVU: 0 **2018 NF PE RVU:** 0
2007 Fac PE RVU: 0 **2018 Fac PE RVU:** 0
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

00811 Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified **Global:** XXX **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent **Tab** 04 **Specialty Developing** ASA
RUC Meeting: April 2017 **Recommendation:**

First **2017 Est.**
Identified: September 2016 **Medicare**
 Utilization:

2007 Work RVU: **2018 Work RVU:** 4.00
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU: **2018 Fac PE RVU:**
Result: Decrease

RUC Recommendation: 4 base units

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

00812 Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy **Global:** XXX **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent **Tab** 04 **Specialty Developing** ASA
RUC Meeting: April 2017 **Recommendation:**

First **2017 Est.**
Identified: September 2016 **Medicare**
 Utilization:

2007 Work RVU: **2018 Work RVU:** 3.00
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU: **2018 Fac PE RVU:**
Result: Decrease

RUC Recommendation: 3 base units

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

00813 Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum **Global:** XXX **Issue:** Anesthesia for Intestinal Endoscopic Procedures **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent **Tab** 04 **Specialty Developing** ASA
RUC Meeting: January 2017 **Recommendation:**

First Identified: September 2016

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU: 5.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: 5 base units

Referred to CPT September 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

01930 Anesthesia for therapeutic interventional radiological procedures involving the venous/lymphatic system (not to include access to the central circulation); not otherwise specified **Global:** XXX **Issue:** Anesthesia for Interventional Radiology **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent **Tab** S **Specialty Developing** ASA
RUC Meeting: February 2008 **Recommendation:**

First Identified: February 2008

2017 Est. Medicare Utilization: 19,829

2007 Work RVU: 0.00

2018 Work RVU: 5.00

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU 0

2018 Fac PE RVU: 0

Result: Remove from Screen

RUC Recommendation: Remove from screen

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

01936 Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic **Global:** XXX **Issue:** Anesthesia for percutaneous image guided spine procedures **Screen:** High Volume Growth4 **Complete?** No

Most Recent **Tab** 38 **Specialty Developing** ASA
RUC Meeting: April 2017 **Recommendation:**

First Identified: October 2016

2017 Est. Medicare Utilization: 277,150

2007 Work RVU:

2018 Work RVU: 5.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result:

RUC Recommendation: Review additional data (October 2019)

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

10021 Fine needle aspiration; without imaging guidance **Global:** XXX **Issue:** Fine Needle Aspiration **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 04 **Specialty Developing Recommendation:** AACE, ASBS, ASC, CAP, ES, AAOHNS, ACS **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 22,780 **2007 Work RVU:** 1.27 **2018 Work RVU:** 1.27 **2007 NF PE RVU:** 2.14 **2018 NF PE RVU:** 2.14 **2007 Fac PE RVU:** 0.5 **2018 Fac PE RVU:** 0.5

RUC Recommendation: 1.20 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

10022 Fine needle aspiration; with imaging guidance **Global:** XXX **Issue:** Fine Needle Aspiration **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 04 **Specialty Developing Recommendation:** AACE, ASBS, ASC, CAP, ES, ACR, SIR **First Identified:** October 2008 **2017 Est. Medicare Utilization:** 188,347 **2007 Work RVU:** 1.27 **2018 Work RVU:** 1.27 **2007 NF PE RVU:** 2.41 **2018 NF PE RVU:** 2.41 **2007 Fac PE RVU:** 0.4 **2018 Fac PE RVU:** 0.4

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

10030 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous **Global:** 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2017 Est. Medicare Utilization:** 8,261 **2007 Work RVU:** **2018 Work RVU:** 2.75 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:**

RUC Recommendation: 3.00 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

10040	Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)	Global: 010	Issue: Acne Surgery	Screen: Harvard Valued - Utilization over 30,000-Part2	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 13 Specialty Developing Recommendation: AAD	First Identified: October 2015	2017 Est. Medicare Utilization: 39,249	2007 Work RVU: 1.19 2007 NF PE RVU: 1.09 2007 Fac PE RVU: 0.84 Result: Decrease	2018 Work RVU: 0.91 2018 NF PE RVU: 1.09 2018 Fac PE RVU: 0.84
RUC Recommendation: 0.91		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	Global: 010	Issue: Incision and Drainage of Abscess	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 07 Specialty Developing Recommendation: APMA	First Identified: February 2010	2017 Est. Medicare Utilization: 403,879	2007 Work RVU: 1.19 2007 NF PE RVU: 1.29 2007 Fac PE RVU: 0.97 Result: Increase	2018 Work RVU: 1.22 2018 NF PE RVU: 1.29 2018 Fac PE RVU: 0.97
RUC Recommendation: 1.50		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
10061	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple	Global: 010	Issue: Incision and Drainage of Abscess	Screen: Harvard Valued - Utilization over 100,000 / 010-Day Global Post-Operative Visits Screen	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 52 Specialty Developing Recommendation: APMA	First Identified: October 2009	2017 Est. Medicare Utilization: 149,597	2007 Work RVU: 2.42 2007 NF PE RVU: 1.89 2007 Fac PE RVU: 1.51 Result: Maintain	2018 Work RVU: 2.45 2018 NF PE RVU: 1.89 2018 Fac PE RVU: 1.51
RUC Recommendation: 2.45		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

10120	Incision and removal of foreign body, subcutaneous tissues; simple	Global: 010	Issue:	Screen: Harvard Valued - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: September 2011	Tab 12	Specialty Developing Recommendation: APMA, AAFP	First Identified: April 2011	2017 Est. Medicare Utilization: 44,653	2007 Work RVU: 1.23 2007 NF PE RVU: 2.12 2007 Fac PE RVU: 0.97 Result: Maintain
RUC Recommendation: 1.25			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.22 2018 NF PE RVU: 2.12 2018 Fac PE RVU: 0.97

10180	Incision and drainage, complex, postoperative wound infection	Global: 010	Issue:	Screen: RUC identified when reviewing comparison codes	Complete? Yes
Most Recent RUC Meeting: October 2013	Tab 18	Specialty Developing Recommendation:	First Identified: January 2013	2017 Est. Medicare Utilization: 10,677	2007 Work RVU: 2.27 2007 NF PE RVU: 3.06 2007 Fac PE RVU: 1.94 Result: Maintain
RUC Recommendation: Remove from re-review			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2.30 2018 NF PE RVU: 3.06 2018 Fac PE RVU: 1.94

10X11		Global:	Issue: Fine Needle Aspiration	Screen: CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2016	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 04	Specialty Developing Recommendation:	First Identified: June 2017	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Decrease
RUC Recommendation: 0.80			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:

Status Report: CMS Requests and Relativity Assessment Issues

10X12

Global:

Issue: Fine Needle Aspiration

Screen: CMS High Expenditure
Procedural Codes2 /
CMS Request - Final
Rule for 2016

Complete? Yes

Most Recent
RUC Meeting: October 2017

Tab 04

Specialty Developing
Recommendation:

First
Identified: June 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 1.63

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

10X13

Global:

Issue: Fine Needle Aspiration

Screen: CMS High Expenditure
Procedural Codes2 /
CMS Request - Final
Rule for 2016

Complete? Yes

Most Recent
RUC Meeting: October 2017

Tab 04

Specialty Developing
Recommendation:

First
Identified: June 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 1.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

10X14

Global:

Issue: Fine Needle Aspiration

Screen: CMS High Expenditure
Procedural Codes2 /
CMS Request - Final
Rule for 2016

Complete? Yes

Most Recent
RUC Meeting: October 2017

Tab 04

Specialty Developing
Recommendation:

First
Identified: June 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 1.81

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

10X15

Global:

Issue: Fine Needle Aspiration

Screen: CMS High Expenditure
Procedural Codes2 /
CMS Request - Final
Rule for 2016

Complete? Yes

Most Recent
RUC Meeting: October 2017

Tab 04

Specialty Developing
Recommendation:

First
Identified: June 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 1.18

Referred to CPT

Referred to CPT Asst

☐

Published in CPT Asst:

10X16

Global:

Issue: Fine Needle Aspiration

Screen: CMS High Expenditure
Procedural Codes2 /
CMS Request - Final
Rule for 2016

Complete? Yes

Most Recent
RUC Meeting: October 2017

Tab 04

Specialty Developing
Recommendation:

First
Identified: June 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 2.43

Referred to CPT

Referred to CPT Asst

☐

Published in CPT Asst:

10X17

Global:

Issue: Fine Needle Aspiration

Screen: CMS High Expenditure
Procedural Codes2 /
CMS Request - Final
Rule for 2016

Complete? Yes

Most Recent
RUC Meeting: October 2017

Tab 04

Specialty Developing
Recommendation:

First
Identified: June 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 1.65

Referred to CPT

Referred to CPT Asst

☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

10X18

Global:

Issue: Fine Needle Aspiration

Screen: CMS High Expenditure
Procedural Codes2 /
CMS Request - Final
Rule for 2016

Complete? Yes

Most Recent
RUC Meeting: January 2018

Tab 04

Specialty Developing
Recommendation:

First
Identified: June 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Contractor Price

RUC Recommendation: Contractor Price

Referred to CPT

Referred to CPT Asst

☐

Published in CPT Asst:

10X19

Global:

Issue: Fine Needle Aspiration

Screen: CMS High Expenditure
Procedural Codes2 /
CMS Request - Final
Rule for 2016

Complete? Yes

Most Recent
RUC Meeting: January 2018

Tab 04

Specialty Developing
Recommendation:

First
Identified: June 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Contractor Price

RUC Recommendation: Contractor Price

Referred to CPT

Referred to CPT Asst

☐

Published in CPT Asst:

11040 Deleted from CPT

Global: 000

Issue: Excision and Debridement

Screen: Site of Service Anomaly

Complete? Yes

Most Recent
RUC Meeting: September 2007

Tab 16

Specialty Developing
Recommendation: APMA, APTA

First
Identified: September 2007

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.50

2018 Work RVU:

2007 NF PE RVU: 0.56

2018 NF PE RVU: 0.56

2007 Fac PE RVU 0.2

2018 Fac PE RVU:0.2

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst

☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

11041 Deleted from CPT

Global: 000 Issue: Excision and Debridement Screen: Site of Service Anomaly Complete? Yes

Most Recent Tab 16 Specialty Developing APMA, APTA First 2017 Est. 2007 Work RVU: 0.60 2018 Work RVU:
 RUC Meeting: September 2007 Recommendation: Identified: September 2007 Medicare Utilization: 2007 NF PE RVU: 0.68 2018 NF PE RVU: 0.68
 2007 Fac PE RVU 0.3 2018 Fac PE RVU:0.3
 RUC Recommendation: Deleted from CPT Referred to CPT October 2009 Result: Deleted from CPT
 Referred to CPT Asst ☐ Published in CPT Asst:

11042 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less

Global: 000 Issue: Excision and Debridement Screen: Site of Service Anomaly Complete? Yes

Most Recent Tab 04 Specialty Developing APMA, APTA First 2017 Est. 2007 Work RVU: 0.80 2018 Work RVU: 1.01
 RUC Meeting: February 2010 Recommendation: Identified: September 2007 Medicare Utilization: 1,816,207 2007 NF PE RVU: 0.97 2018 NF PE RVU: 0.97
 2007 Fac PE RVU 0.39 2018 Fac PE RVU:0.39
 RUC Recommendation: 1.12 Referred to CPT October 2009 Result: Increase
 Referred to CPT Asst ☐ Published in CPT Asst:

11043 Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less

Global: 000 Issue: Debridement Screen: Site of Service Anomaly Complete? Yes

Most Recent Tab 04 Specialty Developing APMA, APTA First 2017 Est. 2007 Work RVU: 3.04 2018 Work RVU: 2.70
 RUC Meeting: February 2010 Recommendation: Identified: September 2007 Medicare Utilization: 362,168 2007 NF PE RVU: 3.45 2018 NF PE RVU: 3.45
 2007 Fac PE RVU 2.62 2018 Fac PE RVU:2.62
 RUC Recommendation: 3.00 Referred to CPT October 2009 Result: Decrease
 Referred to CPT Asst ☐ Published in CPT Asst:

11044 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less

Global: 000 Issue: Debridement Screen: Site of Service Anomaly Complete? Yes

Most Recent Tab 04 Specialty Developing APMA, APTA First 2017 Est. 2007 Work RVU: 4.11 2018 Work RVU: 4.10
 RUC Meeting: February 2010 Recommendation: Identified: September 2007 Medicare Utilization: 77,491 2007 NF PE RVU: 4.58 2018 NF PE RVU: 4.58
 2007 Fac PE RVU 3.73 2018 Fac PE RVU:3.73
 RUC Recommendation: 4.56 Referred to CPT October 2009 Result: Increase
 Referred to CPT Asst ☐ Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

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) **Global:** ZZZ **Issue:** Excision and Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent
RUC Meeting: February 2010

Tab 04

Specialty Developing
Recommendation:

ACS, APMA,
APTA

First
Identified:

2017 Est.
Medicare
Utilization: 422,398

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Increase

2018 Work RVU: 0.50
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.69

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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) **Global:** ZZZ **Issue:** Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent
RUC Meeting: February 2010

Tab 04

Specialty Developing
Recommendation:

ACS, APMA,
APTA

First
Identified:

2017 Est.
Medicare
Utilization: 182,118

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU: 1.03
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.29

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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) **Global:** ZZZ **Issue:** Debridement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent
RUC Meeting: February 2010

Tab 04

Specialty Developing
Recommendation:

ACS, APMA,
APTA

First
Identified:

2017 Est.
Medicare
Utilization: 46,698

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Increase

2018 Work RVU: 1.80
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 2.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11055 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion **Global:** 000 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012

Tab 30 **Specialty Developing Recommendation:** APMA

First Identified: November 2011

2017 Est. Medicare Utilization: 888,532

2007 Work RVU: 0.43 **2018 Work RVU:** 0.35
2007 NF PE RVU: 0.63 **2018 NF PE RVU:** 0.63
2007 Fac PE RVU: 0.16 **2018 Fac PE RVU:** 0.16
Result: Maintain

RUC Recommendation: Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

11056 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions **Global:** 000 **Issue:** Trim Skin Lesions **Screen:** MPC List / CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012

Tab 53 **Specialty Developing Recommendation:** APMA

First Identified: October 2010

2017 Est. Medicare Utilization: 2,012,522

2007 Work RVU: 0.61 **2018 Work RVU:** 0.50
2007 NF PE RVU: 0.7 **2018 NF PE RVU:** 0.7
2007 Fac PE RVU: 0.22 **2018 Fac PE RVU:** 0.22
Result: Decrease

RUC Recommendation: 0.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

11057 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than 4 lesions **Global:** 000 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012

Tab 30 **Specialty Developing Recommendation:** APMA

First Identified: November 2011

2017 Est. Medicare Utilization: 356,216

2007 Work RVU: 0.79 **2018 Work RVU:** 0.65
2007 NF PE RVU: 0.81 **2018 NF PE RVU:** 0.81
2007 Fac PE RVU: 0.28 **2018 Fac PE RVU:** 0.28
Result: Maintain

RUC Recommendation: Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion	Global: 000	Issue: Biopsy of Skin Lesion	Screen: MPC List / CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 05 Specialty Developing Recommendation: AAD	First Identified: October 2010	2017 Est. Medicare Utilization: 3,646,411	2007 Work RVU: 0.81 2007 NF PE RVU: 1.41 2007 Fac PE RVU: 0.38 Result: Deleted from CPT	2018 Work RVU: 0.81 2018 NF PE RVU: 1.41 2018 Fac PE RVU: 0.38
RUC Recommendation: Deleted from CPT		Referred to CPT February 2017 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
11101	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Biopsy of Skin Lesion	Screen: Low Value Billed in Multiple Units / CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 05 Specialty Developing Recommendation: AAD	First Identified: October 2010	2017 Est. Medicare Utilization: 1,537,789	2007 Work RVU: 0.41 2007 NF PE RVU: 0.35 2007 Fac PE RVU: 0.2 Result: Deleted from CPT	2018 Work RVU: 0.41 2018 NF PE RVU: 0.35 2018 Fac PE RVU: 0.2
RUC Recommendation: Deleted from CPT		Referred to CPT February 2017 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
11300	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less	Global: 000	Issue: Shaving of Epidermal or Dermal Lesions	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 38 Specialty Developing Recommendation: AAD	First Identified: January 2012	2017 Est. Medicare Utilization: 96,489	2007 Work RVU: 0.51 2007 NF PE RVU: 1.04 2007 Fac PE RVU: 0.21 Result: Increase	2018 Work RVU: 0.60 2018 NF PE RVU: 1.04 2018 Fac PE RVU: 0.21
RUC Recommendation: 0.60		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

11301	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm	Global: 000	Issue: Shaving of Epidermal or Dermal Lesions	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 38	Specialty Developing Recommendation: AAD	First Identified: January 2012	2017 Est. Medicare Utilization: 185,511	2007 Work RVU: 0.85 2007 NF PE RVU: 1.21 2007 Fac PE RVU: 0.38 Result: Increase
RUC Recommendation: 0.90			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.90 2018 NF PE RVU: 1.21 2018 Fac PE RVU: 0.38
11302	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm	Global: 000	Issue: Shaving of Epidermal or Dermal Lesions	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 38	Specialty Developing Recommendation: AAD	First Identified: January 2012	2017 Est. Medicare Utilization: 110,148	2007 Work RVU: 1.05 2007 NF PE RVU: 1.42 2007 Fac PE RVU: 0.47 Result: Increase
RUC Recommendation: 1.16			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.05 2018 NF PE RVU: 1.42 2018 Fac PE RVU: 0.47
11303	Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm	Global: 000	Issue: Shaving of Epidermal or Dermal Lesions	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 38	Specialty Developing Recommendation: AAD	First Identified: January 2012	2017 Est. Medicare Utilization: 16,824	2007 Work RVU: 1.24 2007 NF PE RVU: 1.69 2007 Fac PE RVU: 0.53 Result: Increase
RUC Recommendation: 1.25			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.25 2018 NF PE RVU: 1.69 2018 Fac PE RVU: 0.53
11305	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	Global: 000	Issue: Shaving of Epidermal or Dermal Lesions	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 38	Specialty Developing Recommendation: AAD	First Identified: January 2012	2017 Est. Medicare Utilization: 100,506	2007 Work RVU: 0.67 2007 NF PE RVU: 0.91 2007 Fac PE RVU: 0.26 Result: Increase
RUC Recommendation: 0.80			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.80 2018 NF PE RVU: 0.91 2018 Fac PE RVU: 0.26

Status Report: CMS Requests and Relativity Assessment Issues

11306	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm	Global: 000	Issue: Shaving of Epidermal or Dermal Lesions	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 38	Specialty Developing Recommendation: AAD	First Identified: January 2012	2017 Est. Medicare Utilization: 98,448	2007 Work RVU: 0.99 2007 NF PE RVU: 1.18 2007 Fac PE RVU: 0.41 Result: Increase
RUC Recommendation: 1.18			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.96 2018 NF PE RVU: 1.18 2018 Fac PE RVU: 0.41
11307	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm	Global: 000	Issue: Shaving of Epidermal or Dermal Lesions	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 38	Specialty Developing Recommendation: AAD	First Identified: January 2012	2017 Est. Medicare Utilization: 49,025	2007 Work RVU: 1.14 2007 NF PE RVU: 1.4 2007 Fac PE RVU: 0.49 Result: Increase
RUC Recommendation: 1.20			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.20 2018 NF PE RVU: 1.4 2018 Fac PE RVU: 0.49
11308	Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm	Global: 000	Issue: Shaving of Epidermal or Dermal Lesions	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 38	Specialty Developing Recommendation: AAD	First Identified: January 2012	2017 Est. Medicare Utilization: 12,993	2007 Work RVU: 1.41 2007 NF PE RVU: 1.53 2007 Fac PE RVU: 0.58 Result: Increase
RUC Recommendation: 1.46			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.46 2018 NF PE RVU: 1.53 2018 Fac PE RVU: 0.58
11310	Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	Global: 000	Issue: Shaving of Epidermal or Dermal Lesions	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 38	Specialty Developing Recommendation: AAD	First Identified: January 2012	2017 Est. Medicare Utilization: 76,010	2007 Work RVU: 0.73 2007 NF PE RVU: 1.18 2007 Fac PE RVU: 0.32 Result: Increase
RUC Recommendation: 1.19			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.80 2018 NF PE RVU: 1.18 2018 Fac PE RVU: 0.32

Status Report: CMS Requests and Relativity Assessment Issues

11311 Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm **Global:** 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012

Tab 38 **Specialty Developing Recommendation:** AAD

First Identified: January 2012

2017 Est. Medicare Utilization: 98,956

2007 Work RVU: 1.05

2018 Work RVU: 1.10

2007 NF PE RVU: 1.34

2018 NF PE RVU: 1.34

2007 Fac PE RVU 0.49

2018 Fac PE RVU:0.49

Result: Increase

RUC Recommendation: 1.43

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

11312 Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm **Global:** 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012

Tab 38 **Specialty Developing Recommendation:** AAD

First Identified: January 2012

2017 Est. Medicare Utilization: 47,855

2007 Work RVU: 1.20

2018 Work RVU: 1.30

2007 NF PE RVU: 1.55

2018 NF PE RVU: 1.55

2007 Fac PE RVU 0.56

2018 Fac PE RVU:0.56

Result: Increase

RUC Recommendation: 1.80

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

11313 Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm **Global:** 000 **Issue:** Shaving of Epidermal or Dermal Lesions **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012

Tab 38 **Specialty Developing Recommendation:** AAD

First Identified: January 2012

2017 Est. Medicare Utilization: 8,209

2007 Work RVU: 1.62

2018 Work RVU: 1.68

2007 NF PE RVU: 1.9

2018 NF PE RVU: 1.9

2007 Fac PE RVU 0.73

2018 Fac PE RVU:0.73

Result: Increase

RUC Recommendation: 2.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

11719 Trimming of nondystrophic nails, any number **Global:** 000 **Issue:** Debridement of Nail **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: January 2012

Tab 32 **Specialty Developing Recommendation:** APMA

First Identified: October 2010

2017 Est. Medicare Utilization: 950,470

2007 Work RVU: 0.17

2018 Work RVU: 0.17

2007 NF PE RVU: 0.28

2018 NF PE RVU: 0.28

2007 Fac PE RVU 0.07

2018 Fac PE RVU:0.07

Result: Maintain

RUC Recommendation: 0.17

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

11720	Debridement of nail(s) by any method(s); 1 to 5	Global: 000	Issue: Debridement of Nail	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: September 2011	Tab 53 Specialty Developing Recommendation: APMA	First Identified:	2017 Est. Medicare Utilization: 2,088,776	2007 Work RVU: 0.32 2007 NF PE RVU: 0.37 2007 Fac PE RVU: 0.11 Result: Maintain	2018 Work RVU: 0.32 2018 NF PE RVU: 0.37 2018 Fac PE RVU: 0.11
RUC Recommendation: 0.32 (Interim)		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

11721	Debridement of nail(s) by any method(s); 6 or more	Global: 000	Issue: Debridement of Nail	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: September 2011	Tab 53 Specialty Developing Recommendation: APMA	First Identified: October 2010	2017 Est. Medicare Utilization: 7,165,195	2007 Work RVU: 0.54 2007 NF PE RVU: 0.47 2007 Fac PE RVU: 0.2 Result: Maintain	2018 Work RVU: 0.54 2018 NF PE RVU: 0.47 2018 Fac PE RVU: 0.2
RUC Recommendation: 0.54 (Interim)		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

11730	Avulsion of nail plate, partial or complete, simple; single	Global: 000	Issue: Removal of Nail Plate	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 56 Specialty Developing Recommendation: APMA	First Identified: July 2015	2017 Est. Medicare Utilization: 416,764	2007 Work RVU: 1.10 2007 NF PE RVU: 1.11 2007 Fac PE RVU: 0.4 Result: Maintain	2018 Work RVU: 1.05 2018 NF PE RVU: 1.11 2018 Fac PE RVU: 0.4
RUC Recommendation: 1.10		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

11750	Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal	Global: 010	Issue: Excision of Nail Bed - HCPAC	Screen: 010-Day Global Post-Operative Visits	Complete? Yes
Most Recent RUC Meeting: September 2014	Tab 26 Specialty Developing Recommendation:	First Identified: January 2014	2017 Est. Medicare Utilization: 206,699	2007 Work RVU: 2.40 2007 NF PE RVU: 2.37 2007 Fac PE RVU: 1.79 Result: Decrease	2018 Work RVU: 1.58 2018 NF PE RVU: 2.37 2018 Fac PE RVU: 1.79
RUC Recommendation: 1.99		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

11752	Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal; with amputation of tuft of distal phalanx	Global: 010	Issue: Excision of Nail Bed - HCPAC	Screen: 010-Day Global Post-Operative Visits	Complete? Yes
Most Recent RUC Meeting: January 2015	Tab 28 Specialty Developing Recommendation:	First Identified: January 2014	2017 Est. Medicare Utilization:	2007 Work RVU: 3.48 2007 NF PE RVU: 3.28 2007 Fac PE RVU: 2.95 Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 3.28 2018 Fac PE RVU: 2.95
RUC Recommendation: Deleted from CPT		Referred to CPT October 2015 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
11755	Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)	Global: 000	Issue: Biopsy of Nail	Screen: CMS 000-Day Global Typically Reported with an E/M	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 41i Specialty Developing Recommendation: APMA	First Identified: July 2016	2017 Est. Medicare Utilization: 62,674	2007 Work RVU: 1.31 2007 NF PE RVU: 1.69 2007 Fac PE RVU: 0.77 Result: Decrease	2018 Work RVU: 1.31 2018 NF PE RVU: 1.69 2018 Fac PE RVU: 0.77
RUC Recommendation: 1.25		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
11900	Injection, intralesional; up to and including 7 lesions	Global: 000	Issue: Skin Injection Services	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 31 Specialty Developing Recommendation: AAD	First Identified: October 2009	2017 Est. Medicare Utilization: 239,824	2007 Work RVU: 0.52 2007 NF PE RVU: 0.72 2007 Fac PE RVU: 0.22 Result: Maintain	2018 Work RVU: 0.52 2018 NF PE RVU: 0.72 2018 Fac PE RVU: 0.22
RUC Recommendation: 0.52		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

11901 Injection, intralesional; more than 7 lesions **Global:** 000 **Issue:** Skin Injection Services **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent
RUC Meeting: April 2010 **Tab** 31 **Specialty Developing Recommendation:** AAD

First Identified: February 2010

2017 Est. Medicare Utilization: 69,094

2007 Work RVU: 0.80 **2018 Work RVU:** 0.80
2007 NF PE RVU: 0.75 **2018 NF PE RVU:** 0.75
2007 Fac PE RVU 0.37 **2018 Fac PE RVU:**0.37
Result: Maintain

RUC Recommendation: 0.80

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

11980 Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin) **Global:** 000 **Issue:** Drug Delivery Implant Procedures **Screen:** High Volume Growth2 / Different Performing Specialty from Survey **Complete?** Yes

Most Recent
RUC Meeting: October 2018 **Tab** 05 **Specialty Developing Recommendation:** AAOS, ACOG, AUA

First Identified: April 2013

2017 Est. Medicare Utilization: 32,117

2007 Work RVU: 1.48 **2018 Work RVU:** 1.10
2007 NF PE RVU: 1.1 **2018 NF PE RVU:** 1.1
2007 Fac PE RVU 0.55 **2018 Fac PE RVU:**0.55
Result: Decrease

RUC Recommendation: 1.10

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

11981 Insertion, non-biodegradable drug delivery implant **Global:** XXX **Issue:** Drug Delivery Implant Procedures **Screen:** High Volume Growth1 / Different Performing Specialty from Survey **Complete?** Yes

Most Recent
RUC Meeting: October 2018 **Tab** 05 **Specialty Developing Recommendation:** AAOS, ACOG, AUA

First Identified: June 2008

2017 Est. Medicare Utilization: 12,730

2007 Work RVU: 1.48 **2018 Work RVU:** 1.48
2007 NF PE RVU: 1.76 **2018 NF PE RVU:** 1.76
2007 Fac PE RVU 0.66 **2018 Fac PE RVU:**0.66
Result: Decrease

RUC Recommendation: 1.30

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11982 Removal, non-biodegradable drug delivery implant

Global: XXX

Issue: Drug Delivery Implant Procedures

Screen: High Volume Growth1 / Different Performing Specialty from Survey

Complete? Yes

Most Recent RUC Meeting: October 2018

Tab 05

Specialty Developing Recommendation:

AAOS, ACOG, AUA

First Identified: February 2008

2017 Est. Medicare Utilization: 4,128

2007 Work RVU: 1.78

2018 Work RVU: 1.78

2007 NF PE RVU: 1.97

2018 NF PE RVU: 1.97

2007 Fac PE RVU 0.81

2018 Fac PE RVU:0.81

Result: Decrease

RUC Recommendation: 1.70

Referred to CPT May 2018

Referred to CPT Asst ☐ **Published in CPT Asst:**

11983 Removal with reinsertion, non-biodegradable drug delivery implant

Global: XXX

Issue: Drug Delivery Implant Procedures

Screen: High Volume Growth1

Complete? Yes

Most Recent RUC Meeting: October 2018

Tab 05

Specialty Developing Recommendation:

AAOS, ACOG, AUA

First Identified: June 2008

2017 Est. Medicare Utilization: 2,427

2007 Work RVU: 3.30

2018 Work RVU: 3.30

2007 NF PE RVU: 2.38

2018 NF PE RVU: 2.38

2007 Fac PE RVU 1.44

2018 Fac PE RVU:1.44

Result: Decrease

RUC Recommendation: 2.10

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

11X02

Global:

Issue: Skin Biopsy

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: April 2017

Tab 05

Specialty Developing Recommendation:

First Identified: February 2017

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 0.66

Referred to CPT February 2017

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

11X03

Global: Issue: Skin Biopsy

Screen: CMS High Expenditure
Procedural Codes2 Complete? Yes

Most Recent
RUC Meeting: April 2017

Tab 05 Specialty Developing
Recommendation:

First
Identified: February 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.38

Referred to CPT February 2017
Referred to CPT Asst ☐ Published in CPT Asst:

11X04

Global: Issue: Skin Biopsy

Screen: CMS High Expenditure
Procedural Codes2 Complete? Yes

Most Recent
RUC Meeting: April 2017

Tab 05 Specialty Developing
Recommendation:

First
Identified: February 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.83

Referred to CPT February 2017
Referred to CPT Asst ☐ Published in CPT Asst:

11X05

Global: Issue: Skin Biopsy

Screen: CMS High Expenditure
Procedural Codes2 Complete? Yes

Most Recent
RUC Meeting: April 2017

Tab 05 Specialty Developing
Recommendation:

First
Identified: February 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.45

Referred to CPT February 2017
Referred to CPT Asst ☐ Published in CPT Asst:

11X06

Global: Issue: Skin Biopsy

Screen: CMS High Expenditure
Procedural Codes2 Complete? Yes

Most Recent
RUC Meeting: April 2017

Tab 05 Specialty Developing
Recommendation:

First
Identified: February 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.01

Referred to CPT February 2017
Referred to CPT Asst ☐ Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

11X07			Global:	Issue: Skin Biopsy	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 05	Specialty Developing Recommendation:	First Identified: February 2017	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.54			Referred to CPT February 2017 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

12001 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less			Global: 000	Issue: Repair of Superficial Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 32	Specialty Developing Recommendation: ACEP, AAFP	First Identified: October 2009	2017 Est. Medicare Utilization: 189,564	2007 Work RVU: 1.72 2007 NF PE RVU: 1.92 2007 Fac PE RVU 0.76 Result: Decrease	2018 Work RVU: 0.84 2018 NF PE RVU: 1.92 2018 Fac PE RVU: 0.76
RUC Recommendation: 0.84			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

12002 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm			Global: 000	Issue: Repair of Superficial Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 32	Specialty Developing Recommendation: ACEP, AAFP	First Identified: October 2009	2017 Est. Medicare Utilization: 146,808	2007 Work RVU: 1.88 2007 NF PE RVU: 1.98 2007 Fac PE RVU 0.89 Result: Decrease	2018 Work RVU: 1.14 2018 NF PE RVU: 1.98 2018 Fac PE RVU: 0.89
RUC Recommendation: 1.14			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

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			Global: 000	Issue: Repair of Superficial Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 32	Specialty Developing Recommendation: ACEP, AAFP	First Identified: April 2010	2017 Est. Medicare Utilization: 22,716	2007 Work RVU: 2.26 2007 NF PE RVU: 2.26 2007 Fac PE RVU 0.99 Result: Decrease	2018 Work RVU: 1.44 2018 NF PE RVU: 2.26 2018 Fac PE RVU: 0.99
RUC Recommendation: 1.44			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

12005 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm **Global:** 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 32 Specialty Developing Recommendation: ACEP, AAFP

First Identified:

2017 Est. Medicare Utilization: 6,135

2007 Work RVU: 2.88

2018 Work RVU: 1.97

2007 NF PE RVU: 2.75

2018 NF PE RVU: 2.75

2007 Fac PE RVU: 1.17

2018 Fac PE RVU: 1.17

Result: Decrease

RUC Recommendation: 1.97

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

12006 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm **Global:** 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 32 Specialty Developing Recommendation: ACEP, AAFP

First Identified: April 2010

2017 Est. Medicare Utilization: 1,218

2007 Work RVU: 3.68

2018 Work RVU: 2.39

2007 NF PE RVU: 3.3

2018 NF PE RVU: 3.3

2007 Fac PE RVU: 1.46

2018 Fac PE RVU: 1.46

Result: Decrease

RUC Recommendation: 2.39

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

12007 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm **Global:** 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 32 Specialty Developing Recommendation: ACEP, AAFP

First Identified: April 2010

2017 Est. Medicare Utilization: 433

2007 Work RVU: 4.13

2018 Work RVU: 2.90

2007 NF PE RVU: 3.71

2018 NF PE RVU: 3.71

2007 Fac PE RVU: 1.73

2018 Fac PE RVU: 1.73

Result: Decrease

RUC Recommendation: 2.90

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

12011 Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less **Global:** 000 **Issue:** Repair of Superficial Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 32 Specialty Developing Recommendation: ACEP, AAFP

First Identified: April 2010

2017 Est. Medicare Utilization: 90,890

2007 Work RVU: 1.78

2018 Work RVU: 1.07

2007 NF PE RVU: 2.07

2018 NF PE RVU: 2.07

2007 Fac PE RVU: 0.78

2018 Fac PE RVU: 0.78

Result: Decrease

RUC Recommendation: 1.07

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

12013	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	Global: 000	Issue: Repair of Superficial Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 32	Specialty Developing Recommendation: ACEP, AAFP	First Identified: April 2010	2017 Est. Medicare Utilization: 50,886	2007 Work RVU: 2.01 2007 NF PE RVU: 2.22 2007 Fac PE RVU: 0.92 Result: Decrease
RUC Recommendation: 1.22			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.22 2018 NF PE RVU: 2.22 2018 Fac PE RVU: 0.92
12014	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm	Global: 000	Issue: Repair of Superficial Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 32	Specialty Developing Recommendation: ACEP, AAFP	First Identified:	2017 Est. Medicare Utilization: 6,734	2007 Work RVU: 2.48 2007 NF PE RVU: 2.5 2007 Fac PE RVU: 1.04 Result: Decrease
RUC Recommendation: 1.57			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.57 2018 NF PE RVU: 2.5 2018 Fac PE RVU: 1.04
12015	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm	Global: 000	Issue: Repair of Superficial Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 32	Specialty Developing Recommendation: ACEP, AAFP	First Identified:	2017 Est. Medicare Utilization: 3,403	2007 Work RVU: 3.21 2007 NF PE RVU: 3.04 2007 Fac PE RVU: 1.22 Result: Decrease
RUC Recommendation: 1.98			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.98 2018 NF PE RVU: 3.04 2018 Fac PE RVU: 1.22
12016	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm	Global: 000	Issue: Repair of Superficial Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 32	Specialty Developing Recommendation: ACEP, AAFP	First Identified:	2017 Est. Medicare Utilization: 541	2007 Work RVU: 3.94 2007 NF PE RVU: 3.45 2007 Fac PE RVU: 1.47 Result: Decrease
RUC Recommendation: 2.68			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2.68 2018 NF PE RVU: 3.45 2018 Fac PE RVU: 1.47

Status Report: CMS Requests and Relativity Assessment Issues

12017	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm	Global: 000	Issue: Repair of Superficial Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 32	Specialty Developing Recommendation: ACEP, AAFP	First Identified:	2017 Est. Medicare Utilization: 69	2007 Work RVU: 4.72 2007 NF PE RVU: NA 2007 Fac PE RVU 1.79 Result: Decrease
RUC Recommendation: 3.18			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 3.18 2018 NF PE RVU: NA 2018 Fac PE RVU: 1.79
12018	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm	Global: 000	Issue: Repair of Superficial Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 32	Specialty Developing Recommendation: ACEP, AAFP	First Identified:	2017 Est. Medicare Utilization: 27	2007 Work RVU: 5.54 2007 NF PE RVU: NA 2007 Fac PE RVU 2.19 Result: Decrease
RUC Recommendation: 3.61			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 3.61 2018 NF PE RVU: NA 2018 Fac PE RVU: 2.19
12031	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less	Global: 010	Issue: Repair of Intermediate Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 22	Specialty Developing Recommendation: AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,	First Identified: February 2010	2017 Est. Medicare Utilization: 61,204	2007 Work RVU: 2.17 2007 NF PE RVU: 2.69 2007 Fac PE RVU 1.17 Result: Decrease
RUC Recommendation: 2.00			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2.00 2018 NF PE RVU: 2.69 2018 Fac PE RVU: 1.17

Status Report: CMS Requests and Relativity Assessment Issues

12032	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm	Global: 010	Issue: Repair of Intermediate Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 22	Specialty Developing Recommendation: AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,	First Identified: October 2009	2017 Est. Medicare Utilization: 265,916	2007 Work RVU: 2.49 2007 NF PE RVU: 4.19 2007 Fac PE RVU: 1.92 2018 Work RVU: 2.52 2018 NF PE RVU: 4.19 2018 Fac PE RVU: 1.92
RUC Recommendation: 2.52			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain
12034	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm	Global: 010	Issue: Repair of Intermediate Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 22	Specialty Developing Recommendation: AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,	First Identified: February 2010	2017 Est. Medicare Utilization: 24,934	2007 Work RVU: 2.94 2007 NF PE RVU: 3.54 2007 Fac PE RVU: 1.59 2018 Work RVU: 2.97 2018 NF PE RVU: 3.54 2018 Fac PE RVU: 1.59
RUC Recommendation: 2.97			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain
12035	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm	Global: 010	Issue: Repair of Intermediate Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 22	Specialty Developing Recommendation: AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,	First Identified: February 2010	2017 Est. Medicare Utilization: 4,959	2007 Work RVU: 3.44 2007 NF PE RVU: 5.21 2007 Fac PE RVU: 2.14 2018 Work RVU: 3.50 2018 NF PE RVU: 5.21 2018 Fac PE RVU: 2.14
RUC Recommendation: 3.60			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

12036	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm	Global: 010	Issue: Repair of Intermediate Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 22	Specialty Developing Recommendation: AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,	First Identified: February 2010	2017 Est. Medicare Utilization: 991	2007 Work RVU: 4.06 2007 NF PE RVU: 5.51 2007 Fac PE RVU: 2.47 2018 Work RVU: 4.23 2018 NF PE RVU: 5.51 2018 Fac PE RVU: 2.47
RUC Recommendation: 4.50			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Increase
12037	Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); over 30.0 cm	Global: 010	Issue: Repair of Intermediate Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 22	Specialty Developing Recommendation: AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,	First Identified: February 2010	2017 Est. Medicare Utilization: 561	2007 Work RVU: 4.68 2007 NF PE RVU: 6.05 2007 Fac PE RVU: 2.88 2018 Work RVU: 5.00 2018 NF PE RVU: 6.05 2018 Fac PE RVU: 2.88
RUC Recommendation: 5.25			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Increase
12041	Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less	Global: 010	Issue: Repair of Intermediate Wounds	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 22	Specialty Developing Recommendation: AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,	First Identified: February 2010	2017 Est. Medicare Utilization: 20,108	2007 Work RVU: 2.39 2007 NF PE RVU: 2.87 2007 Fac PE RVU: 1.29 2018 Work RVU: 2.10 2018 NF PE RVU: 2.87 2018 Fac PE RVU: 1.29
RUC Recommendation: 2.10			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

12042 Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 22

Specialty Developing Recommendation:

AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,

First Identified: February 2010

2017 Est. Medicare Utilization: 50,206

2007 Work RVU: 2.76

2018 Work RVU: 2.79

2007 NF PE RVU: 3.57

2018 NF PE RVU: 3.57

2007 Fac PE RVU 1.63

2018 Fac PE RVU:1.63

RUC Recommendation: 2.79

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Maintain

12044 Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 22

Specialty Developing Recommendation:

AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,

First Identified: February 2010

2017 Est. Medicare Utilization: 2,211

2007 Work RVU: 3.16

2018 Work RVU: 3.19

2007 NF PE RVU: 3.74

2018 NF PE RVU: 3.74

2007 Fac PE RVU 1.69

2018 Fac PE RVU:1.69

RUC Recommendation: 3.19

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Maintain

12045 Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 22

Specialty Developing Recommendation:

AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,

First Identified: February 2010

2017 Est. Medicare Utilization: 382

2007 Work RVU: 3.65

2018 Work RVU: 3.75

2007 NF PE RVU: 5.21

2018 NF PE RVU: 5.21

2007 Fac PE RVU 2.23

2018 Fac PE RVU:2.23

RUC Recommendation: 3.90

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

12046 Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 22

Specialty Developing Recommendation:

AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,

First Identified: February 2010

2017 Est. Medicare Utilization: 106

2007 Work RVU: 4.26
2007 NF PE RVU: 6.28
2007 Fac PE RVU: 2.64

2018 Work RVU: 4.30
2018 NF PE RVU: 6.28
2018 Fac PE RVU: 2.64

RUC Recommendation: 4.60

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Increase

12047 Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; over 30.0 cm **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 22

Specialty Developing Recommendation:

AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,

First Identified: February 2010

2017 Est. Medicare Utilization: 49

2007 Work RVU: 4.66
2007 NF PE RVU: 6.3
2007 Fac PE RVU: 2.95

2018 Work RVU: 4.95
2018 NF PE RVU: 6.3
2018 Fac PE RVU: 2.95

RUC Recommendation: 5.50

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Increase

12051 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 22

Specialty Developing Recommendation:

AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,

First Identified: February 2010

2017 Est. Medicare Utilization: 57,255

2007 Work RVU: 2.49
2007 NF PE RVU: 3.48
2007 Fac PE RVU: 1.57

2018 Work RVU: 2.33
2018 NF PE RVU: 3.48
2018 Fac PE RVU: 1.57

RUC Recommendation: 2.33

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

12052 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 45

Specialty Developing Recommendation: AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,

First Identified: February 2010

2017 Est. Medicare Utilization: 78,220

2007 Work RVU: 2.81

2018 Work RVU: 2.87

2007 NF PE RVU: 3.64

2018 NF PE RVU: 3.64

2007 Fac PE RVU 1.72

2018 Fac PE RVU:1.72

RUC Recommendation: Remove from screen

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Remove from Screen

12053 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 22

Specialty Developing Recommendation: AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,

First Identified: February 2010

2017 Est. Medicare Utilization: 9,389

2007 Work RVU: 3.14

2018 Work RVU: 3.17

2007 NF PE RVU: 3.77

2018 NF PE RVU: 3.77

2007 Fac PE RVU 1.68

2018 Fac PE RVU:1.68

RUC Recommendation: 3.17

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Maintain

12054 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 22

Specialty Developing Recommendation: AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,

First Identified: February 2010

2017 Est. Medicare Utilization: 2,577

2007 Work RVU: 3.47

2018 Work RVU: 3.50

2007 NF PE RVU: 4.02

2018 NF PE RVU: 4.02

2007 Fac PE RVU 1.74

2018 Fac PE RVU:1.74

RUC Recommendation: 3.50

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

12055 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 22

Specialty Developing Recommendation:

AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,

First Identified: February 2010

2017 Est. Medicare Utilization: 342

2007 Work RVU: 4.44

2018 Work RVU: 4.50

2007 NF PE RVU: 4.87

2018 NF PE RVU: 4.87

2007 Fac PE RVU 2.13

2018 Fac PE RVU:2.13

RUC Recommendation: 4.65

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Increase

12056 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 22

Specialty Developing Recommendation:

AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,

First Identified: February 2010

2017 Est. Medicare Utilization: 44

2007 Work RVU: 5.25

2018 Work RVU: 5.30

2007 NF PE RVU: 6.62

2018 NF PE RVU: 6.62

2007 Fac PE RVU 2.89

2018 Fac PE RVU:2.89

RUC Recommendation: 5.50

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Increase

12057 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm **Global:** 010 **Issue:** Repair of Intermediate Wounds **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 22

Specialty Developing Recommendation:

AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS,

First Identified: February 2010

2017 Est. Medicare Utilization: 23

2007 Work RVU: 5.97

2018 Work RVU: 6.00

2007 NF PE RVU: 6.47

2018 NF PE RVU: 6.47

2007 Fac PE RVU 3.53

2018 Fac PE RVU:3.53

RUC Recommendation: 6.28

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

13100 Repair, complex, trunk; 1.1 cm to 2.5 cm **Global:** 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent **Tab** 37 **Specialty Developing** AAD, AAO- **First** **2017 Est.** **2007 Work RVU:** 3.14 **2018 Work RVU:** 3.00
RUC Meeting: April 2012 **Recommendation:** HNS, ASPS **Identified:** **Medicare** **2007 NF PE RVU:** 4.15 **2018 NF PE RVU:** 4.15
Utilization: 5,924 **2007 Fac PE RVU** 2.35 **2018 Fac PE RVU:**2.35
RUC Recommendation: 3.00 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

13101 Repair, complex, trunk; 2.6 cm to 7.5 cm **Global:** 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent **Tab** 37 **Specialty Developing** AAD, AAO- **First** **2017 Est.** **2007 Work RVU:** 3.93 **2018 Work RVU:** 3.50
RUC Meeting: April 2012 **Recommendation:** HNS, ASPS **Identified:** **Medicare** **2007 NF PE RVU:** 4.99 **2018 NF PE RVU:** 4.99
Utilization: 92,384 **2007 Fac PE RVU** 2.77 **2018 Fac PE RVU:**2.77
RUC Recommendation: 3.50 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

13102 Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent **Tab** 37 **Specialty Developing** AAD, AAO- **First** **2017 Est.** **2007 Work RVU:** 1.24 **2018 Work RVU:** 1.24
RUC Meeting: April 2012 **Recommendation:** HNS, ASPS **Identified:** **Medicare** **2007 NF PE RVU:** 1.22 **2018 NF PE RVU:** 1.22
Utilization: 23,600 **2007 Fac PE RVU** 0.57 **2018 Fac PE RVU:**0.57
RUC Recommendation: 1.24 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

13120 Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm **Global:** 010 **Issue:** Complex Wound Repair **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent **Tab** 19 **Specialty Developing** AAD, AAO- **First** **2017 Est.** **2007 Work RVU:** 3.32 **2018 Work RVU:** 3.23
RUC Meeting: October 2017 **Recommendation:** HNS, ASPS **Identified:** October 2008 **Medicare** **2007 NF PE RVU:** 4.26 **2018 NF PE RVU:** 4.26
Utilization: 11,186 **2007 Fac PE RVU** 2.41 **2018 Fac PE RVU:**2.41
RUC Recommendation: 3.23 **Referred to CPT** September 2018 **Referred to CPT Asst** ☒ **Published in CPT Asst:** **Result:** Decrease
 1st article: May 2011; 2nd article July 2016; Sept 2018 CPT Editorial Meeting Tab 9, specialties submitted revisions to the guidelines.

Status Report: CMS Requests and Relativity Assessment Issues

13121	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	Global: 010	Issue: Complex Wound Repair	Screen: CMS Fastest Growing / CPT Assistant Analysis	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 19	Specialty Developing Recommendation: AAD, AAO-HNS, ASPS	First Identified: October 2008	2017 Est. Medicare Utilization: 182,629	2007 Work RVU: 4.36 2007 NF PE RVU: 5.32 2007 Fac PE RVU: 3.02 2018 Work RVU: 4.00 2018 NF PE RVU: 5.32 2018 Fac PE RVU: 3.02
RUC Recommendation: 4.00			Referred to CPT September 2018	Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: 1st article: May 2011; 2nd article July 2016; Sept 2018 CPT Editorial Meeting Tab 9, specialties submitted revisions to the guidelines.
					Result: Decrease
<hr/>					
13122	Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Complex Wound Repair	Screen: CMS Fastest Growing / CPT Assistant Analysis	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 19	Specialty Developing Recommendation: AAD, AAO-HNS, ASPS	First Identified: October 2008	2017 Est. Medicare Utilization: 26,702	2007 Work RVU: 1.44 2007 NF PE RVU: 1.48 2007 Fac PE RVU: 0.63 2018 Work RVU: 1.44 2018 NF PE RVU: 1.48 2018 Fac PE RVU: 0.63
RUC Recommendation: 1.44			Referred to CPT September 2018	Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: 1st article: May 2011; 2nd article July 2016; Sept 2018 CPT Editorial Meeting Tab 9, specialties submitted revisions to the guidelines.
					Result: Maintain
<hr/>					
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm	Global: 010	Issue: Complex Wound Repair	Screen: Harvard Valued - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 37	Specialty Developing Recommendation: AAD, AAO-HNS, ASPS	First Identified: April 2011	2017 Est. Medicare Utilization: 40,127	2007 Work RVU: 3.80 2007 NF PE RVU: 4.53 2007 Fac PE RVU: 2.74 2018 Work RVU: 3.73 2018 NF PE RVU: 4.53 2018 Fac PE RVU: 2.74
RUC Recommendation: 3.73			Referred to CPT	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
					Result: Decrease
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Status Report: CMS Requests and Relativity Assessment Issues

13132	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm	Global: 010	Issue: Complex Wound Repair	Screen: CMS Request	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 37	Specialty Developing Recommendation: AAD, AAO-HNS, ASPS	First Identified: September 2011	2017 Est. Medicare Utilization: 281,904	2007 Work RVU: 6.48 2007 NF PE RVU: 6.42 2007 Fac PE RVU: 4.38 Result: Decrease 2018 Work RVU: 4.78 2018 NF PE RVU: 6.42 2018 Fac PE RVU: 4.38
RUC Recommendation: 4.78			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
13133	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Complex Wound Repair	Screen: CMS Request	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 37	Specialty Developing Recommendation: AAD, AAO-HNS, ASPS	First Identified: September 2011	2017 Est. Medicare Utilization: 15,707	2007 Work RVU: 2.19 2007 NF PE RVU: 1.72 2007 Fac PE RVU: 1.02 Result: Maintain 2018 Work RVU: 2.19 2018 NF PE RVU: 1.72 2018 Fac PE RVU: 1.02
RUC Recommendation: 2.19			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
13150	Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less	Global: 010	Issue: Complex Wound Repair	Screen: CMS Request	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 37	Specialty Developing Recommendation: AAD, AAO-HNS, ASPS	First Identified: September 2011	2017 Est. Medicare Utilization:	2007 Work RVU: 3.82 2007 NF PE RVU: 4.83 2007 Fac PE RVU: 2.76 Result: Deleted from CPT 2018 Work RVU: 2018 NF PE RVU: 4.83 2018 Fac PE RVU: 2.76
RUC Recommendation: Deleted from CPT			Referred to CPT October 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
13151	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm	Global: 010	Issue: Complex Wound Repair	Screen: CMS Request	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 37	Specialty Developing Recommendation: AAD, AAO-HNS, ASPS	First Identified: September 2011	2017 Est. Medicare Utilization: 34,747	2007 Work RVU: 4.46 2007 NF PE RVU: 4.99 2007 Fac PE RVU: 3.17 Result: Decrease 2018 Work RVU: 4.34 2018 NF PE RVU: 4.99 2018 Fac PE RVU: 3.17
RUC Recommendation: 4.34			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

13152	Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm	Global: 010	Issue: Complex Wound Repair	Screen: Harvard Valued - Utilization over 30,000 / Harvard-Valued with Annual Allowed Charges over \$10 million	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 37	Specialty Developing Recommendation: AAD, AAO-HNS, ASPS	First Identified: April 2011	2017 Est. Medicare Utilization: 53,967	2007 Work RVU: 6.34 2007 NF PE RVU: 6.42 2007 Fac PE RVU: 4.03 Result: Decrease
RUC Recommendation: 5.34			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 5.34 2018 NF PE RVU: 6.42 2018 Fac PE RVU: 4.03
<hr/>					
13153	Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Complex Wound Repair	Screen: CMS Request	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 37	Specialty Developing Recommendation: AAD, AAO-HNS, ASPS	First Identified:	2017 Est. Medicare Utilization: 961	2007 Work RVU: 2.38 2007 NF PE RVU: 1.96 2007 Fac PE RVU: 1.11 Result: Maintain
RUC Recommendation: 2.38			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2.38 2018 NF PE RVU: 1.96 2018 Fac PE RVU: 1.11
<hr/>					
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less	Global: 090	Issue: Skin Tissue Rearrangement	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting: October 2008	Tab 9	Specialty Developing Recommendation: ACS, AAD, ASPS	First Identified: April 2008	2017 Est. Medicare Utilization: 8,429	2007 Work RVU: 6.83 2007 NF PE RVU: 8.14 2007 Fac PE RVU: 5.63 Result: Decrease
RUC Recommendation: 6.19			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 6.37 2018 NF PE RVU: 8.14 2018 Fac PE RVU: 5.63

Status Report: CMS Requests and Relativity Assessment Issues

14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm	Global: 090	Issue: Skin Tissue Rearrangement	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting: October 2008	Tab 9	Specialty Developing Recommendation: ACS, AAD, ASPS	First Identified: September 2007	2017 Est. Medicare Utilization: 9,240	2007 Work RVU: 9.60 2007 NF PE RVU: 9.86 2007 Fac PE RVU: 7.22 Result: Decrease
RUC Recommendation: 8.58			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 8.78 2018 NF PE RVU: 9.86 2018 Fac PE RVU: 7.22
<hr/>					
14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less	Global: 090	Issue: Skin Tissue Rearrangement	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting: October 2008	Tab 9	Specialty Developing Recommendation: AAD, ASPS	First Identified: April 2008	2017 Est. Medicare Utilization: 19,701	2007 Work RVU: 7.66 2007 NF PE RVU: 8.98 2007 Fac PE RVU: 6.64 Result: Decrease
RUC Recommendation: 7.02			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 7.22 2018 NF PE RVU: 8.98 2018 Fac PE RVU: 6.64
<hr/>					
14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm	Global: 090	Issue: Skin Tissue Rearrangement	Screen: Site of Service Anomaly / CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: October 2008	Tab 9	Specialty Developing Recommendation: AAD, ASPS	First Identified: September 2007	2017 Est. Medicare Utilization: 18,641	2007 Work RVU: 11.18 2007 NF PE RVU: 10.63 2007 Fac PE RVU: 8.41 Result: Decrease
RUC Recommendation: 9.52			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 9.72 2018 NF PE RVU: 10.63 2018 Fac PE RVU: 8.41
<hr/>					
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	Global: 090	Issue: Skin Tissue Rearrangement	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting: October 2008	Tab 9	Specialty Developing Recommendation: AAD, ASPS, AAO-HNS	First Identified: April 2008	2017 Est. Medicare Utilization: 70,612	2007 Work RVU: 8.44 2007 NF PE RVU: 9.17 2007 Fac PE RVU: 7.17 Result: Maintain
RUC Recommendation: 8.44			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 8.60 2018 NF PE RVU: 9.17 2018 Fac PE RVU: 7.17

Status Report: CMS Requests and Relativity Assessment Issues

14041 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 43,799

RUC Recommendation: 10.63 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 12.67 **2018 Work RVU:** 10.83
2007 NF PE RVU: 11.37 **2018 NF PE RVU:** 11.37
2007 Fac PE RVU: 8.88 **2018 Fac PE RVU:** 8.88
Result: Decrease

14060 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** April 2008 **2017 Est. Medicare Utilization:** 92,863

RUC Recommendation: Maintain **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 9.07 **2018 Work RVU:** 9.23
2007 NF PE RVU: 9.02 **2018 NF PE RVU:** 9.02
2007 Fac PE RVU: 7.39 **2018 Fac PE RVU:** 7.39
Result: Maintain

14061 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 29,557

RUC Recommendation: 11.25 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 13.67 **2018 Work RVU:** 11.48
2007 NF PE RVU: 12.45 **2018 NF PE RVU:** 12.45
2007 Fac PE RVU: 9.72 **2018 Fac PE RVU:** 9.72
Result: Decrease

14300 Deleted from CPT **Global:** 090 **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 04 **Specialty Developing Recommendation:** ACS, AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2017 Est. Medicare Utilization:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

2007 Work RVU: 13.26 **2018 Work RVU:**
2007 NF PE RVU: 11.77 **2018 NF PE RVU:** 11.77
2007 Fac PE RVU: 9.28 **2018 Fac PE RVU:** 9.28
Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

14301 Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm **Global:** 090 **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent
RUC Meeting: April 2009

Tab 04 **Specialty Developing** ACS, AAO-
Recommendation: HNS, ASPS

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 34,098

2007 Work RVU:

2018 Work RVU: 12.65

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 12.47

Referred to CPT February 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

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) **Global:** ZZZ **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent
RUC Meeting: April 2009

Tab 04 **Specialty Developing** ACS, AAO-
Recommendation: HNS, ASPS

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 32,962

2007 Work RVU:

2018 Work RVU: 3.73

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 3.73

Referred to CPT February 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

15002 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; first 100 sq cm or 1% of body area of infants and children **Global:** 000 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent
RUC Meeting: September 2014

Tab 21 **Specialty Developing** ASPS
Recommendation:

First
Identified: January 2014

2017 Est.
Medicare
Utilization: 20,240

2007 Work RVU: 3.65

2018 Work RVU: 3.65

2007 NF PE RVU: 4.12

2018 NF PE RVU: 4.12

2007 Fac PE RVU 1.65

2018 Fac PE RVU: 1.65

Result: Maintain

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15004	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, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children	Global: 000	Issue: RAW	Screen: Pre-Time Analysis	Complete? Yes
Most Recent RUC Meeting: September 2014	Tab 21 Specialty Developing Recommendation: ASPS, APMA	First Identified: January 2014	2017 Est. Medicare Utilization: 28,512	2007 Work RVU: 4.58 2007 NF PE RVU: 4.77 2007 Fac PE RVU: 1.97 Result: Maintain	2018 Work RVU: 4.58 2018 NF PE RVU: 4.77 2018 Fac PE RVU: 1.97
RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.		Referred to CPT			
		Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	
15100	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)	Global: 090	Issue: RAW	Screen: Pre-Time Analysis	Complete? Yes
Most Recent RUC Meeting: September 2014	Tab 21 Specialty Developing Recommendation: ASPS	First Identified: January 2014	2017 Est. Medicare Utilization: 14,694	2007 Work RVU: 9.74 2007 NF PE RVU: 11.91 2007 Fac PE RVU: 7.57 Result: Maintain	2018 Work RVU: 9.90 2018 NF PE RVU: 11.91 2018 Fac PE RVU: 7.57
RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.		Referred to CPT			
		Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	
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)	Global: 090	Issue: Autograft	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting: September 2007	Tab 16 Specialty Developing Recommendation: AAO-HNS, ASPS	First Identified: September 2007	2017 Est. Medicare Utilization: 10,066	2007 Work RVU: 10.96 2007 NF PE RVU: 10.87 2007 Fac PE RVU: 7.71 Result: Remove from Screen	2018 Work RVU: 10.15 2018 NF PE RVU: 10.87 2018 Fac PE RVU: 7.71
RUC Recommendation: Remove from screen		Referred to CPT			
		Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

15170 Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children **Global:** 090 **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010

Tab 31 Specialty Developing Recommendation: APMA, ASPS

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 5.99

2018 Work RVU:

2007 NF PE RVU: 3.79

2018 NF PE RVU: 3.79

2007 Fac PE RVU: 2.37

2018 Fac PE RVU: 2.37

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

15171 Acellular dermal replacement, trunk, arms, legs; 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) **Global:** ZZZ **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010

Tab 31 Specialty Developing Recommendation: APMA, ASPS

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 1.55

2018 Work RVU:

2007 NF PE RVU: 0.68

2018 NF PE RVU: 0.68

2007 Fac PE RVU: 0.6

2018 Fac PE RVU: 0.6

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

15175 Acellular dermal replacement, 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 **Global:** 090 **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010

Tab 31 Specialty Developing Recommendation: APMA, ASPS

First Identified: October 2009

2017 Est. Medicare Utilization:

2007 Work RVU: 7.99

2018 Work RVU:

2007 NF PE RVU: 5.4

2018 NF PE RVU: 5.4

2007 Fac PE RVU: 3.96

2018 Fac PE RVU: 3.96

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

15176	Acellular dermal replacement, 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)	Global: ZZZ	Issue: Acellular Dermal Replacement	Screen: Different Performing Specialty from Survey	Complete? Yes
Most Recent RUC Meeting: February 2010	Tab 31 Specialty Developing Recommendation: APMA, ASPS	First Identified: February 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 2.45 2007 NF PE RVU: 1.1 2007 Fac PE RVU 0.95 Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 1.1 2018 Fac PE RVU: 0.95
RUC Recommendation: Deleted from CPT		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
15220	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less	Global: 090	Issue: Skin Graft	Screen: Site of Service Anomaly (99238-Only)	Complete? Yes
Most Recent RUC Meeting: September 2007	Tab 16 Specialty Developing Recommendation: AAO-HNS, ASPS	First Identified: September 2007	2017 Est. Medicare Utilization: 9,384	2007 Work RVU: 7.95 2007 NF PE RVU: 9.5 2007 Fac PE RVU 6.69 Result: PE Only	2018 Work RVU: 8.09 2018 NF PE RVU: 9.5 2018 Fac PE RVU: 6.69
RUC Recommendation: Reduce 99238 to 0.5		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less	Global: 090	Issue: RAW	Screen: Pre-Time Analysis	Complete? Yes
Most Recent RUC Meeting: September 2014	Tab 21 Specialty Developing Recommendation: ASPS, AAD	First Identified: January 2014	2017 Est. Medicare Utilization: 13,395	2007 Work RVU: 10.15 2007 NF PE RVU: 10.66 2007 Fac PE RVU 8.2 Result: Maintain	2018 Work RVU: 10.41 2018 NF PE RVU: 10.66 2018 Fac PE RVU: 8.2
RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

15271 Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area **Global:** 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011

Tab 04

Specialty Developing Recommendation:

ACS, APMA, ASPS

First Identified: April 2011

2017 Est. Medicare Utilization: 103,189

2007 Work RVU:

2018 Work RVU: 1.50

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 1.50

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

15272 Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011

Tab 04

Specialty Developing Recommendation:

ACS, APMA, ASPS

First Identified: April 2011

2017 Est. Medicare Utilization: 11,229

2007 Work RVU:

2018 Work RVU: 0.33

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 0.59

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

15273 Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children **Global:** 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011

Tab 04

Specialty Developing Recommendation:

ACS, APMA, ASPS

First Identified: April 2011

2017 Est. Medicare Utilization: 4,673

2007 Work RVU:

2018 Work RVU: 3.50

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 3.50

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15274 Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent
RUC Meeting: April 2011

Tab 04 **Specialty Developing**
Recommendation: ACS, APMA, ASPS

First
Identified: April 2011

2017 Est.
Medicare
Utilization: 26,702

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU: 0.80
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.80

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

15275 Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area **Global:** 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent
RUC Meeting: April 2011

Tab 04 **Specialty Developing**
Recommendation: ACS, APMA, ASPS

First
Identified: April 2011

2017 Est.
Medicare
Utilization: 118,110

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU: 1.83
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.83

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

15276 Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent
RUC Meeting: April 2011

Tab 04 **Specialty Developing**
Recommendation: ACS, APMA, ASPS

First
Identified: April 2011

2017 Est.
Medicare
Utilization: 5,216

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU: 0.50
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.59

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15277 Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children **Global:** 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011

Tab 04

Specialty Developing Recommendation:

ACS, APMA, ASPS

First Identified: April 2011

2017 Est. Medicare Utilization: 1,462

2007 Work RVU:

2018 Work RVU: 4.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 4.00

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

15278 Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011

Tab 04

Specialty Developing Recommendation:

ACS, APMA, ASPS

First Identified: April 2011

2017 Est. Medicare Utilization: 2,677

2007 Work RVU:

2018 Work RVU: 1.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 1.00

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

15320 Deleted from CPT **Global:** 090 **Issue:** Skin Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010

Tab 31

Specialty Developing Recommendation:

APMA, ASPS

First Identified: October 2009

2017 Est. Medicare Utilization:

2007 Work RVU: 5.36

2018 Work RVU:

2007 NF PE RVU: 3.66

2018 NF PE RVU: 3.66

2007 Fac PE RVU 2.49

2018 Fac PE RVU: 2.49

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15321 Deleted from CPT **Global:** ZZZ **Issue:** Skin Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 1.50 **2018 Work RVU:** **2007 NF PE RVU:** 0.69 **2018 NF PE RVU:** 0.69 **2007 Fac PE RVU:** 0.57 **2018 Fac PE RVU:** 0.57 **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

15330 Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children **Global:** 090 **Issue:** Allograft **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ASPS **First Identified:** February 2008 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 3.99 **2018 Work RVU:** **2007 NF PE RVU:** 3.18 **2018 NF PE RVU:** 3.18 **2007 Fac PE RVU:** 2.15 **2018 Fac PE RVU:** 2.15 **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

15331 Deleted from CPT **Global:** ZZZ **Issue:** Acellular Dermal Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS **First Identified:** February 2010 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 1.00 **2018 Work RVU:** **2007 NF PE RVU:** 0.46 **2018 NF PE RVU:** 0.46 **2007 Fac PE RVU:** 0.39 **2018 Fac PE RVU:** 0.39 **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

15335 Deleted from CPT **Global:** 090 **Issue:** Acellular Dermal Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS **First Identified:** October 2009 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 4.50 **2018 Work RVU:** **2007 NF PE RVU:** 3.46 **2018 NF PE RVU:** 3.46 **2007 Fac PE RVU:** 2.35 **2018 Fac PE RVU:** 2.35 **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15336 Deleted from CPT

Global: ZZZ

Issue: Acellular Dermal Allograft

Screen: Different Performing Specialty from Survey

Complete? Yes

Most Recent RUC Meeting: February 2010

Tab 31

Specialty Developing Recommendation: AAO-HNS, APMA, ASPS

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 1.43

2018 Work RVU:

2007 NF PE RVU: 0.7

2018 NF PE RVU: 0.7

2007 Fac PE RVU: 0.55

2018 Fac PE RVU: 0.55

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

15360 Deleted from CPT

Global: 090

Issue: Tissue Cultured Allogeneic Dermal Substitute

Screen: Different Performing Specialty from Survey

Complete? Yes

Most Recent RUC Meeting: February 2010

Tab 31

Specialty Developing Recommendation: APMA, ASPS

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 3.93

2018 Work RVU:

2007 NF PE RVU: 4.47

2018 NF PE RVU: 4.47

2007 Fac PE RVU: 3.13

2018 Fac PE RVU: 3.13

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

15361 Deleted from CPT

Global: ZZZ

Issue: Tissue Cultured Allogeneic Dermal Substitute

Screen: Different Performing Specialty from Survey

Complete? Yes

Most Recent RUC Meeting: February 2010

Tab 31

Specialty Developing Recommendation: APMA, ASPS

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 1.15

2018 Work RVU:

2007 NF PE RVU: 0.58

2018 NF PE RVU: 0.58

2007 Fac PE RVU: 0.44

2018 Fac PE RVU: 0.44

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

15365 Deleted from CPT

Global: 090

Issue: Tissue Cultured Allogeneic Dermal Substitute

Screen: Different Performing Specialty from Survey

Complete? Yes

Most Recent RUC Meeting: February 2010

Tab 31

Specialty Developing Recommendation: APMA, ASPS

First Identified: October 2009

2017 Est. Medicare Utilization:

2007 Work RVU: 4.21

2018 Work RVU:

2007 NF PE RVU: 4.5

2018 NF PE RVU: 4.5

2007 Fac PE RVU: 3.2

2018 Fac PE RVU: 3.2

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15366 Deleted from CPT

Global: ZZZ

Issue: Tissue Cultured Allogeneic Dermal Substitute

Screen: Different Performing Specialty from Survey

Complete? Yes

Most Recent RUC Meeting: February 2010

Tab 31

Specialty Developing Recommendation: APMA, ASPS

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 1.45

2018 Work RVU:

2007 NF PE RVU: 0.7

2018 NF PE RVU: 0.7

2007 Fac PE RVU: 0.56

2018 Fac PE RVU: 0.56

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

15400 Deleted from CPT

Global: 090

Issue: Xenograft

Screen: Site of Service Anomaly

Complete? Yes

Most Recent RUC Meeting: September 2007

Tab 16

Specialty Developing Recommendation: APMA, AAO-HNS, ASPS

First Identified: September 2007

2017 Est. Medicare Utilization:

2007 Work RVU: 4.38

2018 Work RVU:

2007 NF PE RVU: 4.25

2018 NF PE RVU: 4.25

2007 Fac PE RVU: 3.95

2018 Fac PE RVU: 3.95

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15401 Deleted from CPT

Global: ZZZ

Issue: Xenograft

Screen: High Volume Growth1

Complete? Yes

Most Recent RUC Meeting: February 2008

Tab S

Specialty Developing Recommendation: ACS, ASPS

First Identified: February 2008

2017 Est. Medicare Utilization:

2007 Work RVU: 1.00

2018 Work RVU:

2007 NF PE RVU: 1.67

2018 NF PE RVU: 1.67

2007 Fac PE RVU: 0.42

2018 Fac PE RVU: 0.42

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15420 Deleted from CPT

Global: 090

Issue: Xenograft Skin

Screen: Different Performing Specialty from Survey

Complete? Yes

Most Recent RUC Meeting: February 2010

Tab 31

Specialty Developing Recommendation: APMA, ASPS, AAD

First Identified: October 2009

2017 Est. Medicare Utilization:

2007 Work RVU: 4.89

2018 Work RVU:

2007 NF PE RVU: 4.86

2018 NF PE RVU: 4.86

2007 Fac PE RVU: 3.83

2018 Fac PE RVU: 3.83

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15421	Deleted from CPT			Global: ZZZ	Issue: Xenograft Skin	Screen: Different Performing Specialty from Survey	Complete? Yes
Most Recent RUC Meeting:	February 2010	Tab 31	Specialty Developing Recommendation:	APMA, ASPS, AAD	First Identified:	February 2010	2017 Est. Medicare Utilization:
RUC Recommendation:	Deleted from CPT				Referred to CPT	February 2011	Published in CPT Asst:
					Referred to CPT Asst	<input type="checkbox"/>	
						2007 Work RVU: 1.50	2018 Work RVU:
						2007 NF PE RVU: 1.29	2018 NF PE RVU: 1.29
						2007 Fac PE RVU 0.6	2018 Fac PE RVU: 0.6
						Result: Deleted from CPT	

15570	Formation of direct or tubed pedicle, with or without transfer; trunk			Global: 090	Issue: Skin Pedicle Flaps	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting:	October 2008	Tab 10	Specialty Developing Recommendation:	ACS, ASPS, AAO-HNS	First Identified:	September 2007	2017 Est. Medicare Utilization: 372
RUC Recommendation:	10.00				Referred to CPT		
					Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:
						2007 Work RVU: 10.00	2018 Work RVU: 10.21
						2007 NF PE RVU: 11.09	2018 NF PE RVU: 11.09
						2007 Fac PE RVU 6.71	2018 Fac PE RVU: 6.71
						Result: Maintain	

15572	Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs			Global: 090	Issue: Skin Pedicle Flaps	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting:	October 2008	Tab 10	Specialty Developing Recommendation:	ACS, ASPS, AAO-HNS	First Identified:	April 2008	2017 Est. Medicare Utilization: 678
RUC Recommendation:	9.94				Referred to CPT		
					Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:
						2007 Work RVU: 9.94	2018 Work RVU: 10.12
						2007 NF PE RVU: 9.59	2018 NF PE RVU: 9.59
						2007 Fac PE RVU 6.53	2018 Fac PE RVU: 6.53
						Result: Maintain	

15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet			Global: 090	Issue: Skin Pedicle Flaps	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting:	October 2008	Tab 10	Specialty Developing Recommendation:	ASPS, AAO-HNS	First Identified:	September 2007	2017 Est. Medicare Utilization: 1,741
RUC Recommendation:	10.52				Referred to CPT		
					Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:
						2007 Work RVU: 10.52	2018 Work RVU: 10.70
						2007 NF PE RVU: 10.64	2018 NF PE RVU: 10.64
						2007 Fac PE RVU 7.6	2018 Fac PE RVU: 7.6
						Result: Maintain	

Status Report: CMS Requests and Relativity Assessment Issues

15576 Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral

Global: 090

Issue: Skin Pedicle Flaps

Screen: Site of Service Anomaly

Complete? Yes

Most Recent RUC Meeting: October 2008

Tab 10

Specialty Developing Recommendation:

ASPS, AAO-HNS

First Identified: September 2007

2017 Est. Medicare Utilization: 4,376

2007 Work RVU: 9.24

2018 Work RVU: 9.37

2007 NF PE RVU: 9.74

2018 NF PE RVU: 9.74

2007 Fac PE RVU 6.81

2018 Fac PE RVU: 6.81

Result: Maintain

RUC Recommendation: 9.24

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

15730 Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)

Global: 090

Issue: Muscle Flaps

Screen: High Level E/M in Global Period

Complete? Yes

Most Recent RUC Meeting: January 2017

Tab 05

Specialty Developing Recommendation:

AAO

First Identified: January 2017

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU: 13.50

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 13.50

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

15731 Forehead flap with preservation of vascular pedicle (eg, axial pattern flap, paramedian forehead flap)

Global: 090

Issue: Muscle Flaps

Screen: High Level E/M in Global Period

Complete? Yes

Most Recent RUC Meeting: January 2017

Tab 05

Specialty Developing Recommendation:

First Identified: April 2016

2017 Est. Medicare Utilization: 2,207

2007 Work RVU: 14.12

2018 Work RVU: 14.38

2007 NF PE RVU: 12.13

2018 NF PE RVU: 12.13

2007 Fac PE RVU 9.56

2018 Fac PE RVU: 9.56

Result: Not Part of RAW

RUC Recommendation: Not part of family

Referred to CPT September 2016

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

15732 Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae) **Global:** 090 **Issue:** Muscle Flaps **Screen:** Site of Service Anomaly / High Level E/M in Global Period **Complete?** Yes

Most Recent **Tab** 05 **Specialty Developing** ASPS
RUC Meeting: January 2017 **Recommendation:**

First Identified: September 2007 **2017 Est. Medicare Utilization:** 10,542

2007 Work RVU: 19.70 **2018 Work RVU:**
2007 NF PE RVU: 17.27 **2018 NF PE RVU:** 17.27
2007 Fac PE RVU 12.01 **2018 Fac PE RVU:**12.01
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

15733 Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae) **Global:** 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent **Tab** 05 **Specialty Developing** ASPS
RUC Meeting: January 2017 **Recommendation:**

First Identified: January 2017 **2017 Est. Medicare Utilization:**

2007 Work RVU: **2018 Work RVU:** 15.68
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU **2018 Fac PE RVU:**
Result: Decrease

RUC Recommendation: 15.68

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

15734 Muscle, myocutaneous, or fasciocutaneous flap; trunk **Global:** 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent **Tab** 14 **Specialty Developing**
RUC Meeting: April 2016 **Recommendation:**

First Identified: October 2015 **2017 Est. Medicare Utilization:** 24,248

2007 Work RVU: 19.62 **2018 Work RVU:** 23.00
2007 NF PE RVU: 17.58 **2018 NF PE RVU:** 17.58
2007 Fac PE RVU 12.32 **2018 Fac PE RVU:**12.32
Result: Increase

RUC Recommendation: 23.00

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15736 Muscle, myocutaneous, or fasciocutaneous flap; upper extremity **Global:** 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 14 **Specialty Developing Recommendation:** ASSH, ASPS **First Identified:** January 2016 **2017 Est. Medicare Utilization:** 1,424 **2007 Work RVU:** 16.92 **2018 Work RVU:** 17.04
2007 NF PE RVU: 17.17 **2018 NF PE RVU:** 17.17
2007 Fac PE RVU: 10.96 **2018 Fac PE RVU:** 10.96
RUC Recommendation: 17.04 **Referred to CPT:** September 2016 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

15738 Muscle, myocutaneous, or fasciocutaneous flap; lower extremity **Global:** 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 14 **Specialty Developing Recommendation:** ASPS **First Identified:** January 2016 **2017 Est. Medicare Utilization:** 6,016 **2007 Work RVU:** 18.92 **2018 Work RVU:** 19.04
2007 NF PE RVU: 17.04 **2018 NF PE RVU:** 17.04
2007 Fac PE RVU: 11.45 **2018 Fac PE RVU:** 11.45
RUC Recommendation: 19.04 **Referred to CPT:** September 2016 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

15740 Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel **Global:** 090 **Issue:** Dermatology and Plastic Surgery Procedures **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 28 **Specialty Developing Recommendation:** AAD, ASPS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 1,931 **2007 Work RVU:** 11.57 **2018 Work RVU:** 11.80
2007 NF PE RVU: 11.01 **2018 NF PE RVU:** 11.01
2007 Fac PE RVU: 8.58 **2018 Fac PE RVU:** 8.58
RUC Recommendation: 11.57 **Referred to CPT:** February 2009 & February 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15777 Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011

Tab 04

Specialty Developing Recommendation:

ACS, APMA, ASPS

First Identified: April 2011

2017 Est. Medicare Utilization: 7,697

2007 Work RVU:

2018 Work RVU: 3.65

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 3.65

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

15823 Blepharoplasty, upper eyelid; with excessive skin weighting down lid

Global: 090

Issue: Upper Eyelid Blepharoplasty

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: April 2010

Tab 33

Specialty Developing Recommendation:

AAO

First Identified: October 2009

2017 Est. Medicare Utilization: 94,664

2007 Work RVU: 8.12

2018 Work RVU: 6.81

2007 NF PE RVU: 7.8

2018 NF PE RVU: 7.8

2007 Fac PE RVU 6.41

2018 Fac PE RVU: 6.41

Result: Decrease

RUC Recommendation: 6.81

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15X00

Global:

Issue: Tissue Grafting Procedures

Screen: Site of Service Anomaly - 2017

Complete? No

Most Recent RUC Meeting: October 2018

Tab 04

Specialty Developing Recommendation:

AAOHNS, ASPS

First Identified: May 2018

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 6.68. Flagged for RAW review April 2022.

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15X01

Global:

Issue: Tissue Grafting Procedures Screen: Site of Service Anomaly - 2017

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 04

Specialty Developing
Recommendation: ASPS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Increase

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 6.73

Referred to CPT
Referred to CPT Asst ☐ Published in CPT Asst:

15X02

Global:

Issue: Tissue Grafting Procedures Screen: Site of Service Anomaly - 2017

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 04

Specialty Developing
Recommendation: ASPS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Increase

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 2.50

Referred to CPT
Referred to CPT Asst ☐ Published in CPT Asst:

15X03

Global:

Issue: Tissue Grafting Procedures Screen: Site of Service Anomaly - 2017

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 04

Specialty Developing
Recommendation: ASPS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Increase

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 6.83

Referred to CPT
Referred to CPT Asst ☐ Published in CPT Asst:

15X04

Global:

Issue: Tissue Grafting Procedures Screen: Site of Service Anomaly - 2017

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 04

Specialty Developing
Recommendation: ASPS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Increase

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 2.41

Referred to CPT
Referred to CPT Asst ☐ Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

16020 Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area) **Global:** 000 **Issue:** Dressings/ Debridement of Partial-Thickness Burns **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 08

Specialty Developing Recommendation: ASPS, AAFP, AAPMR,

First Identified: October 2009

2017 Est. Medicare Utilization: 16,648

2007 Work RVU: 0.80

2018 Work RVU: 0.71

2007 NF PE RVU: 1.25

2018 NF PE RVU: 1.25

2007 Fac PE RVU 0.58

2018 Fac PE RVU:0.58

Result: Maintain

RUC Recommendation: 0.80

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

16025 Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area) **Global:** 000 **Issue:** Dressings/ Debridement of Partial-Thickness Burns **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 08

Specialty Developing Recommendation: ASPS, AAFP, AAPMR,

First Identified: October 2009

2017 Est. Medicare Utilization: 1,994

2007 Work RVU: 1.85

2018 Work RVU: 1.74

2007 NF PE RVU: 1.72

2018 NF PE RVU: 1.72

2007 Fac PE RVU 0.94

2018 Fac PE RVU:0.94

Result: Maintain

RUC Recommendation: 1.85

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

16030 Dressings and/or debridement of partial-thickness burns, initial or subsequent; large (eg, more than 1 extremity, or greater than 10% total body surface area) **Global:** 000 **Issue:** Dressings/ Debridement of Partial-Thickness Burns **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 45

Specialty Developing Recommendation: ACEP, ASPS, AAFP, AAPMR,

First Identified: February 2010

2017 Est. Medicare Utilization: 907

2007 Work RVU: 2.08

2018 Work RVU: 2.08

2007 NF PE RVU: 2.12

2018 NF PE RVU: 2.12

2007 Fac PE RVU 1.08

2018 Fac PE RVU:1.08

Result: Maintain

RUC Recommendation: CPT Assistant article published.

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Oct 2012

Status Report: CMS Requests and Relativity Assessment Issues

17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion	Global: 010	Issue: Destruction of Premalignant Lesions	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 17 Specialty Developing Recommendation: AAD	First Identified: October 2010	2017 Est. Medicare Utilization: 5,965,442	2007 Work RVU: 0.62 2007 NF PE RVU: 1.08 2007 Fac PE RVU: 0.59 Result: Decrease	2018 Work RVU: 0.61 2018 NF PE RVU: 1.08 2018 Fac PE RVU: 0.59
RUC Recommendation: 0.61		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
17003	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)	Global: ZZZ	Issue: Destruction of Premalignant Lesions	Screen: Low Value-Billed in Multiple Units / CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 17 Specialty Developing Recommendation: AAD	First Identified: October 2010	2017 Est. Medicare Utilization: 19,130,304	2007 Work RVU: 0.07 2007 NF PE RVU: 0.11 2007 Fac PE RVU: 0.06 Result: Decrease	2018 Work RVU: 0.04 2018 NF PE RVU: 0.11 2018 Fac PE RVU: 0.06
RUC Recommendation: 0.04		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
17004	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions	Global: 010	Issue: Destruction of Premalignant Lesions	Screen: CMS High Expenditure Procedural Codes1 / Modifier -51 Exempt	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 17 Specialty Developing Recommendation: AAD	First Identified: September 2011	2017 Est. Medicare Utilization: 894,283	2007 Work RVU: 1.82 2007 NF PE RVU: 2.33 2007 Fac PE RVU: 1.54 Result: Decrease	2018 Work RVU: 1.37 2018 NF PE RVU: 2.33 2018 Fac PE RVU: 1.54
RUC Recommendation: Remove from Modifier -51 Exempt List. 1.37		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

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17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	Global: 090	Issue: Destruction of Skin Lesions	Screen: High IWPUT	Complete? Yes
Most Recent RUC Meeting: October 2008	Tab 11 Specialty Developing Recommendation: AAD	First Identified: February 2008	2017 Est. Medicare Utilization: 3,110	2007 Work RVU: 4.62 2007 NF PE RVU: 4.63 2007 Fac PE RVU: 3.33 Result: Decrease	2018 Work RVU: 3.69 2018 NF PE RVU: 4.63 2018 Fac PE RVU: 3.33
RUC Recommendation: 3.61		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	Global: 090	Issue: Destruction of Skin Lesions	Screen: High IWPUT	Complete? Yes
Most Recent RUC Meeting: October 2008	Tab 11 Specialty Developing Recommendation: AAD	First Identified: February 2008	2017 Est. Medicare Utilization: 1,213	2007 Work RVU: 9.19 2007 NF PE RVU: 7.24 2007 Fac PE RVU: 5.41 Result: Decrease	2018 Work RVU: 4.79 2018 NF PE RVU: 7.24 2018 Fac PE RVU: 5.41
RUC Recommendation: 4.68		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	Global: 090	Issue: Destruction of Skin Lesions	Screen: High IWPUT	Complete? Yes
Most Recent RUC Meeting: October 2008	Tab 11 Specialty Developing Recommendation: AAD	First Identified: February 2008	2017 Est. Medicare Utilization: 4,325	2007 Work RVU: 13.22 2007 NF PE RVU: 9.34 2007 Fac PE RVU: 7.49 Result: Decrease	2018 Work RVU: 7.49 2018 NF PE RVU: 9.34 2018 Fac PE RVU: 7.49
RUC Recommendation: 6.37		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions	Global: 010	Issue: RAW	Screen: High Volume Growth2	Complete? Yes
Most Recent RUC Meeting: October 2013	Tab 18 Specialty Developing Recommendation:	First Identified: April 2013	2017 Est. Medicare Utilization: 2,303,305	2007 Work RVU: 0.67 2007 NF PE RVU: 1.66 2007 Fac PE RVU: 0.74 Result: Remove from Screen	2018 Work RVU: 0.70 2018 NF PE RVU: 1.66 2018 Fac PE RVU: 0.74
RUC Recommendation: Remove from screen		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

17111 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions **Global:** 010 **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent **Tab** 18 **Specialty Developing**
RUC Meeting: October 2013 **Recommendation:**

First Identified: April 2013 **2017 Est. Medicare Utilization:** 114,890

2007 Work RVU: 0.94 **2018 Work RVU:** 0.97
2007 NF PE RVU: 1.83 **2018 NF PE RVU:** 1.83
2007 Fac PE RVU 0.89 **2018 Fac PE RVU:**0.89
Result: Remove from screen

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

17250 Chemical cauterization of granulation tissue (ie, proud flesh) **Global:** 000 **Issue:** RAW **Screen:** High Volume Growth3 **Complete?** No

Most Recent **Tab** 54 **Specialty Developing** AAFP, ACS, APMA
RUC Meeting: January 2016 **Recommendation:**

First Identified: October 2015 **2017 Est. Medicare Utilization:** 185,673

2007 Work RVU: 0.50 **2018 Work RVU:** 0.50
2007 NF PE RVU: 1.25 **2018 NF PE RVU:** 1.25
2007 Fac PE RVU 0.35 **2018 Fac PE RVU:**0.35
Result:

RUC Recommendation: CPT Assistant article published

Referred to CPT September 2016
Referred to CPT Asst ☒ **Published in CPT Asst:** Sep 2016

17261 Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.6 to 1.0 cm **Global:** 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent **Tab** 26 **Specialty Developing** AAD, AAFP
RUC Meeting: October 2010 **Recommendation:**

First Identified: October 2009 **2017 Est. Medicare Utilization:** 136,140

2007 Work RVU: 1.19 **2018 Work RVU:** 1.22
2007 NF PE RVU: 1.84 **2018 NF PE RVU:** 1.84
2007 Fac PE RVU 0.9 **2018 Fac PE RVU:**0.9
Result: Maintain

RUC Recommendation: 1.22

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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17262	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 1.1 to 2.0 cm	Global: 010	Issue: Destruction of Malignant Lesion	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 26 Specialty Developing Recommendation: AAD, AAFP	First Identified: February 2010	2017 Est. Medicare Utilization: 275,475	2007 Work RVU: 1.60 2007 NF PE RVU: 2.13 2007 Fac PE RVU: 1.09 Result: Maintain	2018 Work RVU: 1.63 2018 NF PE RVU: 2.13 2018 Fac PE RVU: 1.09
RUC Recommendation: 1.63		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
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17271	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm	Global: 010	Issue: Destruction of Malignant Lesion	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 26 Specialty Developing Recommendation: AAD, AAFP	First Identified: February 2010	2017 Est. Medicare Utilization: 53,746	2007 Work RVU: 1.51 2007 NF PE RVU: 2 2007 Fac PE RVU: 1.05 Result: Maintain	2018 Work RVU: 1.54 2018 NF PE RVU: 2 2018 Fac PE RVU: 1.05
RUC Recommendation: 1.54		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
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17272	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm	Global: 010	Issue: Destruction of Malignant Lesion	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 26 Specialty Developing Recommendation: AAD, AAFP	First Identified: February 2010	2017 Est. Medicare Utilization: 82,607	2007 Work RVU: 1.79 2007 NF PE RVU: 2.24 2007 Fac PE RVU: 1.18 Result: Maintain	2018 Work RVU: 1.82 2018 NF PE RVU: 2.24 2018 Fac PE RVU: 1.18
RUC Recommendation: 1.82		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

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17281	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm	Global: 010	Issue: Destruction of Malignant Lesion	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 26 Specialty Developing Recommendation: AAD, AAFP	First Identified: February 2010	2017 Est. Medicare Utilization: 96,374	2007 Work RVU: 1.74 2007 NF PE RVU: 2.12 2007 Fac PE RVU: 1.16 Result: Maintain	2018 Work RVU: 1.77 2018 NF PE RVU: 2.12 2018 Fac PE RVU: 1.16
RUC Recommendation: 1.77		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
17282	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm	Global: 010	Issue: Destruction of Malignant Lesion	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 26 Specialty Developing Recommendation: AAD, AAFP	First Identified: October 2009	2017 Est. Medicare Utilization: 90,800	2007 Work RVU: 2.06 2007 NF PE RVU: 2.41 2007 Fac PE RVU: 1.31 Result: Maintain	2018 Work RVU: 2.09 2018 NF PE RVU: 2.41 2018 Fac PE RVU: 1.31
RUC Recommendation: 2.09		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
17311	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks	Global: 000	Issue: Mohs Surgery	Screen: CMS High Expenditure Procedural Codes ¹	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 18 Specialty Developing Recommendation: AAD	First Identified: September 2011	2017 Est. Medicare Utilization: 767,757	2007 Work RVU: 6.20 2007 NF PE RVU: 10.79 2007 Fac PE RVU: 3.16 Result: Maintain	2018 Work RVU: 6.20 2018 NF PE RVU: 10.79 2018 Fac PE RVU: 3.16
RUC Recommendation: 6.20		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

17312 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)

Global: ZZZ **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab 18 Specialty Developing Recommendation:** AAD **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 501,705

2007 Work RVU: 3.30 **2018 Work RVU:** 3.30
2007 NF PE RVU: 6.92 **2018 NF PE RVU:** 6.92
2007 Fac PE RVU: 1.68 **2018 Fac PE RVU:** 1.68
Result: Maintain

RUC Recommendation: 3.30 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

17313 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks

Global: 000 **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab 18 Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2017 Est. Medicare Utilization:** 121,810

2007 Work RVU: 5.56 **2018 Work RVU:** 5.56
2007 NF PE RVU: 9.95 **2018 NF PE RVU:** 9.95
2007 Fac PE RVU: 2.83 **2018 Fac PE RVU:** 2.83
Result: Maintain

RUC Recommendation: 5.56 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

17314 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)

Global: ZZZ **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab 18 Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2017 Est. Medicare Utilization:** 54,679

2007 Work RVU: 3.06 **2018 Work RVU:** 3.06
2007 NF PE RVU: 6.41 **2018 NF PE RVU:** 6.41
2007 Fac PE RVU: 1.55 **2018 Fac PE RVU:** 1.55
Result: Maintain

RUC Recommendation: 3.06 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

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17315	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Mohs Surgery	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 18 Specialty Developing Recommendation: AAD	First Identified: January 2012	2017 Est. Medicare Utilization: 20,839	2007 Work RVU: 0.87 2007 NF PE RVU: 1.15 2007 Fac PE RVU: 0.44 Result: Maintain	2018 Work RVU: 0.87 2018 NF PE RVU: 1.15 2018 Fac PE RVU: 0.44
RUC Recommendation: 0.87		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
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19020	Mastotomy with exploration or drainage of abscess, deep	Global: 090	Issue: Mastotomy	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting: September 2007	Tab 16 Specialty Developing Recommendation: ACS	First Identified: September 2007	2017 Est. Medicare Utilization: 1,864	2007 Work RVU: 3.74 2007 NF PE RVU: 6.39 2007 Fac PE RVU: 2.76 Result: PE Only	2018 Work RVU: 3.83 2018 NF PE RVU: 6.39 2018 Fac PE RVU: 2.76
RUC Recommendation: Reduce 99238 to 0.5, remove hospital visits		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
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19081	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance	Global: 000	Issue: Breast Biopsy	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 04 Specialty Developing Recommendation: ACR, ACS, ASBS	First Identified: January 2012	2017 Est. Medicare Utilization: 56,328	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Decrease	2018 Work RVU: 3.29 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 3.29		Referred to CPT October 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

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19082	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Breast Biopsy	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 04 Specialty Developing Recommendation: ACR, ACS, ASBS	First Identified: January 2012	2017 Est. Medicare Utilization: 4,041	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 1.65 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.65		Referred to CPT October 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
19083	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance	Global: 000	Issue: Breast Biopsy	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 04 Specialty Developing Recommendation: ACR, ACS, ASBS	First Identified: January 2012	2017 Est. Medicare Utilization: 100,644	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 3.10 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 3.10		Referred to CPT October 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
19084	Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Breast Biopsy	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 04 Specialty Developing Recommendation: ACR, ACS, ASBS	First Identified: January 2012	2017 Est. Medicare Utilization: 12,339	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 1.55 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.55		Referred to CPT October 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

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19085 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance **Global:** 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 04 Specialty Developing Recommendation: ACR, ACS, ASBS

First Identified: January 2012

2017 Est. Medicare Utilization: 4,236

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 3.64
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 3.64

Referred to CPT October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

19086 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 04 Specialty Developing Recommendation: ACR, ACS, ASBS

First Identified: January 2012

2017 Est. Medicare Utilization: 850

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 1.82
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.82

Referred to CPT October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

19102 Biopsy of breast; percutaneous, needle core, using imaging guidance **Global:** 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 04 Specialty Developing Recommendation: ACR, ACS, ASBS

First Identified: January 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 2.00
2007 NF PE RVU: 3.68
2007 Fac PE RVU 0.64
Result: Deleted from CPT

2018 Work RVU:
2018 NF PE RVU: 3.68
2018 Fac PE RVU: 0.64

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

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19103	Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	Global: 000	Issue: Breast Biopsy	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 04	Specialty Developing Recommendation: ACR, ACS, ASBS	First Identified: January 2012	2017 Est. Medicare Utilization:	2007 Work RVU: 3.69 2007 NF PE RVU: 11.01 2007 Fac PE RVU 1.18 Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT October 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: 11.01 2018 Fac PE RVU: 1.18
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19281	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance	Global: 000	Issue: Breast Biopsy	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 04	Specialty Developing Recommendation: ACR, ACS, ASBS	First Identified: January 2012	2017 Est. Medicare Utilization: 31,502	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease
RUC Recommendation: 2.00			Referred to CPT October 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2.00 2018 NF PE RVU: 2018 Fac PE RVU:
<hr/>					
19282	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Breast Biopsy	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 04	Specialty Developing Recommendation: ACR, ACS, ASBS	First Identified: January 2012	2017 Est. Medicare Utilization: 3,004	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease
RUC Recommendation: 1.00			Referred to CPT October 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.00 2018 NF PE RVU: 2018 Fac PE RVU:

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19283 Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance **Global:** 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 04

Specialty Developing Recommendation: ACR, ACS, ASBS

First Identified: January 2012

2017 Est. Medicare Utilization: 3,684

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 2.00
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 2.00

Referred to CPT October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

19284 Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 04

Specialty Developing Recommendation: ACR, ACS, ASBS

First Identified: January 2012

2017 Est. Medicare Utilization: 392

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 1.00
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.00

Referred to CPT October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

19285 Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance **Global:** 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 04

Specialty Developing Recommendation: ACR, ACS, ASBS

First Identified: January 2012

2017 Est. Medicare Utilization: 22,759

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 1.70
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.70

Referred to CPT October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19286	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Breast Biopsy	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 04 Specialty Developing Recommendation: ACR, ACS, ASBS	First Identified: January 2012	2017 Est. Medicare Utilization: 1,559	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 0.85 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.85		Referred to CPT October 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
19287	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance	Global: 000	Issue: Breast Biopsy	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 04 Specialty Developing Recommendation: ACR, ACS, ASBS	First Identified: January 2012	2017 Est. Medicare Utilization: 271	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 2.55 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 3.02		Referred to CPT October 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
19288	Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Breast Biopsy	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 04 Specialty Developing Recommendation: ACR, ACS, ASBS	First Identified: January 2012	2017 Est. Medicare Utilization: 75	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 1.28 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.51		Referred to CPT October 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

19290	Preoperative placement of needle localization wire, breast;	Global: 000	Issue: Breast Biopsy	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
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Most Recent RUC Meeting: April 2013

Tab 04

Specialty Developing Recommendation: ACR, ACS, ASBS

First Identified: January 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 1.27

2018 Work RVU:

2007 NF PE RVU: 2.81

2018 NF PE RVU: 2.81

2007 Fac PE RVU 0.41

2018 Fac PE RVU:0.41

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

19291 **Preoperative placement of needle localization wire, breast; each additional lesion (List separately in addition to code for primary procedure)**

Global: ZZZ

Issue: Breast Biopsy

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: April 2013

Tab 04

Specialty Developing Recommendation: ACR, ACS, ASBS

First Identified: January 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 0.63

2018 Work RVU:

2007 NF PE RVU: 1.17

2018 NF PE RVU: 1.17

2007 Fac PE RVU 0.2

2018 Fac PE RVU:0.2

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

19295 **Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)**

Global: ZZZ

Issue: Breast Biopsy

Screen: CMS Fastest Growing / Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: April 2013

Tab 04

Specialty Developing Recommendation: ACR, ACS, ASBS

First Identified: October 2008

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 2.57

2018 NF PE RVU: 2.57

2007 Fac PE RVU 2.02

2018 Fac PE RVU:2.02

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19303 Mastectomy, simple, complete **Global:** 090 **Issue:** Mastectomy **Screen:** Site of Service Anomaly - 2015 / High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 15 **Specialty Developing Recommendation:** ACS, ASBS **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 23,283 **2007 Work RVU:** 15.67 **2018 Work RVU:** 15.00 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 5.52 **2018 Fac PE RVU:** 5.52 **Result:** Decrease

RUC Recommendation: 15.00 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

19318 Reduction mammoplasty **Global:** 090 **Issue:** Mammoplasty **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ASPS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 7,453 **2007 Work RVU:** 15.91 **2018 Work RVU:** 16.03 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 10.94 **2018 Fac PE RVU:** 10.94 **Result:** PE Only

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

19340 Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction **Global:** 090 **Issue:** Insertion of Breast Prosthesis **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 10 **Specialty Developing Recommendation:** ASPS **First Identified:** **2017 Est. Medicare Utilization:** 5,084 **2007 Work RVU:** 6.32 **2018 Work RVU:** 13.99 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 3.07 **2018 Fac PE RVU:** 3.07 **Result:** Decrease

RUC Recommendation: 13.99 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19357 Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion **Global:** 090 **Issue:** Breast Reconstruction **Screen:** Site of Service Anomaly / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent **Tab** 52 **Specialty Developing** ASPS
RUC Meeting: April 2014 **Recommendation:**

First Identified: September 2007 **2017 Est. Medicare Utilization:** 6,590

2007 Work RVU: 20.57 **2018 Work RVU:** 18.50
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 15.69 **2018 Fac PE RVU:** 15.69
Result: Decrease

RUC Recommendation: 18.50

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

20000 Deleted from CPT

Global: 010 **Issue:** Incision of Abscess **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent **Tab** 16 **Specialty Developing** APMA, AAOS
RUC Meeting: September 2007 **Recommendation:**

First Identified: September 2007 **2017 Est. Medicare Utilization:**

2007 Work RVU: 2.14 **2018 Work RVU:**
2007 NF PE RVU: 2.71 **2018 NF PE RVU:** 2.71
2007 Fac PE RVU: 1.68 **2018 Fac PE RVU:** 1.68
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT June 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

20005 Incision and drainage of soft tissue abscess, subfascial (ie, involves the soft tissue below the deep fascia)

Global: 010 **Issue:** Incision of Deep Abscess **Screen:** Site of Service Anomaly / Negative IWPOT **Complete?** Yes

Most Recent **Tab** 19 **Specialty Developing** ACS, AAO-HNS
RUC Meeting: October 2017 **Recommendation:**

First Identified: September 2007 **2017 Est. Medicare Utilization:** 3,924

2007 Work RVU: 3.55 **2018 Work RVU:** 3.58
2007 NF PE RVU: 3.54 **2018 NF PE RVU:** 3.54
2007 Fac PE RVU: 2.2 **2018 Fac PE RVU:** 2.2
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20220	Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)	Global: 000	Issue: Bone Biopsy Trocar/Needle	Screen: Different Performing Specialty from Survey	Complete? No
Most Recent RUC Meeting: January 2018	Tab 31	Specialty Developing Recommendation: ACR, SIR	First Identified: January 2018	2017 Est. Medicare Utilization: 11,609	2007 Work RVU: 1.27 2007 NF PE RVU: 4.07 2007 Fac PE RVU 0.75 2018 Work RVU: 1.27 2018 NF PE RVU: 4.07 2018 Fac PE RVU: 0.75
RUC Recommendation: Survey			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result:
<hr/>					
20225	Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)	Global: 000	Issue: Bone Biopsy Trocar/Needle	Screen: Different Performing Specialty from Survey	Complete? No
Most Recent RUC Meeting: January 2018	Tab 31	Specialty Developing Recommendation: ACR, SIR	First Identified: October 2017	2017 Est. Medicare Utilization: 14,299	2007 Work RVU: 1.87 2007 NF PE RVU: 21.49 2007 Fac PE RVU 1.1 2018 Work RVU: 1.87 2018 NF PE RVU: 21.49 2018 Fac PE RVU: 1.1
RUC Recommendation: Survey			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result:
<hr/>					
20240	Biopsy, bone, open; superficial (eg, sternum, spinous process, rib, patella, olecranon process, calcaneus, tarsal, metatarsal, carpal, metacarpal, phalanx)	Global: 000	Issue: Bone Biopsy Excisional	Screen: 010-Day Global Post-Operative Visits	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 04	Specialty Developing Recommendation: AAOS, APMA	First Identified: April 2014	2017 Est. Medicare Utilization: 5,112	2007 Work RVU: 3.25 2007 NF PE RVU: NA 2007 Fac PE RVU 2.44 2018 Work RVU: 2.61 2018 NF PE RVU: NA 2018 Fac PE RVU: 2.44
RUC Recommendation: 3.73			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Increase
<hr/>					
20245	Biopsy, bone, open; deep (eg, humeral shaft, ischium, femoral shaft)	Global: 000	Issue: Bone Biopsy Excisional	Screen: 010-Day Global Post-Operative Visits	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 04	Specialty Developing Recommendation: AAOS	First Identified: January 2014	2017 Est. Medicare Utilization: 4,156	2007 Work RVU: 8.77 2007 NF PE RVU: NA 2007 Fac PE RVU 6.38 2018 Work RVU: 6.00 2018 NF PE RVU: NA 2018 Fac PE RVU: 6.38
RUC Recommendation: 6.50			Referred to CPT October 2015 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

20525 Removal of foreign body in muscle or tendon sheath; deep or complicated **Global:** 010 **Issue:** Removal of Foreign Body **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent **Tab** 16 **Specialty Developing** ACS, AAOS **First** **2017 Est.** **2007 Work RVU:** 3.51 **2018 Work RVU:** 3.54
RUC Meeting: September 2007 **Recommendation:** **Identified:** September 2007 **Medicare** **2007 NF PE RVU:** 8.62 **2018 NF PE RVU:** 8.62
Utilization: 1,777 **2007 Fac PE RVU** 2.52 **2018 Fac PE RVU:**2.52

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: PE Only

20526 Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel **Global:** 000 **Issue:** RAW **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent **Tab** 30 **Specialty Developing** **First** **2017 Est.** **2007 Work RVU:** 0.94 **2018 Work RVU:** 0.94
RUC Meeting: January 2017 **Recommendation:** **Identified:** July 2016 **Medicare** **2007 NF PE RVU:** 0.93 **2018 NF PE RVU:** 0.93
Utilization: 93,355 **2007 Fac PE RVU** 0.5 **2018 Fac PE RVU:**0.5

RUC Recommendation: Remove from screen

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Remove from Screen

20550 Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia") **Global:** 000 **Issue:** Injection of Tendon **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent **Tab** 27 **Specialty Developing** AAOS, **First** **2017 Est.** **2007 Work RVU:** 0.75 **2018 Work RVU:** 0.75
RUC Meeting: January 2016 **Recommendation:** AAPM&R, **Identified:** October 2008 **Medicare** **2007 NF PE RVU:** 0.69 **2018 NF PE RVU:** 0.69
Utilization: 844,203 **2007 Fac PE RVU** 0.25 **2018 Fac PE RVU:**0.25

RUC Recommendation: 0.75

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

20551	Injection(s); single tendon origin/insertion			Global: 000	Issue: Therapeutic Injection Carpal Tunnel	Screen: CMS Fastest Growing / CMS 000-Day Global Typically Reported with an E/M	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 10	Specialty Developing Recommendation:	AAPMR, AAOS, ACRrh, APMA, ASSH	First Identified: October 2008	2017 Est. Medicare Utilization: 207,679	2007 Work RVU: 0.75 2007 NF PE RVU: 0.67 2007 Fac PE RVU 0.32	2018 Work RVU: 0.75 2018 NF PE RVU: 0.67 2018 Fac PE RVU: 0.32
RUC Recommendation: 0.75				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain	
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)			Global: 000	Issue:	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 28	Specialty Developing Recommendation:	AAPM&R, ACRrh, ASA	First Identified: July 2015	2017 Est. Medicare Utilization: 371,780	2007 Work RVU: 0.66 2007 NF PE RVU: 0.69 2007 Fac PE RVU 0.21	2018 Work RVU: 0.66 2018 NF PE RVU: 0.69 2018 Fac PE RVU: 0.21
RUC Recommendation: 0.66				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain	
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles			Global: 000	Issue:	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 28	Specialty Developing Recommendation:	AAPM&R, ACRrh, ASA	First Identified: July 2015	2017 Est. Medicare Utilization: 346,970	2007 Work RVU: 0.75 2007 NF PE RVU: 0.78 2007 Fac PE RVU 0.23	2018 Work RVU: 0.75 2018 NF PE RVU: 0.78 2018 Fac PE RVU: 0.23
RUC Recommendation: 0.75				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain	

Status Report: CMS Requests and Relativity Assessment Issues

20600	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance		Global: 000	Issue: Arthrocentesis	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting:	January 2014	Tab 04	Specialty Developing Recommendation: AAFP, AAOS, ACR, ACRh, APMA, ASSH	First Identified: February 2010	2017 Est. Medicare Utilization: 431,227	2007 Work RVU: 0.66 2007 NF PE RVU: 0.66 2007 Fac PE RVU 0.34 2018 Work RVU: 0.66 2018 NF PE RVU: 0.66 2018 Fac PE RVU:0.34
RUC Recommendation: 0.66 and new PE inputs				Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain
20604	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting		Global: 000	Issue: Arthrocentesis	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting:	January 2014	Tab 04	Specialty Developing Recommendation: AAFP, AAOS, ACR, ACRh, APMA, ASSH	First Identified: July 2013	2017 Est. Medicare Utilization: 40,141	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU 2018 Work RVU: 0.89 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.89				Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease
20605	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance		Global: 000	Issue: Arthrocentesis	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting:	January 2014	Tab 04	Specialty Developing Recommendation: AAFP, AAOS, ACR, ACRh, APMA, ASSH	First Identified: October 2009	2017 Est. Medicare Utilization: 486,329	2007 Work RVU: 0.68 2007 NF PE RVU: 0.76 2007 Fac PE RVU 0.35 2018 Work RVU: 0.68 2018 NF PE RVU: 0.76 2018 Fac PE RVU:0.35
RUC Recommendation: 0.68 and new PE inputs				Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

20606	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting	Global: 000	Issue: Arthrocentesis	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 04 Specialty Developing Recommendation: AAFP, AAOS, ACR, ACRh, APMA, ASSH	First Identified: July 2013	2017 Est. Medicare Utilization: 52,651	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU	2018 Work RVU: 1.00 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.00		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	October 2013 Published in CPT Asst:	Result: Decrease	
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	Global: 000	Issue: Arthrocentesis	Screen: Harvard Valued - Utilization over 100,000 / MPC List / CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 04 Specialty Developing Recommendation: AAFP, AAOS, ACR, ACRh, APMA, ASSH	First Identified: February 2010	2017 Est. Medicare Utilization: 6,819,323	2007 Work RVU: 0.79 2007 NF PE RVU: 0.98 2007 Fac PE RVU 0.42	2018 Work RVU: 0.79 2018 NF PE RVU: 0.98 2018 Fac PE RVU:0.42
RUC Recommendation: 0.79 and new PE inputs		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	October 2013 Published in CPT Asst:	Result: Maintain	
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	Global: 000	Issue: Arthrocentesis	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 04 Specialty Developing Recommendation: AAFP, AAOS, ACR, ACRh, APMA, ASSH	First Identified: July 2013	2017 Est. Medicare Utilization: 1,001,062	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU	2018 Work RVU: 1.10 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.10		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	October 2013 Published in CPT Asst:	Result: Decrease	

Status Report: CMS Requests and Relativity Assessment Issues

20612	Aspiration and/or injection of ganglion cyst(s) any location	Global: 000	Issue: RAW	Screen: CMS 000-Day Global Typically Reported with an E/M	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 30	Specialty Developing Recommendation:	First Identified: July 2016	2017 Est. Medicare Utilization: 26,691	2007 Work RVU: 0.70 2007 NF PE RVU: 0.71 2007 Fac PE RVU 0.35 2018 Work RVU: 0.70 2018 NF PE RVU: 0.71 2018 Fac PE RVU: 0.35
RUC Recommendation: Remove from screen			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Remove from Screen
20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	Global: 090	Issue: RAW	Screen: Pre-Time Analysis	Complete? Yes
Most Recent RUC Meeting: September 2014	Tab 21	Specialty Developing Recommendation: AAOS, APMA	First Identified: January 2014	2017 Est. Medicare Utilization: 56,800	2007 Work RVU: 5.90 2007 NF PE RVU: 8.63 2007 Fac PE RVU 3.82 2018 Work RVU: 5.96 2018 NF PE RVU: 8.63 2018 Fac PE RVU: 3.82
RUC Recommendation: 5.96 and adjustments to pre-service time package 3.			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain
20692	Application of a multiplane (pins or wires in more than 1 plane), unilateral, external fixation system (eg, Ilizarov, Monticelli type)	Global: 090	Issue: RAW	Screen: 090-Day Global Post- Operative Visits	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 52	Specialty Developing Recommendation:	First Identified: January 2014	2017 Est. Medicare Utilization: 2,928	2007 Work RVU: 6.40 2007 NF PE RVU: NA 2007 Fac PE RVU 3.65 2018 Work RVU: 16.27 2018 NF PE RVU: NA 2018 Fac PE RVU: 3.65
RUC Recommendation: Maintain			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

20694 Removal, under anesthesia, of external fixation system

Global: 090

Issue: External Fixation

Screen: Site of Service Anomaly (99238-Only)

Complete? Yes

Most Recent RUC Meeting: September 2007

Tab 16

Specialty Developing Recommendation: AAOS

First Identified: September 2007

2017 Est. Medicare Utilization: 6,034

2007 Work RVU: 4.20

2018 Work RVU: 4.28

2007 NF PE RVU: 6.69

2018 NF PE RVU: 6.69

2007 Fac PE RVU 3.92

2018 Fac PE RVU:3.92

Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

206X0

Global:

Issue: Drug Delivery Implant Procedures

Screen: Different Performing Specialty from Survey

Complete? Yes

Most Recent RUC Meeting: October 2018

Tab 05

Specialty Developing Recommendation: AAOS, AUA

First Identified: May 2018

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 1.50

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

206X1

Global:

Issue: Drug Delivery Implant Procedures

Screen: Different Performing Specialty from Survey

Complete? Yes

Most Recent RUC Meeting: October 2018

Tab 05

Specialty Developing Recommendation: AAOS, AUA

First Identified: May 2018

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 2.50

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

206X2

Global:

Issue: Drug Delivery Implant Procedures

Screen: Different Performing Specialty from Survey

Complete? Yes

Most Recent RUC Meeting: October 2018

Tab 05

Specialty Developing Recommendation: AAOS, AUA

First Identified: May 2018

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 2.60

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

206X3

Most Recent
RUC Meeting: October 2018

Tab 05

Specialty Developing
Recommendation: AAOS, AUA

First
Identified: May 2018

Global:

Issue: Drug Delivery Implant
Procedures

Screen: Different Performing
Specialty from Survey

Complete? Yes

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Increase

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.13

Referred to CPT
Referred to CPT Asst ☐

Published in CPT Asst:

206X4

Most Recent
RUC Meeting: October 2018

Tab 05

Specialty Developing
Recommendation: AAOS, AUA

First
Identified: May 2018

Global:

Issue: Drug Delivery Implant
Procedures

Screen: Different Performing
Specialty from Survey

Complete? Yes

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Increase

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.80

Referred to CPT
Referred to CPT Asst ☐

Published in CPT Asst:

206X5

Most Recent
RUC Meeting: October 2018

Tab 05

Specialty Developing
Recommendation: AAOS, AUA

First
Identified: May 2018

Global:

Issue: Drug Delivery Implant
Procedures

Screen: Different Performing
Specialty from Survey

Complete? Yes

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Increase

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 2.15

Referred to CPT
Referred to CPT Asst ☐

Published in CPT Asst:

20900 Bone graft, any donor area; minor or small (eg, dowel or button)

Most Recent
RUC Meeting: April 2008

Tab 29

Specialty Developing
Recommendation: AOFAS,
AAOS

First
Identified: September 2007

Global: 000

Issue: Bone Graft Procedures

Screen: Site of Service Anomaly

Complete? Yes

2017 Est.
Medicare
Utilization: 4,070

2007 Work RVU: 5.77
2007 NF PE RVU: 8.65
2007 Fac PE RVU 5.5
Result: Decrease

2018 Work RVU: 3.00
2018 NF PE RVU: 8.65
2018 Fac PE RVU: 5.5

RUC Recommendation: 3.00

Referred to CPT
Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

20902 Bone graft, any donor area; major or large

Global: 000

Issue: Bone Graft Procedures

Screen: Site of Service Anomaly

Complete? Yes

Most Recent
RUC Meeting: April 2008

Tab 29

Specialty Developing
Recommendation: AOFAS,
AAOS

First
Identified: April 2008

2017 Est.
Medicare
Utilization: 4,794

2007 Work RVU: 7.98

2018 Work RVU: 4.58

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 6.63

2018 Fac PE RVU:6.63

Result: Decrease

RUC Recommendation: 4.58

Referred to CPT

Referred to CPT Asst

☐

Published in CPT Asst:

20926 Tissue grafts, other (eg, paratenon, fat, dermis)

Global: 090

Issue: Tissue Grafting Procedures

Screen: CMS Fastest Growing /
Site of Service
Anomaly - 2017

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 04

Specialty Developing
Recommendation: AAOS,
ASPS,
AANS, CNS

First
Identified: October 2008

2017 Est.
Medicare
Utilization: 15,975

2007 Work RVU: 5.70

2018 Work RVU: 5.79

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 4.67

2018 Fac PE RVU:4.67

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT May 2018

Referred to CPT Asst

☒

Published in CPT Asst: Deleted for 2020

21015 Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm

Global: 090

Issue: Radical Resection of Soft
Tissue Tumor

Screen: Site of Service Anomaly

Complete? Yes

Most Recent
RUC Meeting: February 2009

Tab 6

Specialty Developing
Recommendation: ACS, AAOS,
AAO-HNS,
ASPS

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 622

2007 Work RVU: 5.59

2018 Work RVU: 9.89

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 4.85

2018 Fac PE RVU:4.85

Result: Increase

RUC Recommendation: 9.71

Referred to CPT June 2008

Referred to CPT Asst

☐

Published in CPT Asst:

21025 Excision of bone (eg, for osteomyelitis or bone abscess); mandible

Global: 090

Issue: Excision of Bone –
Mandible

Screen: Site of Service Anomaly

Complete? Yes

Most Recent
RUC Meeting: October 2010

Tab 61

Specialty Developing
Recommendation: AAOMS

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 3,377

2007 Work RVU: 11.07

2018 Work RVU: 10.03

2007 NF PE RVU: 12.32

2018 NF PE RVU: 12.32

2007 Fac PE RVU 9.21

2018 Fac PE RVU:9.21

Result: Decrease

RUC Recommendation: 10.03

Referred to CPT

Referred to CPT Asst

☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

21495 Open treatment of hyoid fracture

Global: 090

Issue: Laryngoplasty

Screen: 090-Day Global Post-Operative Visits

Complete? Yes

Most Recent
RUC Meeting: January 2016

Tab 09

Specialty Developing
Recommendation:

First
Identified: October 2015

2017 Est.
Medicare
Utilization:

2007 Work RVU: 6.55

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 8.73

2018 Fac PE RVU:8.73

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

21557 Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; less than 5 cm

Global: 090

Issue: Radical Resection of Soft Tissue Tumor

Screen: Site of Service Anomaly

Complete? Yes

Most Recent
RUC Meeting: February 2009

Tab 6

Specialty Developing
Recommendation: ACS, AAOS

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 537

2007 Work RVU: 8.91

2018 Work RVU: 14.75

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 5.13

2018 Fac PE RVU:5.13

Result: Decrease

RUC Recommendation: 14.57

Referred to CPT June 2008

Referred to CPT Asst ☐

Published in CPT Asst:

21800 Closed treatment of rib fracture, uncomplicated, each

Global: 090

Issue: Internal Fixation of Rib Fracture

Screen: CMS Request - Final Rule for 2014

Complete? Yes

Most Recent
RUC Meeting: April 2014

Tab 05

Specialty Developing
Recommendation: STS, ACS

First
Identified: July 2013

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.98

2018 Work RVU:

2007 NF PE RVU: 1.34

2018 NF PE RVU: 1.34

2007 Fac PE RVU 1.34

2018 Fac PE RVU:1.34

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014

Referred to CPT Asst ☐

Published in CPT Asst:

21805 Open treatment of rib fracture without fixation, each

Global: 090

Issue: Internal Fixation of Rib Fracture

Screen: CMS Request - Final Rule for 2014

Complete? Yes

Most Recent
RUC Meeting: April 2014

Tab 05

Specialty Developing
Recommendation: STS, ACS

First
Identified: January 2014

2017 Est.
Medicare
Utilization:

2007 Work RVU: 2.80

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.28

2018 Fac PE RVU:3.28

Result: Deleted from CPT

RUC Recommendation: Referred to CPT for deletion

Referred to CPT October 2014

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

21810 Treatment of rib fracture requiring external fixation (flail chest) **Global:** 090 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 6.92 **2018 Work RVU:** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 5.03 **2018 Fac PE RVU:** 5.03 **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

21811 Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs **Global:** 000 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2017 Est. Medicare Utilization:** 347 **2007 Work RVU:** **2018 Work RVU:** 10.79 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 19.55 **Referred to CPT** October 2013 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

21812 Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 4-6 ribs **Global:** 000 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2017 Est. Medicare Utilization:** 328 **2007 Work RVU:** **2018 Work RVU:** 13.00 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 25.00 **Referred to CPT** October 2013 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

21813 Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs **Global:** 000 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2017 Est. Medicare Utilization:** 60 **2007 Work RVU:** **2018 Work RVU:** 17.61 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 35.00 **Referred to CPT** October 2013 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

21820 Closed treatment of sternum fracture **Global:** 090 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 / Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** January 2014 **2017 Est. Medicare Utilization:** 185 **2007 Work RVU:** 1.31 **2018 Work RVU:** 1.36 **2007 NF PE RVU:** 1.82 **2018 NF PE RVU:** 1.82 **2007 Fac PE RVU:** 1.77 **2018 Fac PE RVU:** 1.77

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** October 2013 **Result:** PE Only **Referred to CPT Asst** ☒ **Published in CPT Asst:** Jan 2018

21825 Open treatment of sternum fracture with or without skeletal fixation **Global:** 090 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2017 Est. Medicare Utilization:** 921 **2007 Work RVU:** 7.65 **2018 Work RVU:** 7.76 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 6.16 **2018 Fac PE RVU:** 6.16

RUC Recommendation: Unrelated to the family **Referred to CPT** October 2013 **Result:** Remove from screen **Referred to CPT Asst** ☐ **Published in CPT Asst:**

21935 Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; less than 5 cm **Global:** 090 **Issue:** Radical Resection of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 6 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 370 **2007 Work RVU:** 18.38 **2018 Work RVU:** 15.72 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 9.37 **2018 Fac PE RVU:** 9.37

RUC Recommendation: 15.54 **Referred to CPT** June 2008 **Result:** Decrease **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar	Global: 090	Issue: RAW	Screen: CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: September 2014	Tab 21	Specialty Developing Recommendation: AAOS, NASS, AANS/CNS	First Identified: October 2008	2017 Est. Medicare Utilization: 5,697	2007 Work RVU: 20.77 2007 NF PE RVU: NA 2007 Fac PE RVU: 13.53 Result: Maintain
RUC Recommendation: Maintain			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 21.02 2018 NF PE RVU: NA 2018 Fac PE RVU: 13.53

22305	Closed treatment of vertebral process fracture(s)	Global: 090	Issue: Closed treatment of vertebral process fracture	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2015	Tab 23	Specialty Developing Recommendation: AANS/CNS, NASS	First Identified: July 2013	2017 Est. Medicare Utilization:	2007 Work RVU: 2.08 2007 NF PE RVU: 2.27 2007 Fac PE RVU: 1.89 Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT May 2016 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: 2.27 2018 Fac PE RVU: 1.89

22310	Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing	Global: 090	Issue: Closed Treatment Vertebral Fracture	Screen: Negative IWPUT	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 06	Specialty Developing Recommendation: AANS, AAOS, CNS, ISASS, NASS	First Identified: April 2017	2017 Est. Medicare Utilization: 8,237	2007 Work RVU: 3.69 2007 NF PE RVU: 2.85 2007 Fac PE RVU: 2.4 Result: Decrease
RUC Recommendation: 3.75			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 3.89 2018 NF PE RVU: 2.85 2018 Fac PE RVU: 2.4

Status Report: CMS Requests and Relativity Assessment Issues

22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic	Global: 010	Issue: Percutaneous Vertebroplasty and Augmentation	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes	
Most Recent RUC Meeting: April 2014	Tab 06	Specialty Developing Recommendation: AANS, CNS, AAOS, NASS, ACR, SIR, ASNR	First Identified:	2017 Est. Medicare Utilization: 4,575	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU	2018 Work RVU: 7.90 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 8.15			Referred to CPT February 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease	
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral	Global: 010	Issue: Percutaneous Vertebroplasty and Augmentation	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes	
Most Recent RUC Meeting: April 2014	Tab 06	Specialty Developing Recommendation: AANS, CNS, AAOS, NASS, ACR, SIR, ASNR	First Identified:	2017 Est. Medicare Utilization: 4,639	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU	2018 Work RVU: 7.33 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 8.05			Referred to CPT February 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease	
22512	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Percutaneous Vertebroplasty and Augmentation	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes	
Most Recent RUC Meeting: April 2014	Tab 06	Specialty Developing Recommendation: AANS, CNS, AAOS, NASS, ACR, SIR, ASNR	First Identified:	2017 Est. Medicare Utilization: 2,822	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU	2018 Work RVU: 4.00 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 4.00			Referred to CPT February 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease	

Status Report: CMS Requests and Relativity Assessment Issues

22513 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic **Global:** 010 **Issue:** Percutaneous Vertebroplasty and Augmentation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 06

Specialty Developing Recommendation:

AANS, CNS, AAOS, NASS, ACR, SIR, ASNR

First Identified:

2017 Est. Medicare Utilization: 23,670

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU:

2018 Work RVU: 8.65
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 8.90

Referred to CPT February 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

22514 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar **Global:** 010 **Issue:** Percutaneous Vertebroplasty and Augmentation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 06

Specialty Developing Recommendation:

AANS, CNS, AAOS, NASS, ACR, SIR, ASNR

First Identified:

2017 Est. Medicare Utilization: 26,157

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU:

2018 Work RVU: 7.99
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 8.24

Referred to CPT February 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

22515 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Percutaneous Vertebroplasty and Augmentation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 06

Specialty Developing Recommendation:

AANS, CNS, AAOS, NASS, ACR, SIR, ASNR

First Identified:

2017 Est. Medicare Utilization: 14,942

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU:

2018 Work RVU: 4.00
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.00

Referred to CPT February 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

22520	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic	Global: 010	Issue: Percutaneous Vertebroplasty and Augmentation	Screen: CMS Request - Practice Expense Review / Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 06	Specialty Developing Recommendation: AANS, CNS, AAOS, NASS, ACR, SIR, ASNR	First Identified: February 2009	2017 Est. Medicare Utilization:	2007 Work RVU: 9.17 2007 NF PE RVU: 56.83 2007 Fac PE RVU: 4.84 2018 Work RVU: 2018 NF PE RVU: 56.83 2018 Fac PE RVU: 4.84
RUC Recommendation: Deleted from CPT			Referred to CPT February 2014	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:

22521	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar	Global: 010	Issue: Percutaneous Vertebroplasty and Augmentation	Screen: Site of Service Anomaly (99238-Only); CMS Request - PE Inputs / Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 06	Specialty Developing Recommendation: AANS, CNS, AAOS, NASS, ACR, SIR, ASNR	First Identified: September 2007	2017 Est. Medicare Utilization:	2007 Work RVU: 8.60 2007 NF PE RVU: 52.87 2007 Fac PE RVU: 4.69 2018 Work RVU: 2018 NF PE RVU: 52.87 2018 Fac PE RVU: 4.69
RUC Recommendation: Deleted from CPT			Referred to CPT February 2014	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:

22522	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Percutaneous Vertebroplasty and Augmentation	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 06	Specialty Developing Recommendation: AANS, CNS, AAOS, NASS, ACR, SIR, ASNR	First Identified:	2017 Est. Medicare Utilization:	2007 Work RVU: 4.30 2007 NF PE RVU: NA 2007 Fac PE RVU: 1.59 2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 1.59
RUC Recommendation: Deleted from CPT			Referred to CPT February 2014	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

22523	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic	Global: 010	Issue: Percutaneous Vertebroplasty and Augmentation	Screen: CMS Request: PE Review	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 06	Specialty Developing Recommendation: AANS, CNS, AAOS, NASS, ACR, SIR, ASNR	First Identified: September 2011	2017 Est. Medicare Utilization:	2007 Work RVU: 9.21 2007 NF PE RVU: NA 2007 Fac PE RVU 5.6 2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 5.6
RUC Recommendation: Deleted from CPT			Referred to CPT February 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Deleted from CPT
22524	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar	Global: 010	Issue: Percutaneous Vertebroplasty and Augmentation	Screen: CMS Request: PE Review	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 06	Specialty Developing Recommendation: AANS, CNS, AAOS, NASS, ACR, SIR, ASNR	First Identified: September 2011	2017 Est. Medicare Utilization:	2007 Work RVU: 8.81 2007 NF PE RVU: NA 2007 Fac PE RVU 5.4 2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 5.4
RUC Recommendation: Deleted from CPT			Referred to CPT February 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Deleted from CPT
22525	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Percutaneous Vertebroplasty and Augmentation	Screen: CMS Request: PE Review	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 06	Specialty Developing Recommendation: AANS, CNS, AAOS, NASS, ACR, SIR, ASNR	First Identified: September 2011	2017 Est. Medicare Utilization:	2007 Work RVU: 4.47 2007 NF PE RVU: NA 2007 Fac PE RVU 2.12 2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 2.12
RUC Recommendation: Deleted from CPT			Referred to CPT February 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

22533 Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar **Global:** 090 **Issue:** Arthrodesis **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** AAOS, NASS, AANS/CNS **First Identified:** October 2008 **2017 Est. Medicare Utilization:** 1,037 **2007 Work RVU:** 24.61 **2018 Work RVU:** 24.79
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 13.57 **2018 Fac PE RVU:** 13.57
Result: Remove from Screen

RUC Recommendation: Remove from screen. CPT Assistant article published. **Referred to CPT**

Referred to CPT Asst ☒ **Published in CPT Asst:** Oct 2009

22551 Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2 **Global:** 090 **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS, AAOS **First Identified:** **2017 Est. Medicare Utilization:** 39,944 **2007 Work RVU:** **2018 Work RVU:** 25.00
2007 NF PE RVU: **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 24.50 **Referred to CPT** October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

22552 Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure) **Global:** ZZZ **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS, AAOS **First Identified:** **2017 Est. Medicare Utilization:** 34,976 **2007 Work RVU:** **2018 Work RVU:** 6.50
2007 NF PE RVU: **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Maintain

RUC Recommendation: 6.50 **Referred to CPT** October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22554 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2 **Global:** 090 **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 5 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** February 2008 **2017 Est. Medicare Utilization:** 5,001 **2007 Work RVU:** 17.54 **2018 Work RVU:** 17.69 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 11.97 **2018 Fac PE RVU:** 11.97 **Result:** Maintain

RUC Recommendation: 17.69 **Referred to CPT:** October 2009 **Referred to CPT Asst:** ☐ **Published in CPT Asst:**

22558 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar **Global:** 090 **Issue:** Vertebral Corpectomy with Arthrodesis **Screen:** High Volume Growth2 / Codes Reported Together 75% or More-Part3 **Complete?** No

Most Recent RUC Meeting: January 2017 **Tab** 30 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** April 2013 **2017 Est. Medicare Utilization:** 17,679 **2007 Work RVU:** 23.33 **2018 Work RVU:** 23.53 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 12.86 **2018 Fac PE RVU:** 12.86 **Result:**

RUC Recommendation: Review action plan and additional data **Referred to CPT:** September 2016 **Referred to CPT Asst:** ☐ **Published in CPT Asst:**

22585 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** **2017 Est. Medicare Utilization:** 15,890 **2007 Work RVU:** 5.52 **2018 Work RVU:** 5.52 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 2.62 **2018 Fac PE RVU:** 2.62 **Result:** Maintain

RUC Recommendation: Remove from screen **Referred to CPT:** October 2009 **Referred to CPT Asst:** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22612 Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed) **Global:** 090 **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015

Tab 21

Specialty Developing Recommendation: AANS/CNS, AAOS, NASS

First Identified: February 2010

2017 Est. Medicare Utilization: 46,466

2007 Work RVU: 23.38

2018 Work RVU: 23.53

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 13.83

2018 Fac PE RVU:13.83

Result: Maintain

RUC Recommendation: Review utilization data October 2015. 23.53. Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

22614 Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Lumbar Arthrodesis

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: February 2011

Tab 04

Specialty Developing Recommendation: AANS/CNS, AAOS, NASS

First Identified: February 2010

2017 Est. Medicare Utilization: 132,756

2007 Work RVU: 6.43

2018 Work RVU: 6.43

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.15

2018 Fac PE RVU:3.15

Result: Decrease

RUC Recommendation: 6.43

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

22630 Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar **Global:** 090 **Issue:** Lumbar Arthrodesis

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: February 2011

Tab 04

Specialty Developing Recommendation: AANS/CNS, AAOS, NASS

First Identified: February 2010

2017 Est. Medicare Utilization: 6,535

2007 Work RVU: 21.89

2018 Work RVU: 22.09

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 13.39

2018 Fac PE RVU:13.39

Result: Maintain

RUC Recommendation: 22.09

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Lumbar Arthrodesis	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes		
Most Recent RUC Meeting:	February 2011	Tab 04	Specialty Developing Recommendation: AANS/CNS, AAOS, NASS	First Identified: February 2010	2017 Est. Medicare Utilization: 2,278	2007 Work RVU: 5.22	2018 Work RVU: 5.22
						2007 NF PE RVU: NA	2018 NF PE RVU: NA
						2007 Fac PE RVU Result: Decrease	2018 Fac PE RVU:2.51
RUC Recommendation:	5.22			Referred to CPT Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar	Global: 090	Issue: Lumbar Arthrodesis	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes		
Most Recent RUC Meeting:	February 2011	Tab 04	Specialty Developing Recommendation: AANS/CNS, AAOS, NASS	First Identified: February 2010	2017 Est. Medicare Utilization: 37,550	2007 Work RVU:	2018 Work RVU: 27.75
						2007 NF PE RVU:	2018 NF PE RVU:
						2007 Fac PE RVU Result: Decrease	2018 Fac PE RVU:
RUC Recommendation:	27.75			Referred to CPT Referred to CPT Asst	October 2010 <input type="checkbox"/>	Published in CPT Asst:	
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; each additional interspace and segment (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Lumbar Arthrodesis	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes		
Most Recent RUC Meeting:	February 2011	Tab 04	Specialty Developing Recommendation: AANS/CNS, AAOS, NASS	First Identified: February 2010	2017 Est. Medicare Utilization: 14,153	2007 Work RVU:	2018 Work RVU: 8.16
						2007 NF PE RVU:	2018 NF PE RVU:
						2007 Fac PE RVU Result: Decrease	2018 Fac PE RVU:
RUC Recommendation:	8.16			Referred to CPT Referred to CPT Asst	October 2010 <input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

22843 Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Spine Fixation Device **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** AAOS, NASS, AANS **First Identified:** October 2008 **2017 Est. Medicare Utilization:** 7,681 **2007 Work RVU:** 13.44 **2018 Work RVU:** 13.44 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 6.28 **2018 Fac PE RVU:** 6.28 **RUC Recommendation:** Remove from screen **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

22849 Reinsertion of spinal fixation device **Global:** 090 **Issue:** RAW **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** AAOS, NASS, AANS/CNS **First Identified:** October 2008 **2017 Est. Medicare Utilization:** 4,741 **2007 Work RVU:** 19.08 **2018 Work RVU:** 19.17 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 11.39 **2018 Fac PE RVU:** 11.39 **RUC Recommendation:** Maintain **Referred to CPT** June 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

22851 Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Biomechanical Device Insertion-Intervertebral, Interbody **Screen:** CMS Fastest Growing / High Volume Growth1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 06 **Specialty Developing Recommendation:** AANS/CNS, NASS **First Identified:** October 2008 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 6.70 **2018 Work RVU:** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 3.18 **2018 Fac PE RVU:** 3.18 **RUC Recommendation:** Deleted from CPT **Referred to CPT** October 2015 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22859	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Biomechanical Device Insertion-Intervertebral, Interbody	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 06	Specialty Developing Recommendation: AAOS, AANS, CNS, ISASS, NASS	First Identified: October 2015	2017 Est. Medicare Utilization: 2,955	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease
RUC Recommendation: 6.00			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 5.50 2018 NF PE RVU: 2018 Fac PE RVU:
<hr/>					
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	Global: 090	Issue: Biomechanical Device Insertion-Intervertebral, Interbody	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 06	Specialty Developing Recommendation: AAOS, AANS, CNS, ISASS, NASS	First Identified: October 2015	2017 Est. Medicare Utilization: 2,198	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease
RUC Recommendation: 4.88			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 13.50 2018 NF PE RVU: 2018 Fac PE RVU:
<hr/>					
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Biomechanical Device Insertion-Intervertebral, Interbody	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 06	Specialty Developing Recommendation: AAOS, AANS, CNS, ISASS, NASS	First Identified: October 2015	2017 Est. Medicare Utilization: 529	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease
RUC Recommendation: 5.50			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 4.00 2018 NF PE RVU: 2018 Fac PE RVU:

Status Report: CMS Requests and Relativity Assessment Issues

22900 Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm **Global:** 090 **Issue:** Subfascial Excision of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009

Tab 5

Specialty Developing Recommendation: ACS, AAOS

First Identified: September 2007

2017 Est. Medicare Utilization: 817

2007 Work RVU: 6.14

2018 Work RVU: 8.32

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.3

2018 Fac PE RVU:3.3

Result: Increase

RUC Recommendation: 8.21

Referred to CPT June 2008

Referred to CPT Asst ☐ **Published in CPT Asst:**

23076 Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm **Global:** 090 **Issue:** Subfascial Excision of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009

Tab 5

Specialty Developing Recommendation: ACS, AAOS

First Identified: September 2007

2017 Est. Medicare Utilization: 661

2007 Work RVU: 7.77

2018 Work RVU: 7.41

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 5.5

2018 Fac PE RVU:5.5

Result: Decrease

RUC Recommendation: 7.28

Referred to CPT June 2008

Referred to CPT Asst ☐ **Published in CPT Asst:**

23120 Claviculectomy; partial **Global:** 090 **Issue:** Claviculectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008

Tab 30

Specialty Developing Recommendation: AAOS

First Identified: September 2007

2017 Est. Medicare Utilization: 7,859

2007 Work RVU: 7.23

2018 Work RVU: 7.39

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 6.22

2018 Fac PE RVU:6.22

Result: Maintain

RUC Recommendation: 7.23

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

23130 Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release **Global:** 090 **Issue:** Removal of Bone **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007

Tab 16

Specialty Developing Recommendation: AAOS

First Identified: September 2007

2017 Est. Medicare Utilization: 2,557

2007 Work RVU: 7.63

2018 Work RVU: 7.77

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 6.88

2018 Fac PE RVU:6.88

Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

23350 Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography **Global:** 000 **Issue:** Injection for Shoulder X-Ray **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 13 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** April 2011 **2017 Est. Medicare Utilization:** 37,824 **2007 Work RVU:** 1.00 **2018 Work RVU:** 1.00 **2007 NF PE RVU:** 3.23 **2018 NF PE RVU:** 3.23 **2007 Fac PE RVU:** 0.32 **2018 Fac PE RVU:** 0.32 **Result:** Maintain

RUC Recommendation: 1.00 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

23405 Tenotomy, shoulder area; single tendon **Global:** 090 **Issue:** Tenotomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 2,742 **2007 Work RVU:** 8.43 **2018 Work RVU:** 8.54 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 6.69 **2018 Fac PE RVU:** 6.69 **Result:** PE Only

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

23410 Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute **Global:** 090 **Issue:** Rotator Cuff **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 3,782 **2007 Work RVU:** 12.63 **2018 Work RVU:** 11.39 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 9.02 **2018 Fac PE RVU:** 9.02 **Result:** Decrease

RUC Recommendation: 11.23 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

23412 Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic **Global:** 090 **Issue:** Rotator Cuff **Screen:** Site of Service Anomaly / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 14,584 **2007 Work RVU:** 13.55 **2018 Work RVU:** 11.93 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 9.49 **2018 Fac PE RVU:** 9.49 **Result:** Decrease

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4. 11.77 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

23415 Coracoacromial ligament release, with or without acromioplasty

Global: 090

Issue: Shoulder Ligament Release

Screen: Site of Service Anomaly

Complete? Yes

Most Recent
RUC Meeting: October 2010

Tab 62

Specialty Developing
Recommendation: AAOS

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 668

2007 Work RVU: 10.09

2018 Work RVU: 9.23

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 7.65

2018 Fac PE RVU:7.65

Result: Decrease

RUC Recommendation: 9.23

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

23420 Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)

Global: 090

Issue: Rotator Cuff

Screen: Site of Service Anomaly

Complete? Yes

Most Recent
RUC Meeting: February 2008

Tab 12

Specialty Developing
Recommendation: AAOS

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 3,290

2007 Work RVU: 14.75

2018 Work RVU: 13.54

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 10.59

2018 Fac PE RVU:10.59

Result: Decrease

RUC Recommendation: 13.35

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

23430 Tenodesis of long tendon of biceps

Global: 090

Issue: Tenodesis

Screen: CMS Fastest Growing,
Site of Service Anomaly
(99238-Only)

Complete? Yes

Most Recent
RUC Meeting: October 2009

Tab 12

Specialty Developing
Recommendation: AAOS

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 19,013

2007 Work RVU: 10.05

2018 Work RVU: 10.17

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 7.78

2018 Fac PE RVU:7.78

Result: Maintain

RUC Recommendation: 10.17

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

23440 Resection or transplantation of long tendon of biceps

Global: 090

Issue: Tendon Transfer

Screen: Site of Service Anomaly
(99238-Only)

Complete? Yes

Most Recent
RUC Meeting: September 2007

Tab 16

Specialty Developing
Recommendation: AAOS

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 1,526

2007 Work RVU: 10.53

2018 Work RVU: 10.64

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 7.91

2018 Fac PE RVU:7.91

Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

23472 Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)) **Global:** 090 **Issue:** Arthroplasty **Screen:** CMS Fastest Growing / High Volume Growth3 **Complete?** Yes

Most Recent **Tab** 21 **Specialty Developing** AAOS
RUC Meeting: October 2015 **Recommendation:**

First Identified: October 2008 **2017 Est. Medicare Utilization:** 55,895

2007 Work RVU: 22.47 **2018 Work RVU:** 22.13
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 13.89 **2018 Fac PE RVU:**13.89
Result: Remove from Screen

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

23540 Closed treatment of acromioclavicular dislocation; without manipulation **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent **Tab** 46 **Specialty Developing** AAOS, ACEP, and orthopaedic subspecialties
RUC Meeting: April 2016 **Recommendation:**

First Identified: October 2015 **2017 Est. Medicare Utilization:** 415

2007 Work RVU: 2.28 **2018 Work RVU:** 2.36
2007 NF PE RVU: 2.80 **2018 NF PE RVU:** 2.80
2007 Fac PE RVU 2.43 **2018 Fac PE RVU:**2.43

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT
Referred to CPT Asst ☒ **Published in CPT Asst:** Jan 2018

Result: PE Only

23600 Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation **Global:** 090 **Issue:** Treatment of Humerus Fracture **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent **Tab** 14 **Specialty Developing** AAOS
RUC Meeting: September 2011 **Recommendation:**

First Identified: April 2011 **2017 Est. Medicare Utilization:** 33,756

2007 Work RVU: 3.00 **2018 Work RVU:** 3.00
2007 NF PE RVU: 4.43 **2018 NF PE RVU:** 4.43
2007 Fac PE RVU 3.58 **2018 Fac PE RVU:**3.58
Result: Decrease

RUC Recommendation: 3.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

23625 Closed treatment of greater humeral tuberosity fracture; with manipulation **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent **Tab** 46 **Specialty Developing** AAOS, ACEP, and orthopaedic subspecialties
RUC Meeting: April 2016 **Recommendation:**

First Identified: October 2015 **2017 Est. Medicare Utilization:** 187

2007 Work RVU: 3.99 **2018 Work RVU:** 4.10
2007 NF PE RVU: 4.82 **2018 NF PE RVU:** 4.82
2007 Fac PE RVU 4.19 **2018 Fac PE RVU:**4.19

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT
Referred to CPT Asst ☒ **Published in CPT Asst:** Jan 2018

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

23650 Closed treatment of shoulder dislocation, with manipulation; without anesthesia **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 14,098 **2007 Work RVU:** 3.44 **2018 Work RVU:** 3.53 **2007 NF PE RVU:** 3.65 **2018 NF PE RVU:** 3.65 **2007 Fac PE RVU:** 2.77 **2018 Fac PE RVU:** 2.77

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

23655 Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 2,604 **2007 Work RVU:** 4.64 **2018 Work RVU:** 4.76 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 4.17 **2018 Fac PE RVU:** 4.17

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

23665 Closed treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with manipulation **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 621 **2007 Work RVU:** 4.54 **2018 Work RVU:** 4.66 **2007 NF PE RVU:** 5.21 **2018 NF PE RVU:** 5.21 **2007 Fac PE RVU:** 4.61 **2018 Fac PE RVU:** 4.61

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

24505 Closed treatment of humeral shaft fracture; with manipulation, with or without skeletal traction **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 924 **2007 Work RVU:** 5.25 **2018 Work RVU:** 5.39 **2007 NF PE RVU:** 6.42 **2018 NF PE RVU:** 6.42 **2007 Fac PE RVU:** 5.27 **2018 Fac PE RVU:** 5.27

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

24600 Treatment of closed elbow dislocation; without anesthesia **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 1,298 **2007 Work RVU:** 4.28 **2018 Work RVU:** 4.37 **2007 NF PE RVU:** 4.61 **2018 NF PE RVU:** 4.61 **2007 Fac PE RVU:** 3.45 **2018 Fac PE RVU:** 3.45

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

24605 Treatment of closed elbow dislocation; requiring anesthesia **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 446 **2007 Work RVU:** 5.50 **2018 Work RVU:** 5.64 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 5.26 **2018 Fac PE RVU:** 5.26

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

25116 Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum **Global:** 090 **Issue:** Forearm Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 63 **Specialty Developing Recommendation:** ASSH, AAOS, ASPS

First Identified: September 2007

2017 Est. Medicare Utilization: 989

2007 Work RVU: 7.38

2018 Work RVU: 7.56

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 12.13

2018 Fac PE RVU:12.13

Result: Maintain

RUC Recommendation: 7.56

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

25210 Carpectomy; 1 bone

Global: 090 **Issue:** Carpectomy

Screen: Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007

Tab 16 **Specialty Developing Recommendation:** AAOS

First Identified: September 2007

2017 Est. Medicare Utilization: 2,692

2007 Work RVU: 6.01

2018 Work RVU: 6.12

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 6.49

2018 Fac PE RVU:6.49

Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

25260 Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle

Global: 090 **Issue:** Tendon Repair

Screen: Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007

Tab 16 **Specialty Developing Recommendation:** AAOS

First Identified: September 2007

2017 Est. Medicare Utilization: 1,113

2007 Work RVU: 7.89

2018 Work RVU: 8.04

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 12.3

2018 Fac PE RVU:12.3

Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

25280 Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist, single, each tendon **Global:** 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007

Tab 16 **Specialty Developing Recommendation:** AAOS

First Identified: September 2007

2017 Est. Medicare Utilization: 1,556

2007 Work RVU: 7.28

2018 Work RVU: 7.39

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 11.6

2018 Fac PE RVU:11.6

Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

25310 Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon

Global: 090

Issue: Forearm Repair

Screen: Site of Service Anomaly

Complete? Yes

Most Recent RUC Meeting: February 2008

Tab 15 **Specialty Developing Recommendation:** ASSH, AAOS

First Identified: September 2007

2017 Est. Medicare Utilization: 7,808

2007 Work RVU: 8.26

2018 Work RVU: 8.08

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 11.99

2018 Fac PE RVU:11.99

Result: Decrease

RUC Recommendation: 7.94

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

25565 Closed treatment of radial and ulnar shaft fractures; with manipulation

Global: 090

Issue: PE Subcommittee

Screen: Emergent Procedures

Complete? Yes

Most Recent RUC Meeting: April 2016

Tab 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties

First Identified: October 2015

2017 Est. Medicare Utilization: 788

2007 Work RVU: 5.71

2018 Work RVU: 5.85

2007 NF PE RVU: 6.52

2018 NF PE RVU: 6.52

2007 Fac PE RVU 5.32

2018 Fac PE RVU:5.32

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

25605 Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016

Tab 46

Specialty Developing Recommendation: AAOS, ACEP, and orthopaedic subspecialties

First Identified: October 2015

2017 Est. Medicare Utilization: 19,944

2007 Work RVU: 7.02

2018 Work RVU: 6.25

2007 NF PE RVU: 7.15

2018 NF PE RVU: 7.15

2007 Fac PE RVU 6.21

2018 Fac PE RVU:6.21

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018 **Result:** PE Only

25606 Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation **Global:** 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014

Tab 21

Specialty Developing Recommendation: AAOS, ASSH

First Identified: September 2014

2017 Est. Medicare Utilization: 2,625

2007 Work RVU: 8.10

2018 Work RVU: 8.31

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 8.41

2018 Fac PE RVU:8.41

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Maintain

25607 Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation **Global:** 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014

Tab 21

Specialty Developing Recommendation: AAOS, ASSH

First Identified: September 2014

2017 Est. Medicare Utilization: 9,171

2007 Work RVU: 9.35

2018 Work RVU: 9.56

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 7.26

2018 Fac PE RVU:7.26

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments **Global:** 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent **Tab** 21 **Specialty Developing** AAOS, ASSH **First** **2017 Est.**
RUC Meeting: September 2014 **Recommendation:** **Identified:** September 2014 **Medicare**
Utilization: 7,135 **2007 Work RVU:** 10.86 **2018 Work RVU:** 11.07
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 7.88 **2018 Fac PE RVU:** 7.88
Result: Maintain

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments **Global:** 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent **Tab** 21 **Specialty Developing** AAOS, ASSH **First** **2017 Est.**
RUC Meeting: September 2014 **Recommendation:** **Identified:** January 2014 **Medicare**
Utilization: 16,767 **2007 Work RVU:** 14.12 **2018 Work RVU:** 14.38
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 9.77 **2018 Fac PE RVU:** 9.77
Result: Maintain

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

25675 Closed treatment of distal radioulnar dislocation with manipulation **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent **Tab** 46 **Specialty Developing** AAOS, ACEP, and orthopaedic subspecialties **First** **2017 Est.**
RUC Meeting: April 2016 **Recommendation:** **Identified:** October 2015 **Medicare**
Utilization: 390 **2007 Work RVU:** 4.75 **2018 Work RVU:** 4.89
2007 NF PE RVU: 5.46 **2018 NF PE RVU:** 5.46
2007 Fac PE RVU 4.53 **2018 Fac PE RVU:** 4.53

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒ **Published in CPT Asst:** Jan 2018

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

26020	Drainage of tendon sheath, digit and/or palm, each	Global: 090	Issue: Tendon Sheath Procedures	Screen: Negative IWPUT	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 07 Specialty Developing Recommendation: AAOS, ASPS, ASSH	First Identified: April 2017	2017 Est. Medicare Utilization: 2,380	2007 Work RVU: 4.97 2007 NF PE RVU: NA 2007 Fac PE RVU: 5.21 Result: Increase	2018 Work RVU: 5.08 2018 NF PE RVU: NA 2018 Fac PE RVU: 5.21
RUC Recommendation: 7.79		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
26055	Tendon sheath incision (eg, for trigger finger)	Global: 090	Issue: Tendon Sheath Procedures	Screen: Negative IWPUT	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 07 Specialty Developing Recommendation: AAOS, ASPS, ASSH	First Identified: April 2017	2017 Est. Medicare Utilization: 96,877	2007 Work RVU: 3.00 2007 NF PE RVU: 13.02 2007 Fac PE RVU: 3.92 Result: Increase	2018 Work RVU: 3.11 2018 NF PE RVU: 13.02 2018 Fac PE RVU: 3.92
RUC Recommendation: 3.75		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
26080	Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each	Global: 090	Issue: RAW	Screen: Site of Service Anomaly / CPT Assistant Analysis	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 21 Specialty Developing Recommendation: ASSH, AAOS	First Identified: September 2007	2017 Est. Medicare Utilization: 1,914	2007 Work RVU: 4.36 2007 NF PE RVU: NA 2007 Fac PE RVU: 4.73 Result: Maintain	2018 Work RVU: 4.47 2018 NF PE RVU: NA 2018 Fac PE RVU: 4.73
RUC Recommendation: Action plan for RAW Oct 2015. Maintain		Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Sep 2012		
<hr/>					
26160	Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger	Global: 090	Issue: Tendon Sheath Procedures	Screen: Negative IWPUT	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 07 Specialty Developing Recommendation: AAOS, ASPS, ASSH	First Identified: April 2017	2017 Est. Medicare Utilization: 16,768	2007 Work RVU: 3.46 2007 NF PE RVU: 11.53 2007 Fac PE RVU: 4.08 Result: Maintain	2018 Work RVU: 3.57 2018 NF PE RVU: 11.53 2018 Fac PE RVU: 4.08
RUC Recommendation: 3.57		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

26356 Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon **Global:** 090 **Issue:** Repair Flexor Tendon **Screen:** Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015

Tab 25

Specialty Developing Recommendation: AAOS, ASPS, ASSH

First Identified: September 2007

2017 Est. Medicare Utilization: 1,166

2007 Work RVU: 10.22

2018 Work RVU: 9.56

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 17.22

2018 Fac PE RVU:17.22

Result: Decrease

RUC Recommendation: 10.03

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

26357 Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, without free graft, each tendon

Global: 090

Issue: Repair Flexor Tendon

Screen: 090-Day Global Post-Operative Visits

Complete? Yes

Most Recent RUC Meeting: April 2015

Tab 25

Specialty Developing Recommendation: AAOS, ASPS, ASSH

First Identified: April 2014

2017 Est. Medicare Utilization: 52

2007 Work RVU: 8.65

2018 Work RVU: 11.00

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 14.29

2018 Fac PE RVU:14.29

Result: Increase

RUC Recommendation: 11.50

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

26358 Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, with free graft (includes obtaining graft), each tendon

Global: 090

Issue: Repair Flexor Tendon

Screen: 090-Day Global Post-Operative Visits

Complete? Yes

Most Recent RUC Meeting: April 2015

Tab 25

Specialty Developing Recommendation: AAOS, ASPS, ASSH

First Identified: April 2014

2017 Est. Medicare Utilization: 59

2007 Work RVU: 9.22

2018 Work RVU: 12.60

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 15.19

2018 Fac PE RVU:15.19

Result: Increase

RUC Recommendation: 13.10

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

26480 Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon **Global:** 090 **Issue:** Tendon Transfer **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 26 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** October 2008 **2017 Est. Medicare Utilization:** 9,651 **2007 Work RVU:** 6.76 **2018 Work RVU:** 6.90
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 13.68 **2018 Fac PE RVU:** 13.68
Result: Maintain

RUC Recommendation: 6.76 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

26700 Closed treatment of metacarpophalangeal dislocation, single, with manipulation; without anesthesia **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 516 **2007 Work RVU:** 3.74 **2018 Work RVU:** 3.83
2007 NF PE RVU: 3.65 **2018 NF PE RVU:** 3.65
2007 Fac PE RVU: 2.89 **2018 Fac PE RVU:** 2.89

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT**
Referred to CPT Asst ☒ **Published in CPT Asst:** Jan 2018 **Result:** PE Only

26750 Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 7,282 **2007 Work RVU:** 1.74 **2018 Work RVU:** 1.80
2007 NF PE RVU: 2.42 **2018 NF PE RVU:** 2.42
2007 Fac PE RVU: 2.07 **2018 Fac PE RVU:** 2.07

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT**
Referred to CPT Asst ☒ **Published in CPT Asst:** Jan 2018 **Result:** PE Only

Status Report: CMS Requests and Relativity Assessment Issues

26755 Closed treatment of distal phalangeal fracture, finger or thumb; with manipulation, each **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 478 **2007 Work RVU:** 3.15 **2018 Work RVU:** 3.23 **2007 NF PE RVU:** 4.27 **2018 NF PE RVU:** 4.27 **2007 Fac PE RVU** 3 **2018 Fac PE RVU:**3

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

26770 Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 5,584 **2007 Work RVU:** 3.07 **2018 Work RVU:** 3.15 **2007 NF PE RVU:** 3.3 **2018 NF PE RVU:** 3.3 **2007 Fac PE RVU** 2.44 **2018 Fac PE RVU:**2.44

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

27048 Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm **Global:** 090 **Issue:** Excision of Subfascial Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 05 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 369 **2007 Work RVU:** 6.44 **2018 Work RVU:** 8.85 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU** 4.76 **2018 Fac PE RVU:**4.76

RUC Recommendation: 8.74

Referred to CPT June 2008

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

27062 Excision; trochanteric bursa or calcification

Global: 090

Issue: Trochanteric Bursa
Excision

Screen: Site of Service Anomaly

Complete? Yes

Most Recent
RUC Meeting: April 2008

Tab 32 Specialty Developing
Recommendation: AAOS

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 1,690

2007 Work RVU: 5.66

2018 Work RVU: 5.75

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 5.05

2018 Fac PE RVU:5.05

Result: Maintain

RUC Recommendation: 5.66

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

27096 Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed

Global: 000

Issue: Injection for Sacroiliac Joint

Screen: Different Performing
Specialty from Survey

Complete? Yes

Most Recent
RUC Meeting: April 2011

Tab 06 Specialty Developing
Recommendation: AAPM,
AAPMR,
ASA, ASIPP,
ISIS, NASS

First
Identified: October 2009

2017 Est.
Medicare
Utilization: 470,242

2007 Work RVU: 1.40

2018 Work RVU: 1.48

2007 NF PE RVU: 3.88

2018 NF PE RVU: 3.88

2007 Fac PE RVU 0.33

2018 Fac PE RVU:0.33

Result: Decrease

RUC Recommendation: 1.48

Referred to CPT February 2011

Referred to CPT Asst ☐

Published in CPT Asst:

27130 Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft

Global: 090

Issue: Arthroplasty

Screen: CMS High Expenditure
Procedural Codes1

Complete? Yes

Most Recent
RUC Meeting: January 2013

Tab 20 Specialty Developing
Recommendation: AAOS,
AAHKS

First
Identified: September 2011

2017 Est.
Medicare
Utilization: 158,135

2007 Work RVU: 21.61

2018 Work RVU: 20.72

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 12.96

2018 Fac PE RVU:12.96

Result: Decrease

RUC Recommendation: 21.79

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

27134 Revision of total hip arthroplasty; both components, with or without autograft or allograft **Global:** 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent **Tab** 21 **Specialty Developing** AAOS,
RUC Meeting: September 2014 **Recommendation:** AAHKS

First **2017 Est.**
Identified: January 2014 **Medicare**
Utilization: 10,938

2007 Work RVU: 30.13 **2018 Work RVU:** 30.28
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 17.08 **2018 Fac PE RVU:**17.08
Result: Maintain

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

27193 Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; without manipulation **Global:** 090 **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent **Tab** 07 **Specialty Developing** AAOS
RUC Meeting: January 2016 **Recommendation:**

First **2017 Est.**
Identified: July 2013 **Medicare**
Utilization:

2007 Work RVU: 5.98 **2018 Work RVU:**
2007 NF PE RVU: 4.98 **2018 NF PE RVU:** 4.98
2007 Fac PE RVU 4.98 **2018 Fac PE RVU:**4.98
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

27194 Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; with manipulation, requiring more than local anesthesia **Global:** 090 **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent **Tab** 07 **Specialty Developing** AAOS
RUC Meeting: January 2016 **Recommendation:**

First **2017 Est.**
Identified: October 2015 **Medicare**
Utilization:

2007 Work RVU: 10.08 **2018 Work RVU:**
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 7.4 **2018 Fac PE RVU:**7.4
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27197 Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation **Global:** 000 **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 07

Specialty Developing Recommendation: AAOS

First Identified: October 2015

2017 Est. Medicare Utilization: 13,357

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 1.53
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 5.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

27198 Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; with manipulation, requiring more than local anesthesia (ie, general anesthesia, moderate sedation, spinal/epidural) **Global:** 000 **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 07

Specialty Developing Recommendation: AAOS

First Identified: October 2015

2017 Est. Medicare Utilization: 323

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 4.75
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 9.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

27220 Closed treatment of acetabulum (hip socket) fracture(s); without manipulation **Global:** 090 **Issue:** Closed Treatment Fracture - Hip **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018

Tab 08

Specialty Developing Recommendation: AAOS

First Identified: April 2017

2017 Est. Medicare Utilization: 3,307

2007 Work RVU: 6.72
2007 NF PE RVU: 5.61
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 6.83
2018 NF PE RVU: 5.61
2018 Fac PE RVU: 5.52

RUC Recommendation: 6.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27230 Closed treatment of femoral fracture, proximal end, neck; without manipulation **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent **Tab** 46 **Specialty Developing** AAOS, **First** **2017 Est.** **2007 Work RVU:** 5.69 **2018 Work RVU:** 5.81
RUC Meeting: April 2016 **Recommendation:** ACEP, and **Identified:** October 2015 **Medicare** **2007 NF PE RVU:** 5.38 **2018 NF PE RVU:** 5.38
Utilization: 1,854 **2007 Fac PE RVU** 5.06 **2018 Fac PE RVU:**5.06

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

27232 Closed treatment of femoral fracture, proximal end, neck; with manipulation, with or without skeletal traction **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent **Tab** 46 **Specialty Developing** AAOS, **First** **2017 Est.** **2007 Work RVU:** 11.66 **2018 Work RVU:** 11.72
RUC Meeting: April 2016 **Recommendation:** ACEP, and **Identified:** October 2015 **Medicare** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA
Utilization: 250 **2007 Fac PE RVU** 6.88 **2018 Fac PE RVU:**6.88

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

27236 Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement **Global:** 090 **Issue:** Open Treatment of Femoral Fracture **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent **Tab** 16 **Specialty Developing** AAOS **First** **2017 Est.** **2007 Work RVU:** 17.43 **2018 Work RVU:** 17.61
RUC Meeting: October 2012 **Recommendation:** **Identified:** September 2011 **Medicare** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA
Utilization: 57,989 **2007 Fac PE RVU** 10.85 **2018 Fac PE RVU:**10.85

RUC Recommendation: 17.61

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

27240 Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with manipulation, with or without skin or skeletal traction **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 309

2007 Work RVU: 13.66 **2018 Work RVU:** 13.81
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 9.13 **2018 Fac PE RVU:** 9.13

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

27244 Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage **Global:** 090 **Issue:** Treat Thigh Fracture **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** April 2008 **2017 Est. Medicare Utilization:** 8,768

2007 Work RVU: 17.08 **2018 Work RVU:** 18.18
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 10.91 **2018 Fac PE RVU:** 10.91

RUC Recommendation: 18.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Increase

27245 Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage **Global:** 090 **Issue:** Treat Thigh Fracture **Screen:** High IWPUT / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2008 **2017 Est. Medicare Utilization:** 82,507

2007 Work RVU: 21.09 **2018 Work RVU:** 18.18
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 13.19 **2018 Fac PE RVU:** 13.19

RUC Recommendation: 18.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

27250	Closed treatment of hip dislocation, traumatic; without anesthesia	Global: 000	Issue: Closed Treatment of Hip Dislocation	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting: February 2008	Tab 18 Specialty Developing Recommendation: ACEP	First Identified: September 2007	2017 Est. Medicare Utilization: 3,134	2007 Work RVU: 7.21 2007 NF PE RVU: NA 2007 Fac PE RVU 4.54 Result: Decrease	2018 Work RVU: 3.82 2018 NF PE RVU: NA 2018 Fac PE RVU: 4.54
RUC Recommendation: 3.82		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
27252	Closed treatment of hip dislocation, traumatic; requiring anesthesia	Global: 090	Issue: PE Subcommittee	Screen: Emergent Procedures	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 46 Specialty Developing Recommendation: AAOS, ACEP, and orthopaedic subspecialties	First Identified: October 2015	2017 Est. Medicare Utilization: 932	2007 Work RVU: 10.92 2007 NF PE RVU: NA 2007 Fac PE RVU 7.21	2018 Work RVU: 11.03 2018 NF PE RVU: NA 2018 Fac PE RVU: 7.21
RUC Recommendation: PE Clinical staff pre-time revised		Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Jan 2018	Result: PE Only	
<hr/>					
27265	Closed treatment of post hip arthroplasty dislocation; without anesthesia	Global: 090	Issue: PE Subcommittee	Screen: Emergent Procedures	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 46 Specialty Developing Recommendation: AAOS, ACEP, and orthopaedic subspecialties	First Identified: October 2015	2017 Est. Medicare Utilization: 8,120	2007 Work RVU: 5.12 2007 NF PE RVU: NA 2007 Fac PE RVU 4.59	2018 Work RVU: 5.24 2018 NF PE RVU: NA 2018 Fac PE RVU: 4.59
RUC Recommendation: PE Clinical staff pre-time revised		Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Jan 2018	Result: PE Only	

Status Report: CMS Requests and Relativity Assessment Issues

27266 Closed treatment of post hip arthroplasty dislocation; requiring regional or general anesthesia **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 6,241 **2007 Work RVU:** 7.67 **2018 Work RVU:** 7.78 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 6.15 **2018 Fac PE RVU:** 6.15

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

27279 Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device **Global:** 090 **Issue:** Arthrodesis - Sacroiliac Joint **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 09 **Specialty Developing Recommendation:** AANS, AAOS, CNS, ISASS, NASS **First Identified:** July 2017 **2017 Est. Medicare Utilization:** 2,408 **2007 Work RVU:** **2018 Work RVU:** 9.03 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Maintain

RUC Recommendation: 9.03

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

27324 Biopsy, soft tissue of thigh or knee area; deep (subfascial or intramuscular) **Global:** 090 **Issue:** Soft Tissue Biopsy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 778 **2007 Work RVU:** 4.95 **2018 Work RVU:** 5.04 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 4.1 **2018 Fac PE RVU:** 4.1 **Result:** PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

27370 Injection of contrast for knee arthrography **Global:** 000 **Issue:** Knee Arthrography Injection **Screen:** High Volume Growth1 / CMS Fastest Growing / High Volume Growth2 / Harvard Valued - Utilization Over 30,000-Part2 / High Volume Growth3 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 05 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2017 Est. Medicare Utilization:** 143,751 **2007 Work RVU:** 0.96 **2018 Work RVU:** 0.96 **2007 NF PE RVU:** 3.47 **2018 NF PE RVU:** 3.47 **2007 Fac PE RVU:** 0.32 **2018 Fac PE RVU:** 0.32 **RUC Recommendation:** Code Deleted **Referred to CPT:** June 2017 **Referred to CPT Asst:** ☒ **Published in CPT Asst:** Clinical Examples of Radiology Bulletin #1 2010 **Result:** Deleted from CPT

27446 Arthroplasty, knee, condyle and plateau; medial OR lateral compartment **Global:** 090 **Issue:** Arthroplasty **Screen:** CMS High Expenditure Procedural Codes1 / Harvard-Valued with Annual Allowed Charges Greater than \$10 million **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 20 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 16,514 **2007 Work RVU:** 16.26 **2018 Work RVU:** 17.48 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 10.81 **2018 Fac PE RVU:** 10.81 **RUC Recommendation:** 17.48 **Referred to CPT:** **Referred to CPT Asst:** ☐ **Published in CPT Asst:** **Result:** Increase

27447 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) **Global:** 090 **Issue:** Arthroplasty **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 20 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 306,264 **2007 Work RVU:** 23.04 **2018 Work RVU:** 20.72 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 14.14 **2018 Fac PE RVU:** 14.14 **RUC Recommendation:** 19.60 **Referred to CPT:** **Referred to CPT Asst:** ☐ **Published in CPT Asst:** **Result:** Decrease

Status Report: CMS Requests and Relativity Assessment Issues

27502 Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 419 **2007 Work RVU:** 11.24 **2018 Work RVU:** 11.36 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 7.82 **2018 Fac PE RVU:** 7.82

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

27510 Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 351 **2007 Work RVU:** 9.68 **2018 Work RVU:** 9.80 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 7.09 **2018 Fac PE RVU:** 7.09

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

27550 Closed treatment of knee dislocation; without anesthesia **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 795 **2007 Work RVU:** 5.84 **2018 Work RVU:** 5.98 **2007 NF PE RVU:** 5.84 **2018 NF PE RVU:** 5.84 **2007 Fac PE RVU:** 4.85 **2018 Fac PE RVU:** 4.85

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

27552 Closed treatment of knee dislocation; requiring anesthesia **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent **Tab** 46 **Specialty Developing** AAOS, **First** **2017 Est.** **2007 Work RVU:** 8.04 **2018 Work RVU:** 8.18
RUC Meeting: April 2016 **Recommendation:** ACEP, and **Identified:** October 2015 **Medicare** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA
orthopaedic **Utilization:** 316 **2007 Fac PE RVU:** 6.75 **2018 Fac PE RVU:** 6.75
subspecialties

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

27615 Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; less than 5 cm **Global:** 090 **Issue:** Radical Resection of Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 6 **Specialty Developing** ACS, AAOS **First** **2017 Est.** **2007 Work RVU:** 12.93 **2018 Work RVU:** 15.72
RUC Meeting: February 2009 **Recommendation:** **Identified:** September 2007 **Medicare** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA
Utilization: 293 **2007 Fac PE RVU:** 9.07 **2018 Fac PE RVU:** 9.07

RUC Recommendation: 15.54

Referred to CPT June 2008

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Increase

27619 Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm **Global:** 090 **Issue:** Excision of Subfascial Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 5 **Specialty Developing** ACS, AAOS **First** **2017 Est.** **2007 Work RVU:** 8.47 **2018 Work RVU:** 6.91
RUC Meeting: February 2009 **Recommendation:** **Identified:** September 2007 **Medicare** **2007 NF PE RVU:** 9.65 **2018 NF PE RVU:** 9.65
Utilization: 673 **2007 Fac PE RVU:** 5.79 **2018 Fac PE RVU:** 5.79

RUC Recommendation: 6.80

Referred to CPT June 2008

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

27640 Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia **Global:** 090 **Issue:** Leg Bone Resection Partial **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 19 **Specialty Developing** AOFAS, **First** **2017 Est.** **2007 Work RVU:** 12.10 **2018 Work RVU:** 12.24
RUC Meeting: February 2008 **Recommendation:** AAOS **Identified:** September 2007 **Medicare** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA
Utilization: 1,473 **2007 Fac PE RVU:** 9.79 **2018 Fac PE RVU:** 9.79

RUC Recommendation: 12.10

Referred to CPT June 2008

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

27641 Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); fibula **Global:** 090 **Issue:** Leg Bone Resection Partial **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 19 **Specialty Developing** AOFAS, **First** **2017 Est.** **2007 Work RVU:** 9.73 **2018 Work RVU:** 9.84
RUC Meeting: February 2008 **Recommendation:** AAOS **Identified:** February 2008 **Medicare** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA
Utilization: 889 **2007 Fac PE RVU** 7.96 **2018 Fac PE RVU:**7.96
RUC Recommendation: 9.72 **Referred to CPT** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27650 Repair, primary, open or percutaneous, ruptured Achilles tendon; **Global:** 090 **Issue:** Achilles Tendon Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 20 **Specialty Developing** AAOS, **First** **2017 Est.** **2007 Work RVU:** 9.94 **2018 Work RVU:** 9.21
RUC Meeting: February 2008 **Recommendation:** AOFAS, **Identified:** September 2007 **Medicare** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA
Utilization: 2,624 **2007 Fac PE RVU** 7.22 **2018 Fac PE RVU:**7.22
RUC Recommendation: 9.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27654 Repair, secondary, Achilles tendon, with or without graft **Global:** 090 **Issue:** Achilles Tendon Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 33 **Specialty Developing** AOFAS, **First** **2017 Est.** **2007 Work RVU:** 10.32 **2018 Work RVU:** 10.53
RUC Meeting: April 2008 **Recommendation:** APMA, AAOS **Identified:** September 2007 **Medicare** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA
Utilization: 2,865 **2007 Fac PE RVU** 6.86 **2018 Fac PE RVU:**6.86
RUC Recommendation: 10.32 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

27685 Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure) **Global:** 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent **Tab** 16 **Specialty Developing** AAOS **First** **2017 Est.** **2007 Work RVU:** 6.57 **2018 Work RVU:** 6.69
RUC Meeting: September 2007 **Recommendation:** **Identified:** September 2007 **Medicare** **2007 NF PE RVU:** 7.68 **2018 NF PE RVU:** 7.68
Utilization: 3,807 **2007 Fac PE RVU** 5.26 **2018 Fac PE RVU:**5.26
RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27687 Gastrocnemius recession (eg, Strayer procedure)

Global: 090

Issue: Tendon Repair

Screen: Site of Service Anomaly (99238-Only)

Complete? Yes

Most Recent RUC Meeting: September 2007

Tab 16

Specialty Developing Recommendation: AAOS

First Identified: September 2007

2017 Est. Medicare Utilization: 6,708

2007 Work RVU: 6.30

2018 Work RVU: 6.41

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 5.12

2018 Fac PE RVU:5.12

Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

27690 Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)

Global: 090

Issue: Tendon Transfer

Screen: Site of Service Anomaly

Complete? Yes

Most Recent RUC Meeting: April 2008

Tab 34

Specialty Developing Recommendation: AOFAS, APMA, AAOS

First Identified: September 2007

2017 Est. Medicare Utilization: 1,453

2007 Work RVU: 8.96

2018 Work RVU: 9.17

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 6.15

2018 Fac PE RVU:6.15

Result: Maintain

RUC Recommendation: 8.96

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

27691 Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)

Global: 090

Issue: Tendon Transfer

Screen: Site of Service Anomaly

Complete? Yes

Most Recent RUC Meeting: April 2008

Tab 34

Specialty Developing Recommendation: AOFAS, APMA, AAOS

First Identified: September 2007

2017 Est. Medicare Utilization: 4,301

2007 Work RVU: 10.28

2018 Work RVU: 10.49

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 7.51

2018 Fac PE RVU:7.51

Result: Maintain

RUC Recommendation: 10.28

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

27752 Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation, with or without skeletal traction **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 1,320 **2007 Work RVU:** 6.15 **2018 Work RVU:** 6.27 **2007 NF PE RVU:** 6.48 **2018 NF PE RVU:** 6.48 **2007 Fac PE RVU:** 5.54 **2018 Fac PE RVU:** 5.54

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

27762 Closed treatment of medial malleolus fracture; with manipulation, with or without skin or skeletal traction **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 324 **2007 Work RVU:** 5.33 **2018 Work RVU:** 5.47 **2007 NF PE RVU:** 6.14 **2018 NF PE RVU:** 6.14 **2007 Fac PE RVU:** 5.14 **2018 Fac PE RVU:** 5.14

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

27792 Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed **Global:** 090 **Issue:** Treatment of Ankle Fracture **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 18 **Specialty Developing Recommendation:** AAOS, AOFAS, **First Identified:** June 2010 **2017 Est. Medicare Utilization:** 6,860 **2007 Work RVU:** 7.91 **2018 Work RVU:** 8.75 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 6.71 **2018 Fac PE RVU:** 6.71

RUC Recommendation: 9.71

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

27810 Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); with manipulation **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016

Tab 46

Specialty Developing Recommendation:

AAOS, ACEP, and orthopaedic subspecialties

First Identified: October 2015

2017 Est. Medicare Utilization: 2,796

2007 Work RVU: 5.20

2018 Work RVU: 5.32

2007 NF PE RVU: 6.05

2018 NF PE RVU: 6.05

2007 Fac PE RVU 5.02

2018 Fac PE RVU:5.02

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

27814 Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed **Global:** 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014

Tab 21

Specialty Developing Recommendation:

AAOS

First Identified: January 2014

2017 Est. Medicare Utilization: 11,351

2007 Work RVU: 11.10

2018 Work RVU: 10.62

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 8.25

2018 Fac PE RVU:8.25

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Maintain

27818 Closed treatment of trimalleolar ankle fracture; with manipulation **Global:** 090 **Issue:** Treatment of Fracture **Screen:** Site of Service Anomaly (99238-Only) / Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016

Tab 46

Specialty Developing Recommendation:

AAOS, ACEP, and orthopaedic subspecialties

First Identified: September 2007

2017 Est. Medicare Utilization: 3,012

2007 Work RVU: 5.57

2018 Work RVU: 5.69

2007 NF PE RVU: 6.14

2018 NF PE RVU: 6.14

2007 Fac PE RVU 5

2018 Fac PE RVU:5

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

27825 Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; with skeletal traction and/or requiring manipulation **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 659 **2007 Work RVU:** 6.60 **2018 Work RVU:** 6.69 **2007 NF PE RVU:** 6.42 **2018 NF PE RVU:** 6.42 **2007 Fac PE RVU:** 5.25 **2018 Fac PE RVU:** 5.25

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

27840 Closed treatment of ankle dislocation; without anesthesia **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 2,098 **2007 Work RVU:** 4.65 **2018 Work RVU:** 4.77 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 3.73 **2018 Fac PE RVU:** 3.73

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2018

Result: PE Only

27X69 **Global:** **Issue:** Knee Arthrography Injection **Screen:** Harvard Valued - Utilization Over 30,000-Part2 / High Volume Growth3 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 05 **Specialty Developing Recommendation:** ACR **First Identified:** June 2017 **2017 Est. Medicare Utilization:** **2007 Work RVU:** **2018 Work RVU:** **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:**

RUC Recommendation: 0.96

Referred to CPT February 2018

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

28002 Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space **Global:** 010 **Issue:** RAW **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 52 **Specialty Developing Recommendation:**

First Identified: January 2014

2017 Est. Medicare Utilization: 6,034

2007 Work RVU: 5.78

2018 Work RVU: 5.34

2007 NF PE RVU: 5.44

2018 NF PE RVU: 5.44

2007 Fac PE RVU: 3.74

2018 Fac PE RVU: 3.74

Result: Maintain

RUC Recommendation: Maintain

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

28111 Ostectomy, complete excision; first metatarsal head

Global: 090

Issue: Ostectomy

Screen: Site of Service Anomaly (99238-Only)

Complete? Yes

Most Recent RUC Meeting: September 2007

Tab 16 **Specialty Developing Recommendation:** APMA, AAOS

First Identified: September 2007

2017 Est. Medicare Utilization: 986

2007 Work RVU: 5.06

2018 Work RVU: 5.15

2007 NF PE RVU: 6.55

2018 NF PE RVU: 6.55

2007 Fac PE RVU: 3.58

2018 Fac PE RVU: 3.58

Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

28118 Ostectomy, calcaneus;

Global: 090

Issue: Ostectomy

Screen: Site of Service Anomaly (99238-Only)

Complete? Yes

Most Recent RUC Meeting: September 2007

Tab 16 **Specialty Developing Recommendation:** APMA, AAOS

First Identified: September 2007

2017 Est. Medicare Utilization: 2,969

2007 Work RVU: 6.02

2018 Work RVU: 6.13

2007 NF PE RVU: 6.68

2018 NF PE RVU: 6.68

2007 Fac PE RVU: 4.28

2018 Fac PE RVU: 4.28

Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

28120 Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus

Global: 090

Issue: Removal of Foot Bone

Screen: Site of Service Anomaly

Complete? Yes

Most Recent RUC Meeting: February 2011

Tab 19 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS

First Identified: September 2007

2017 Est. Medicare Utilization: 5,045

2007 Work RVU: 5.64

2018 Work RVU: 7.31

2007 NF PE RVU: 7.5

2018 NF PE RVU: 7.5

2007 Fac PE RVU: 4.31

2018 Fac PE RVU: 4.31

Result: Increase

RUC Recommendation: 8.27

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

28122 Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus **Global:** 090 **Issue:** Removal of Foot Bone **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011

Tab 19 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS

First Identified: September 2007

2017 Est. Medicare Utilization: 14,075

2007 Work RVU: 7.56

2018 Work RVU: 6.76

2007 NF PE RVU: 7.27

2018 NF PE RVU: 7.27

2007 Fac PE RVU 5.17

2018 Fac PE RVU:5.17

Result: Maintain

RUC Recommendation: 7.72

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

28124 Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe **Global:** 090 **Issue:** Toe Removal **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007

Tab 16 **Specialty Developing Recommendation:** APMA, AAOS

First Identified: September 2007

2017 Est. Medicare Utilization: 11,958

2007 Work RVU: 4.88

2018 Work RVU: 5.00

2007 NF PE RVU: 5.46

2018 NF PE RVU: 5.46

2007 Fac PE RVU 3.62

2018 Fac PE RVU:3.62

Result: PE Only

RUC Recommendation: Remove 99238

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

28285 Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy) **Global:** 090 **Issue:** Orthopaedic Surgery/Podiatry **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 31 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA

First Identified: February 2010

2017 Est. Medicare Utilization: 75,822

2007 Work RVU: 4.65

2018 Work RVU: 5.62

2007 NF PE RVU: 5.34

2018 NF PE RVU: 5.34

2007 Fac PE RVU 3.42

2018 Fac PE RVU:3.42

Result: Increase

RUC Recommendation: 5.62

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28289 Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant **Global:** 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 08

Specialty Developing Recommendation: AAOS, AOFAS, APMA

First Identified: October 2015

2017 Est. Medicare Utilization: 4,814

2007 Work RVU: 8.11

2018 Work RVU: 6.90

2007 NF PE RVU: 8.37

2018 NF PE RVU: 8.37

2007 Fac PE RVU: 5.68

2018 Fac PE RVU: 5.68

RUC Recommendation: 6.90

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

28290 Correction, hallux valgus (bunion), with or without sesamoidectomy; simple exostectomy (eg, Silver type procedure)

Global: 090

Issue: Bunionectomy

Screen: 090-Day Global Post-Operative Visits

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab 08

Specialty Developing Recommendation: AAOS, AOFAS, APMA

First Identified: October 2015

2017 Est. Medicare Utilization:

2007 Work RVU: 5.72

2018 Work RVU:

2007 NF PE RVU: 6.75

2018 NF PE RVU: 6.75

2007 Fac PE RVU: 4.55

2018 Fac PE RVU: 4.55

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

28291 Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant

Global: 090

Issue: Bunionectomy

Screen: 090-Day Global Post-Operative Visits

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab 08

Specialty Developing Recommendation: AAOS, AOFAS, APMA

First Identified: October 2015

2017 Est. Medicare Utilization: 3,615

2007 Work RVU:

2018 Work RVU: 8.01

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: 8.01

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

28292 Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method **Global:** 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 08

Specialty Developing Recommendation: AAOS, AOFAS, APMA

First Identified: October 2015

2017 Est. Medicare Utilization: 7,978

2007 Work RVU: 8.72

2018 Work RVU: 7.44

2007 NF PE RVU: 8.21

2018 NF PE RVU: 8.21

2007 Fac PE RVU 5.72

2018 Fac PE RVU:5.72

Result: Decrease

RUC Recommendation: 7.44

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

28293 Correction, hallux valgus (bunion), with or without sesamoidectomy; resection of joint with implant **Global:** 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 08

Specialty Developing Recommendation: AAOS, AOFAS, APMA

First Identified: January 2014

2017 Est. Medicare Utilization:

2007 Work RVU: 11.10

2018 Work RVU:

2007 NF PE RVU: 11.72

2018 NF PE RVU: 11.72

2007 Fac PE RVU 6.34

2018 Fac PE RVU:6.34

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

28294 Correction, hallux valgus (bunion), with or without sesamoidectomy; with tendon transplants (eg, Joplin type procedure) **Global:** 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 08

Specialty Developing Recommendation: AAOS, AOFAS, APMA

First Identified: October 2015

2017 Est. Medicare Utilization:

2007 Work RVU: 8.63

2018 Work RVU:

2007 NF PE RVU: 7.88

2018 NF PE RVU: 7.88

2007 Fac PE RVU 4.7

2018 Fac PE RVU:4.7

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28295	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal metatarsal osteotomy, any method	Global: 090	Issue: Bunionectomy	Screen: 090-Day Global Post-Operative Visits	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 08	Specialty Developing Recommendation: AAOS, AOFAS, APMA	First Identified: October 2015	2017 Est. Medicare Utilization: 526	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease
RUC Recommendation: 8.57			Referred to CPT October 2015 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		2018 Work RVU: 8.57 2018 NF PE RVU: 2018 Fac PE RVU:
<hr/>					
28296	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method	Global: 090	Issue: Bunionectomy	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 08	Specialty Developing Recommendation: AAOS, AOFAS, APMA	First Identified: September 2007	2017 Est. Medicare Utilization: 11,715	2007 Work RVU: 9.31 2007 NF PE RVU: 8.54 2007 Fac PE RVU 5.29 Result: Decrease
RUC Recommendation: 8.25			Referred to CPT October 2015 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		2018 Work RVU: 8.25 2018 NF PE RVU: 8.54 2018 Fac PE RVU: 5.29
<hr/>					
28297	Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method	Global: 090	Issue: Bunionectomy	Screen: 090-Day Global Post-Operative Visits	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 08	Specialty Developing Recommendation: AAOS, AOFAS, APMA	First Identified: October 2015	2017 Est. Medicare Utilization: 2,327	2007 Work RVU: 9.31 2007 NF PE RVU: 9.34 2007 Fac PE RVU 6.04 Result: Decrease
RUC Recommendation: 9.29			Referred to CPT October 2015 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		2018 Work RVU: 9.29 2018 NF PE RVU: 9.34 2018 Fac PE RVU: 6.04
<hr/>					

Status Report: CMS Requests and Relativity Assessment Issues

28298 Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal phalanx osteotomy, any method **Global:** 090 **Issue:** Bunionectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 08 Specialty Developing Recommendation: AAOS, AOFAS, APMA

First Identified: September 2007 **2017 Est. Medicare Utilization:** 2,663

2007 Work RVU: 8.01 **2018 Work RVU:** 7.75
2007 NF PE RVU: 7.74 **2018 NF PE RVU:** 7.74
2007 Fac PE RVU: 4.91 **2018 Fac PE RVU:** 4.91
Result: Decrease

RUC Recommendation: 7.75

Referred to CPT October 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

28299 Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method

Global: 090 **Issue:** Bunionectomy

Screen: 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 08 Specialty Developing Recommendation: AAOS, AOFAS, APMA

First Identified: October 2015 **2017 Est. Medicare Utilization:** 4,918

2007 Work RVU: 11.39 **2018 Work RVU:** 9.29
2007 NF PE RVU: 9.24 **2018 NF PE RVU:** 9.24
2007 Fac PE RVU: 6.01 **2018 Fac PE RVU:** 6.01
Result: Decrease

RUC Recommendation: 9.29

Referred to CPT October 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

28300 Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation

Global: 090 **Issue:** Osteotomy

Screen: Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007

Tab 16 Specialty Developing Recommendation: AAOS

First Identified: September 2007 **2017 Est. Medicare Utilization:** 2,394

2007 Work RVU: 9.61 **2018 Work RVU:** 9.73
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 6.81 **2018 Fac PE RVU:** 6.81
Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

28310 Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)

Global: 090 **Issue:** Osteotomy

Screen: Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007

Tab 16 Specialty Developing Recommendation: APMA, AAOS

First Identified: September 2007 **2017 Est. Medicare Utilization:** 1,792

2007 Work RVU: 5.48 **2018 Work RVU:** 5.57
2007 NF PE RVU: 6.2 **2018 NF PE RVU:** 6.2
2007 Fac PE RVU: 3.53 **2018 Fac PE RVU:** 3.53
Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28470 Closed treatment of metatarsal fracture; without manipulation, each **Global:** 090 **Issue:** Treatment of Metatarsal Fracture **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 15 **Specialty Developing Recommendation:** AAOS, APMA, AOFAS **First Identified:** April 2011 **2017 Est. Medicare Utilization:** 32,517 **2007 Work RVU:** 1.99 **2018 Work RVU:** 2.03 **2007 NF PE RVU:** 3.05 **2018 NF PE RVU:** 3.05 **2007 Fac PE RVU:** 2.43 **2018 Fac PE RVU:** 2.43 **Result:** Maintain

RUC Recommendation: 2.03 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

28660 Closed treatment of interphalangeal joint dislocation; without anesthesia **Global:** 010 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 655 **2007 Work RVU:** 1.25 **2018 Work RVU:** 1.28 **2007 NF PE RVU:** 1.27 **2018 NF PE RVU:** 1.27 **2007 Fac PE RVU:** 0.79 **2018 Fac PE RVU:** 0.79

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Referred to CPT Asst** ☒ **Published in CPT Asst:** Jan 2018 **Result:** PE Only

28725 Arthrodesis; subtalar **Global:** 090 **Issue:** Foot Arthrodesis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 20 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 4,089 **2007 Work RVU:** 11.97 **2018 Work RVU:** 11.22 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 7.93 **2018 Fac PE RVU:** 7.93 **Result:** Maintain

RUC Recommendation: 12.18 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

28730 Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; **Global:** 090 **Issue:** Foot Arthrodesis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 20 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 3,152 **2007 Work RVU:** 12.21 **2018 Work RVU:** 10.70 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 8.32 **2018 Fac PE RVU:** 8.32 **Result:** Maintain

RUC Recommendation: 12.42 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28740	Arthrodesis, midtarsal or tarsometatarsal, single joint		Global: 090	Issue: Arthrodesis	Screen: Site of Service Anomaly (99238-Only)	Complete? Yes
Most Recent RUC Meeting: September 2007	Tab 16	Specialty Developing Recommendation: AAOS	First Identified: September 2007	2017 Est. Medicare Utilization: 3,774	2007 Work RVU: 9.09 2007 NF PE RVU: 10.89 2007 Fac PE RVU: 6.37 Result: PE Only	2018 Work RVU: 9.29 2018 NF PE RVU: 10.89 2018 Fac PE RVU: 6.37
RUC Recommendation: Reduce 99238 to 0.5			Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	
28820	Amputation, toe; metatarsophalangeal joint		Global: 090	Issue:	Screen: Site of Service Anomaly - 2018	Complete? No
Most Recent RUC Meeting: October 2018	Tab 27	Specialty Developing Recommendation:	First Identified: October 2018	2017 Est. Medicare Utilization: 29,665	2007 Work RVU: 4.89 2007 NF PE RVU: 7.6 2007 Fac PE RVU: 3.74 Result:	2018 Work RVU: 5.82 2018 NF PE RVU: 7.6 2018 Fac PE RVU: 3.74
RUC Recommendation: Review action plan			Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	
28825	Amputation, toe; interphalangeal joint		Global: 090	Issue: Partial Amputation of Toe	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting: February 2011	Tab 21	Specialty Developing Recommendation: AOFAS, ACS, APMA, AAOS, SVS	First Identified: September 2007	2017 Est. Medicare Utilization: 13,856	2007 Work RVU: 3.71 2007 NF PE RVU: 7.04 2007 Fac PE RVU: 3.4 Result: Increase	2018 Work RVU: 5.37 2018 NF PE RVU: 7.04 2018 Fac PE RVU: 3.4
RUC Recommendation: 6.01			Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	
29075	Application, cast; elbow to finger (short arm)		Global: 000	Issue: Application of Forearm Cast	Screen: Harvard Valued - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: September 2011	Tab 16	Specialty Developing Recommendation: AAOS, ASSH	First Identified: April 2011	2017 Est. Medicare Utilization: 71,050	2007 Work RVU: 0.77 2007 NF PE RVU: 1.25 2007 Fac PE RVU: 0.68 Result: Maintain	2018 Work RVU: 0.77 2018 NF PE RVU: 1.25 2018 Fac PE RVU: 0.68
RUC Recommendation: 0.77			Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

29105	Application of long arm splint (shoulder to hand)			Global: 000	Issue: Application of Long Arm Splint	Screen: CMS 000-Day Global Typically Reported with an E/M	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 11	Specialty Developing Recommendation: AAOS, ACEP, ASSH	First Identified: July 2016	2017 Est. Medicare Utilization: 25,935	2007 Work RVU: 0.87 2007 NF PE RVU: 1.2 2007 Fac PE RVU: 0.52 Result: Decrease	2018 Work RVU: 0.87 2018 NF PE RVU: 1.2 2018 Fac PE RVU: 0.52	
RUC Recommendation: 0.80			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:			
29200	Strapping; thorax			Global: 000	Issue: Strapping Procedures	Screen: High Volume Growth2	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 35	Specialty Developing Recommendation: APTA	First Identified: April 2013	2017 Est. Medicare Utilization: 14,253	2007 Work RVU: 0.65 2007 NF PE RVU: 0.69 2007 Fac PE RVU: 0.34 Result: Decrease	2018 Work RVU: 0.39 2018 NF PE RVU: 0.69 2018 Fac PE RVU: 0.34	
RUC Recommendation: 0.39			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:			
29220	Deleted from CPT			Global: 000	Issue: Strapping; low back	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: April 2008	Tab 57	Specialty Developing Recommendation: AAFP	First Identified: February 2008	2017 Est. Medicare Utilization:	2007 Work RVU: 0.64 2007 NF PE RVU: 0.69 2007 Fac PE RVU: 0.38 Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 0.69 2018 Fac PE RVU: 0.38	
RUC Recommendation: Deleted from CPT			Referred to CPT October 2008 Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Deleted from CPT, no further action necessary			
29240	Strapping; shoulder (eg, Velpeau)			Global: 000	Issue: Strapping Procedures	Screen: High Volume Growth2	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 35	Specialty Developing Recommendation: APTA	First Identified: April 2013	2017 Est. Medicare Utilization: 20,741	2007 Work RVU: 0.71 2007 NF PE RVU: 0.81 2007 Fac PE RVU: 0.37 Result: Decrease	2018 Work RVU: 0.39 2018 NF PE RVU: 0.81 2018 Fac PE RVU: 0.37	
RUC Recommendation: 0.39			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:			

Status Report: CMS Requests and Relativity Assessment Issues

29260 Strapping; elbow or wrist Global: 000 Issue: Strapping Procedures Screen: High Volume Growth2 Complete? Yes

Most Recent	Tab 35	Specialty Developing Recommendation:	APTA	First Identified: October 2013	2017 Est. Medicare Utilization: 5,314	2007 Work RVU: 0.55	2018 Work RVU: 0.39
RUC Meeting: January 2014						2007 NF PE RVU: 0.72	2018 NF PE RVU: 0.72
						2007 Fac PE RVU 0.33	2018 Fac PE RVU: 0.33
RUC Recommendation: 0.39				Referred to CPT		Result: Decrease	
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

29280 Strapping; hand or finger Global: 000 Issue: Strapping Procedures Screen: High Volume Growth2 Complete? Yes

Most Recent	Tab 35	Specialty Developing Recommendation:	APTA	First Identified: October 2013	2017 Est. Medicare Utilization: 3,885	2007 Work RVU: 0.51	2018 Work RVU: 0.39
RUC Meeting: January 2014						2007 NF PE RVU: 0.77	2018 NF PE RVU: 0.77
						2007 Fac PE RVU 0.33	2018 Fac PE RVU: 0.33
RUC Recommendation: 0.39				Referred to CPT		Result: Decrease	
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

29445 Application of rigid total contact leg cast Global: 000 Issue: Application of Rigid Leg Cast Screen: High Volume Growth3 Complete? Yes

Most Recent	Tab 17	Specialty Developing Recommendation:	AAOS, AHKNS, AOFAS, AOA, NASS	First Identified: October 2015	2017 Est. Medicare Utilization: 40,994	2007 Work RVU: 1.78	2018 Work RVU: 1.78
RUC Meeting: April 2016						2007 NF PE RVU: 1.76	2018 NF PE RVU: 1.76
						2007 Fac PE RVU 0.96	2018 Fac PE RVU: 0.96
RUC Recommendation: 1.78				Referred to CPT		Result: Maintain	
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

29520 Strapping; hip Global: 000 Issue: Strapping Procedures Screen: High Volume Growth2 Complete? Yes

Most Recent	Tab 35	Specialty Developing Recommendation:	APTA	First Identified: April 2013	2017 Est. Medicare Utilization: 15,954	2007 Work RVU: 0.54	2018 Work RVU: 0.39
RUC Meeting: January 2014						2007 NF PE RVU: 0.81	2018 NF PE RVU: 0.81
						2007 Fac PE RVU 0.45	2018 Fac PE RVU: 0.45
RUC Recommendation: 0.39				Referred to CPT		Result: Decrease	
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

29530 Strapping; knee

Global: 000

Issue: Strapping Procedures

Screen: High Volume Growth2

Complete? Yes

**Most Recent
RUC Meeting:** January 2014

Tab 35

**Specialty Developing
Recommendation:** APTA

**First
Identified:** April 2013

**2017 Est.
Medicare
Utilization:** 29,771

2007 Work RVU: 0.57

2018 Work RVU: 0.39

2007 NF PE RVU: 0.75

2018 NF PE RVU: 0.75

2007 Fac PE RVU 0.34

2018 Fac PE RVU:0.34

Result: Decrease

RUC Recommendation: 0.39

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

29540 Strapping; ankle and/or foot

Global: 000

Issue: Strapping Lower Extremity

Screen: Harvard Valued -
Utilization over 100,000
/ CMS 000-Day Global
Typically Reported with
an E/M

Complete? Yes

**Most Recent
RUC Meeting:** April 2017

Tab 41ii

**Specialty Developing
Recommendation:** APMA

**First
Identified:** October 2009

**2017 Est.
Medicare
Utilization:** 235,022

2007 Work RVU: 0.51

2018 Work RVU: 0.39

2007 NF PE RVU: 0.45

2018 NF PE RVU: 0.45

2007 Fac PE RVU 0.31

2018 Fac PE RVU:0.31

Result: Decrease

RUC Recommendation: 0.39

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

29550 Strapping; toes

Global: 000

Issue: Strapping Lower Extremity

Screen: Harvard Valued -
Utilization over 100,000
/ CMS 000-Day Global
Typically Reported with
an E/M

Complete? Yes

**Most Recent
RUC Meeting:** April 2017

Tab 41ii

**Specialty Developing
Recommendation:** APMA

**First
Identified:** February 2010

**2017 Est.
Medicare
Utilization:** 53,948

2007 Work RVU: 0.47

2018 Work RVU: 0.25

2007 NF PE RVU: 0.46

2018 NF PE RVU: 0.46

2007 Fac PE RVU 0.29

2018 Fac PE RVU:0.29

Result: Decrease

RUC Recommendation: 0.25

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

29580 Strapping; Unna boot **Global:** 000 **Issue:** Strapping Multi Layer Compression **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 13 **Specialty Developing Recommendation:** ACS, APMA, SVS **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 299,550 **2007 Work RVU:** 0.55 **2018 Work RVU:** 0.55
2007 NF PE RVU: 0.67 **2018 NF PE RVU:** 0.67
2007 Fac PE RVU: 0.35 **2018 Fac PE RVU:** 0.35
RUC Recommendation: 0.55 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

29581 Application of multi-layer compression system; leg (below knee), including ankle and foot **Global:** 000 **Issue:** Strapping Multi Layer Compression **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 13 **Specialty Developing Recommendation:** ACS, APMA, SVS **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 175,056 **2007 Work RVU:** 0.60 **2018 Work RVU:** 0.60
2007 NF PE RVU: 0.67 **2018 NF PE RVU:** 0.67
2007 Fac PE RVU: 0.35 **2018 Fac PE RVU:** 0.35
RUC Recommendation: 0.60 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

29582 Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed **Global:** 000 **Issue:** New Technology Review **Screen:** New Technology/New Services **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 21 **Specialty Developing Recommendation:** APTA **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 6,095 **2007 Work RVU:** 0.60 **2018 Work RVU:** 0.60
2007 NF PE RVU: 0.67 **2018 NF PE RVU:** 0.67
2007 Fac PE RVU: 0.35 **2018 Fac PE RVU:** 0.35
RUC Recommendation: Deleted form CPT **Referred to CPT** September 2016 **Referred to CPT Asst** ☒ **Published in CPT Asst:** Aug 2016 **Result:** Deleted from CPT

29583 Application of multi-layer compression system; upper arm and forearm **Global:** 000 **Issue:** New Technology Review **Screen:** New Technology/New Services **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 21 **Specialty Developing Recommendation:** APTA **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 871 **2007 Work RVU:** 0.60 **2018 Work RVU:** 0.60
2007 NF PE RVU: 0.67 **2018 NF PE RVU:** 0.67
2007 Fac PE RVU: 0.35 **2018 Fac PE RVU:** 0.35
RUC Recommendation: Deleted form CPT **Referred to CPT** September 2016 **Referred to CPT Asst** ☒ **Published in CPT Asst:** Aug 2016 **Result:** Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

29584 Application of multi-layer compression system; upper arm, forearm, hand, and fingers **Global:** 000 **Issue:** New Technology Review **Screen:** New Technology/New Services **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab** 27 **Specialty Developing Recommendation:** APTA **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 2,321 **2007 Work RVU:** **2018 Work RVU:** 0.35 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU** **2018 Fac PE RVU:**

RUC Recommendation: Develop CPT Assistant Article

Referred to CPT
Referred to CPT Asst ☒ **Published in CPT Asst:** Aug 2016

29590 Denis-Browne splint strapping **Global:** 000 **Issue:** Dennis-Browne splint revision **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 07 **Specialty Developing Recommendation:** APMA **First Identified:** February 2010 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 0.76 **2018 Work RVU:** **2007 NF PE RVU:** 0.54 **2018 NF PE RVU:** 0.54 **2007 Fac PE RVU** 0.29 **2018 Fac PE RVU:** 0.29

RUC Recommendation: Refer to CPT for deletion

Referred to CPT February 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

29805 Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure) **Global:** 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2017 Est. Medicare Utilization:** 647 **2007 Work RVU:** 5.94 **2018 Work RVU:** 6.03 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU** 5.44 **2018 Fac PE RVU:** 5.44

RUC Recommendation: No NF PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

29822 Arthroscopy, shoulder, surgical; debridement, limited **Global:** 090 **Issue:** Arthroscopy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 26 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2008 **2017 Est. Medicare Utilization:** 12,756 **2007 Work RVU:** 7.49 **2018 Work RVU:** 7.60 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU** 6.43 **2018 Fac PE RVU:** 6.43

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29823	Arthroscopy, shoulder, surgical; debridement, extensive	Global: 090	Issue:	Screen: Harvard-Valued Annual Allowed Charges Greater than \$10 million / Harvard Valued - Utilization over 30,000-Part3	Complete? Yes
Most Recent RUC Meeting: October 2012	Tab 27 Specialty Developing Recommendation: AAOS	First Identified: October 2012	2017 Est. Medicare Utilization: 45,189	2007 Work RVU: 8.24 2007 NF PE RVU: NA 2007 Fac PE RVU: 6.94 Result: Remove from Screen	2018 Work RVU: 8.36 2018 NF PE RVU: NA 2018 Fac PE RVU: 6.94
RUC Recommendation: Review action plan		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
29824	Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)	Global: 090	Issue: RAW	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 21 Specialty Developing Recommendation: AAOS	First Identified: February 2010	2017 Est. Medicare Utilization: 41,497	2007 Work RVU: 8.82 2007 NF PE RVU: NA 2007 Fac PE RVU: 7.3 Result: Maintain	2018 Work RVU: 8.98 2018 NF PE RVU: NA 2018 Fac PE RVU: 7.3
RUC Recommendation: 8.82		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: RAW	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 21 Specialty Developing Recommendation: AAOS	First Identified: February 2010	2017 Est. Medicare Utilization: 80,955	2007 Work RVU: 9.05 2007 NF PE RVU: NA 2007 Fac PE RVU: 7.21 Result: Decrease	2018 Work RVU: 3.00 2018 NF PE RVU: NA 2018 Fac PE RVU: 7.21
RUC Recommendation: 3.00		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	Global: 090	Issue: RAW	Screen: CMS Fastest Growing/ Codes Reported Together 75% or More- Part1 / Pre-Time Analysis	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 21 Specialty Developing Recommendation: AAOS	First Identified: October 2008	2017 Est. Medicare Utilization: 67,878	2007 Work RVU: 15.44 2007 NF PE RVU: NA 2007 Fac PE RVU 11.01 Result: Maintain	2018 Work RVU: 15.59 2018 NF PE RVU: NA 2018 Fac PE RVU: 11.01
RUC Recommendation: 15.59. Maintain work RVU and adjust the times from pre-time package 3.		Referred to CPT Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
29828	Arthroscopy, shoulder, surgical; biceps tenodesis	Global: 090	Issue: RAW	Screen: Codes Reported Together 75% or More- Part1	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 21 Specialty Developing Recommendation: AAOS	First Identified: February 2010	2017 Est. Medicare Utilization: 15,976	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain	2018 Work RVU: 13.16 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 13.16		Referred to CPT Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
29830	Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)	Global: 090	Issue: Arthroscopy	Screen: CMS Request - Practice Expense Review	Complete? Yes
Most Recent RUC Meeting: April 2008	Tab 51 Specialty Developing Recommendation: AAOS	First Identified: NA	2017 Est. Medicare Utilization: 95	2007 Work RVU: 5.80 2007 NF PE RVU: NA 2007 Fac PE RVU 5.14 Result: PE Only	2018 Work RVU: 5.88 2018 NF PE RVU: NA 2018 Fac PE RVU: 5.14
RUC Recommendation: No NF PE inputs		Referred to CPT Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			

Status Report: CMS Requests and Relativity Assessment Issues

29840 Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure) **Global:** 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008

Tab 51

Specialty Developing Recommendation: AAOS

First Identified: NA

2017 Est. Medicare Utilization: 115

2007 Work RVU: 5.59

2018 Work RVU: 5.68

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 5.16

2018 Fac PE RVU:5.16

Result: PE Only

RUC Recommendation: No NF PE inputs

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

29870 Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)

Global: 090

Issue: Arthroscopy

Screen: CMS Request - Practice Expense Review

Complete? Yes

Most Recent RUC Meeting: October 2009

Tab 13

Specialty Developing Recommendation: AAOS

First Identified: NA

2017 Est. Medicare Utilization: 1,127

2007 Work RVU: 5.11

2018 Work RVU: 5.19

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 4.72

2018 Fac PE RVU:4.72

Result: PE Only

RUC Recommendation: New PE non-facility inputs

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

29888 Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction

Global: 090

Issue: ACL Repair

Screen: Site of Service Anomaly

Complete? Yes

Most Recent RUC Meeting: April 2008

Tab 38

Specialty Developing Recommendation: AAOS

First Identified: September 2007

2017 Est. Medicare Utilization: 1,356

2007 Work RVU: 14.14

2018 Work RVU: 14.30

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 9.75

2018 Fac PE RVU:9.75

Result: Maintain

RUC Recommendation: 14.14

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

29900 Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy

Global: 090

Issue: Arthroscopy

Screen: CMS Request - Practice Expense Review

Complete? Yes

Most Recent RUC Meeting: April 2008

Tab 51

Specialty Developing Recommendation: AAOS

First Identified: NA

2017 Est. Medicare Utilization:

2007 Work RVU: 5.74

2018 Work RVU: 5.88

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 5.6

2018 Fac PE RVU:5.6

Result: PE Only

RUC Recommendation: No NF PE inputs

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

30140	Submucous resection inferior turbinate, partial or complete, any method	Global: 000	Issue: Resection of Inferior Turbinate	Screen: Harvard Valued - Utilization over 30,000-Part2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 14	Specialty Developing Recommendation: AAOHNS	First Identified: October 2015	2017 Est. Medicare Utilization: 45,229	2007 Work RVU: 3.48 2007 NF PE RVU: NA 2007 Fac PE RVU 6.29 Result: Decrease
RUC Recommendation: 3.00			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 3.00 2018 NF PE RVU: NA 2018 Fac PE RVU: 6.29
<hr/>					
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)	Global: 090	Issue: Repair Nasal Stenosis	Screen: Site of Service Anomaly (99238-Only)	Complete? Yes
Most Recent RUC Meeting: September 2007	Tab 16	Specialty Developing Recommendation: AAO-HNS	First Identified: September 2007	2017 Est. Medicare Utilization: 4,005	2007 Work RVU: 12.20 2007 NF PE RVU: NA 2007 Fac PE RVU 11.58 Result: PE Only
RUC Recommendation: Reduce 99238 to 0.5			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 12.36 2018 NF PE RVU: NA 2018 Fac PE RVU: 11.58
<hr/>					
30901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method	Global: 000	Issue: Control Nasal Hemorrhage	Screen: Harvard Valued - Utilization over 100,000 / CMS Request - Final Rule for 2016	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 20	Specialty Developing Recommendation: AAOHNS	First Identified: October 2009	2017 Est. Medicare Utilization: 95,832	2007 Work RVU: 1.21 2007 NF PE RVU: 1.32 2007 Fac PE RVU 0.31 Result: Maintain
RUC Recommendation: 1.10			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.10 2018 NF PE RVU: 1.32 2018 Fac PE RVU: 0.31

Status Report: CMS Requests and Relativity Assessment Issues

30903	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method	Global: 000	Issue: Control Nasal Hemorrhage	Screen: CMS Request - Final Rule for 2016	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 20	Specialty Developing Recommendation: AAOHNS	First Identified: July 2015	2017 Est. Medicare Utilization: 52,927	2007 Work RVU: 1.54 2007 NF PE RVU: 2.8 2007 Fac PE RVU: 0.47 Result: Maintain
RUC Recommendation: 1.54			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.54 2018 NF PE RVU: 2.8 2018 Fac PE RVU: 0.47
30905	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial	Global: 000	Issue: Control Nasal Hemorrhage	Screen: CMS Request - Final Rule for 2016	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 20	Specialty Developing Recommendation: AAOHNS	First Identified: July 2015	2017 Est. Medicare Utilization: 6,104	2007 Work RVU: 1.97 2007 NF PE RVU: 3.57 2007 Fac PE RVU: 0.69 Result: Maintain
RUC Recommendation: 1.97			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.97 2018 NF PE RVU: 3.57 2018 Fac PE RVU: 0.69
30906	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent	Global: 000	Issue: Control Nasal Hemorrhage	Screen: CMS Request - Final Rule for 2016	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 20	Specialty Developing Recommendation: AAOHNS	First Identified: July 2015	2017 Est. Medicare Utilization: 1,043	2007 Work RVU: 2.45 2007 NF PE RVU: 3.91 2007 Fac PE RVU: 1.07 Result: Maintain
RUC Recommendation: 2.45			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2.45 2018 NF PE RVU: 3.91 2018 Fac PE RVU: 1.07
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	Global: 000	Issue: Nasal/Sinus Endoscopy	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2012	Tab 19	Specialty Developing Recommendation: AAO-HNS	First Identified: October 2010	2017 Est. Medicare Utilization: 595,854	2007 Work RVU: 1.10 2007 NF PE RVU: 3.37 2007 Fac PE RVU: 0.84 Result: Maintain
RUC Recommendation: 1.10			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.10 2018 NF PE RVU: 3.37 2018 Fac PE RVU: 0.84

Status Report: CMS Requests and Relativity Assessment Issues

31237 Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure) **Global:** 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 19 **Specialty Developing Recommendation:** AAO-HNS

First Identified: September 2011

2017 Est. Medicare Utilization: 130,424

2007 Work RVU: 2.98

2018 Work RVU: 2.60

2007 NF PE RVU: 5.03

2018 NF PE RVU: 5.03

2007 Fac PE RVU: 1.72

2018 Fac PE RVU: 1.72

Result: Decrease

RUC Recommendation: 2.60

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

31238 Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage

Global: 000

Issue: Nasal/Sinus Endoscopy

Screen: CMS High Expenditure Procedural Codes1

Complete? Yes

Most Recent RUC Meeting: April 2013

Tab 19 **Specialty Developing Recommendation:** AAO-HNS

First Identified: January 2012

2017 Est. Medicare Utilization: 28,856

2007 Work RVU: 3.26

2018 Work RVU: 2.74

2007 NF PE RVU: 5.04

2018 NF PE RVU: 5.04

2007 Fac PE RVU: 1.9

2018 Fac PE RVU: 1.9

Result: Decrease

RUC Recommendation: 2.74

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

31239 Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy

Global: 010

Issue: Nasal/Sinus Endoscopy

Screen: CMS High Expenditure Procedural Codes1

Complete? Yes

Most Recent RUC Meeting: April 2013

Tab 19 **Specialty Developing Recommendation:** AAO-HNS

First Identified: January 2012

2017 Est. Medicare Utilization: 1,262

2007 Work RVU: 9.23

2018 Work RVU: 9.04

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 7.59

2018 Fac PE RVU: 7.59

Result: Decrease

RUC Recommendation: 9.04

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

31240 Nasal/sinus endoscopy, surgical; with concha bullosa resection

Global: 000

Issue: Nasal/Sinus Endoscopy

Screen: CMS High Expenditure Procedural Codes1

Complete? Yes

Most Recent RUC Meeting: April 2013

Tab 19 **Specialty Developing Recommendation:** AAO-HNS

First Identified: January 2012

2017 Est. Medicare Utilization: 5,816

2007 Work RVU: 2.61

2018 Work RVU: 2.61

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 1.59

2018 Fac PE RVU: 1.59

Result: Maintain

RUC Recommendation: 2.61

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

31241	Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery	Global: 000	Issue: Nasal/Sinus Endoscopy	Screen: Codes Reported Together 75% or More-Part3	Complete? Yes	
Most Recent RUC Meeting: January 2017	Tab 07	Specialty Developing Recommendation: AAOHNS	First Identified: April 2015	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 8.00 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 8.51			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	September 2016 Published in CPT Asst:		
31253	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed	Global: 000	Issue: Nasal/Sinus Endoscopy	Screen: Codes Reported Together 75% or More-Part3	Complete? Yes	
Most Recent RUC Meeting: January 2017	Tab 07	Specialty Developing Recommendation: AAOHNS	First Identified: April 2015	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 9.00 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 9.00			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	September 2016 Published in CPT Asst:		
31254	Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)	Global: 000	Issue: Nasal/Sinus Endoscopy	Screen: CMS Request - Final Rule for 2016	Complete? Yes	
Most Recent RUC Meeting: January 2017	Tab 07	Specialty Developing Recommendation: AAOHNS	First Identified: July 2015	2017 Est. Medicare Utilization: 12,205	2007 Work RVU: 4.64 2007 NF PE RVU: NA 2007 Fac PE RVU 2.57 Result: Decrease	2018 Work RVU: 4.27 2018 NF PE RVU: NA 2018 Fac PE RVU:2.57
RUC Recommendation: 4.27			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	September 2016 Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

31255 Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior) **Global:** 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 07 **Specialty Developing Recommendation:** AAOHNS

First Identified: April 2015

2017 Est. Medicare Utilization: 34,238

2007 Work RVU: 6.95

2018 Work RVU: 5.75

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 3.69

2018 Fac PE RVU: 3.69

Result: Decrease

RUC Recommendation: 5.75

Referred to CPT September 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

31256 Nasal/sinus endoscopy, surgical, with maxillary antrostomy;

Global: 000

Issue: Nasal/Sinus Endoscopy

Screen: CMS Request - Final Rule for 2016

Complete? Yes

Most Recent RUC Meeting: January 2017

Tab 07 **Specialty Developing Recommendation:** AAOHNS

First Identified: July 2015

2017 Est. Medicare Utilization: 16,719

2007 Work RVU: 3.29

2018 Work RVU: 3.11

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 1.92

2018 Fac PE RVU: 1.92

Result: Decrease

RUC Recommendation: 3.11

Referred to CPT September 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

31257 Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy

Global: 000

Issue: Nasal/Sinus Endoscopy

Screen: Codes Reported Together 75% or More-Part3

Complete? Yes

Most Recent RUC Meeting: January 2017

Tab 07 **Specialty Developing Recommendation:** AAOHNS

First Identified: April 2015

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU: 8.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 8.00

Referred to CPT September 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31259 Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus **Global:** 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 07

Specialty Developing Recommendation: AAOHNS

First Identified: April 2015

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU: 8.48

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 8.48

Referred to CPT September 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

31267 Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus **Global:** 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 07

Specialty Developing Recommendation: AAOHNS

First Identified: July 2015

2017 Est. Medicare Utilization: 28,550

2007 Work RVU: 5.45

2018 Work RVU: 4.68

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 2.96

2018 Fac PE RVU:2.96

Result: Decrease

RUC Recommendation: 4.68

Referred to CPT September 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

31276 Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed **Global:** 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 07

Specialty Developing Recommendation: AAOHNS

First Identified: April 2015

2017 Est. Medicare Utilization: 24,542

2007 Work RVU: 8.84

2018 Work RVU: 6.75

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 4.58

2018 Fac PE RVU:4.58

Result: Decrease

RUC Recommendation: 6.75

Referred to CPT September 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy;	Global: 000	Issue: Nasal/Sinus Endoscopy	Screen: Codes Reported Together 75% or More- Part3 / CMS Request - Final Rule for 2016	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 07 Specialty Developing Recommendation: AAOHNS	First Identified: April 2015	2017 Est. Medicare Utilization: 9,796	2007 Work RVU: 3.91 2007 NF PE RVU: NA 2007 Fac PE RVU: 2.22 Result: Decrease	2018 Work RVU: 3.50 2018 NF PE RVU: NA 2018 Fac PE RVU: 2.22
RUC Recommendation: 3.50		Referred to CPT September 2016 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus	Global: 000	Issue: Nasal/Sinus Endoscopy	Screen: Codes Reported Together 75% or More- Part3 / CMS Request - Final Rule for 2016	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 07 Specialty Developing Recommendation: AAOHNS	First Identified: April 2015	2017 Est. Medicare Utilization: 11,121	2007 Work RVU: 4.57 2007 NF PE RVU: NA 2007 Fac PE RVU: 2.54 Result: Decrease	2018 Work RVU: 4.10 2018 NF PE RVU: NA 2018 Fac PE RVU: 2.54
RUC Recommendation: 4.10		Referred to CPT September 2016 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa	Global: 000	Issue: Nasal/Sinus Endoscopy	Screen: Codes Reported Together 75% or More- Part3 / CMS Request - Final Rule for 2016	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 07 Specialty Developing Recommendation: AAOHNS	First Identified: April 2015	2017 Est. Medicare Utilization: 29,789	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Maintain	2018 Work RVU: 2.70 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 2.70		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

31296 Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation) **Global:** 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 07

Specialty Developing Recommendation: AAOHNS

First Identified: April 2015

2017 Est. Medicare Utilization: 29,242

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 3.10
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 3.10

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

31297 Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation) **Global:** 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 07

Specialty Developing Recommendation: AAOHNS

First Identified: April 2015

2017 Est. Medicare Utilization: 21,274

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 2.44
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 2.44

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

31298 Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia (eg, balloon dilation) **Global:** 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 07

Specialty Developing Recommendation: AAOHNS

First Identified: April 2015

2017 Est. Medicare Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 4.50
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.50

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31500 Intubation, endotracheal, emergency procedure **Global:** 000 **Issue:** Endotracheal Intubation **Screen:** CMS High Expenditure Procedural Codes2 / Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 27 **Specialty Developing Recommendation:** ACEP, ASA **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 276,024 **2007 Work RVU:** 2.33 **2018 Work RVU:** 3.00 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 0.52 **2018 Fac PE RVU:** 0.52 **RUC Recommendation:** 3.00 **Referred to CPT** **Referred to CPT Asst** ☒ **Published in CPT Asst:** Oct 2016 **Result:** Increase

31551 Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, younger than 12 years of age **Global:** 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2017 Est. Medicare Utilization:** **2007 Work RVU:** **2018 Work RVU:** 21.50 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** 21.50 **Referred to CPT** October 2015 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

31552 Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, age 12 years or older **Global:** 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 22 **2007 Work RVU:** **2018 Work RVU:** 20.50 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** 20.50 **Referred to CPT** October 2015 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

Status Report: CMS Requests and Relativity Assessment Issues

31553 Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, younger than 12 years of age **Global:** 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 09 **Specialty Developing Recommendation:** AAOHNS

First Identified: October 2015

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU: 22.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 22.00

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

31554 Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, age 12 years or older

Global: 090

Issue: Laryngoplasty

Screen: 090-Day Global Post-Operative Visits

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab 09 **Specialty Developing Recommendation:** AAOHNS

First Identified: October 2015

2017 Est. Medicare Utilization: 25

2007 Work RVU:

2018 Work RVU: 22.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 22.00

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

31571 Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope or telescope

Global: 000

Issue: Laryngoscopy

Screen: Site of Service Anomaly (99238-Only)

Complete? Yes

Most Recent RUC Meeting: September 2007

Tab 16 **Specialty Developing Recommendation:** AAO-HNS

First Identified: September 2007

2017 Est. Medicare Utilization: 4,940

2007 Work RVU: 4.26

2018 Work RVU: 4.26

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 2.36

2018 Fac PE RVU: 2.36

Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31575 Laryngoscopy, flexible; diagnostic **Global:** 000 **Issue:** **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent **Tab** 08 **Specialty Developing** AAO-HNS
RUC Meeting: October 2015 **Recommendation:**

First Identified: October 2010 **2017 Est. Medicare Utilization:** 644,666

2007 Work RVU: 1.10 **2018 Work RVU:** 0.94
2007 NF PE RVU: 1.82 **2018 NF PE RVU:** 1.82
2007 Fac PE RVU: 0.84 **2018 Fac PE RVU:** 0.84
Result: Decrease

RUC Recommendation: 1.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

31579 Laryngoscopy, flexible or rigid telescopic, with stroboscopy

Global: 000 **Issue:** Laryngoscopy

Screen: CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent **Tab** 08 **Specialty Developing** AAO-HNS
RUC Meeting: October 2015 **Recommendation:**

First Identified: October 2008 **2017 Est. Medicare Utilization:** 79,278

2007 Work RVU: 2.26 **2018 Work RVU:** 1.88
2007 NF PE RVU: 3.5 **2018 NF PE RVU:** 3.5
2007 Fac PE RVU: 1.37 **2018 Fac PE RVU:** 1.37
Result: Decrease

RUC Recommendation: 1.94

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

31580 Laryngoplasty; for laryngeal web, with indwelling keel or stent insertion

Global: 090 **Issue:** Laryngoplasty

Screen: 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent **Tab** 09 **Specialty Developing** AAO-HNS
RUC Meeting: January 2016 **Recommendation:**

First Identified: April 2014 **2017 Est. Medicare Utilization:** 45

2007 Work RVU: 14.46 **2018 Work RVU:** 14.60
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 15.31 **2018 Fac PE RVU:** 15.31
Result: Decrease

RUC Recommendation: 14.60

Referred to CPT October 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31582	Laryngoplasty; for laryngeal stenosis, with graft or core mold, including tracheotomy	Global: 090	Issue: Laryngoplasty	Screen: 090-Day Global Post-Operative Visits	Complete? Yes
Most Recent RUC Meeting: January 2015	Tab 09 Specialty Developing Recommendation: AAO-HNS	First Identified: April 2014	2017 Est. Medicare Utilization:	2007 Work RVU: 22.87 2007 NF PE RVU: NA 2007 Fac PE RVU: 24.48 Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 24.48
RUC Recommendation: Deleted from CPT		Referred to CPT October 2015 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

31584	Laryngoplasty; with open reduction and fixation of (eg, plating) fracture, includes tracheostomy, if performed	Global: 090	Issue: Laryngoplasty	Screen: 090-Day Global Post-Operative Visits	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 09 Specialty Developing Recommendation: AAO-HNS	First Identified: April 2014	2017 Est. Medicare Utilization: 18	2007 Work RVU: 20.35 2007 NF PE RVU: NA 2007 Fac PE RVU: 17.19 Result: Decrease	2018 Work RVU: 17.58 2018 NF PE RVU: NA 2018 Fac PE RVU: 17.19
RUC Recommendation: 20.00		Referred to CPT October 2015 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

31587	Laryngoplasty, cricoid split, without graft placement	Global: 090	Issue: Laryngoplasty	Screen: 090-Day Global Post-Operative Visits	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 09 Specialty Developing Recommendation: AAO-HNS	First Identified: April 2014	2017 Est. Medicare Utilization: 23	2007 Work RVU: 15.12 2007 NF PE RVU: NA 2007 Fac PE RVU: 8.96 Result: Decrease	2018 Work RVU: 15.27 2018 NF PE RVU: NA 2018 Fac PE RVU: 8.96
RUC Recommendation: 15.27		Referred to CPT October 2015 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

31588	Laryngoplasty, not otherwise specified (eg, for burns, reconstruction after partial laryngectomy)	Global: 090	Issue: Laryngoplasty	Screen: 090-Day Global Post-Operative Visits	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 09 Specialty Developing Recommendation: AAO-HNS	First Identified: January 2014	2017 Est. Medicare Utilization:	2007 Work RVU: 14.62 2007 NF PE RVU: NA 2007 Fac PE RVU: 13.07 Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 13.07
RUC Recommendation: Deleted from CPT		Referred to CPT October 2015 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

31591 Laryngoplasty, medialization, unilateral

Global: 090

Issue: Laryngoplasty

Screen: 090-Day Global Post-Operative Visits

Complete? Yes

Most Recent
RUC Meeting: January 2016

Tab 09

Specialty Developing
Recommendation: AAOHNS

First
Identified: October 2015

2017 Est.
Medicare
Utilization: 1,115

2007 Work RVU:

2018 Work RVU: 13.56

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 15.60

Referred to CPT October 2015

Referred to CPT Asst ☐ Published in CPT Asst:

31592 Cricotracheal resection

Global: 090

Issue: Laryngoplasty

Screen: 090-Day Global Post-Operative Visits

Complete? Yes

Most Recent
RUC Meeting: January 2016

Tab 09

Specialty Developing
Recommendation: AAOHNS

First
Identified: October 2015

2017 Est.
Medicare
Utilization: 28

2007 Work RVU:

2018 Work RVU: 25.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 25.00

Referred to CPT October 2015

Referred to CPT Asst ☐ Published in CPT Asst:

31600 Tracheostomy, planned (separate procedure);

Global: 000

Issue: Tracheostomy

Screen: CMS High Expenditure
Procedural Codes2

Complete? Yes

Most Recent
RUC Meeting: April 2016

Tab 21

Specialty Developing
Recommendation: AAOHNS

First
Identified: July 2015

2017 Est.
Medicare
Utilization: 26,835

2007 Work RVU: 7.17

2018 Work RVU: 5.56

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 2.95

2018 Fac PE RVU:2.95

Result: Increase

RUC Recommendation: 5.56

Referred to CPT

Referred to CPT Asst ☐ Published in CPT Asst:

31601 Tracheostomy, planned (separate procedure); younger than 2 years

Global: 000

Issue: Tracheostomy

Screen: CMS High Expenditure
Procedural Codes2

Complete? Yes

Most Recent
RUC Meeting: April 2016

Tab 21

Specialty Developing
Recommendation: AAOHNS

First
Identified: July 2015

2017 Est.
Medicare
Utilization: 7

2007 Work RVU: 4.44

2018 Work RVU: 8.00

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 2.21

2018 Fac PE RVU:2.21

Result: Increase

RUC Recommendation: 8.00

Referred to CPT

Referred to CPT Asst ☐ Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

31603 Tracheostomy, emergency procedure; transtracheal

Global: 000

Issue: Tracheostomy

Screen: CMS High Expenditure
Procedural Codes2

Complete? Yes

Most Recent
RUC Meeting: April 2016

Tab 21

Specialty Developing
Recommendation: AAOHNS

First
Identified: July 2015

2017 Est.
Medicare
Utilization: 943

2007 Work RVU: 4.14

2018 Work RVU: 6.00

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 1.57

2018 Fac PE RVU:1.57

Result: Increase

RUC Recommendation: 6.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

31605 Tracheostomy, emergency procedure; cricothyroid membrane

Global: 000

Issue: Tracheostomy

Screen: CMS High Expenditure
Procedural Codes2

Complete? Yes

Most Recent
RUC Meeting: April 2016

Tab 21

Specialty Developing
Recommendation: AAOHNS

First
Identified: July 2015

2017 Est.
Medicare
Utilization: 305

2007 Work RVU: 3.57

2018 Work RVU: 6.45

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 1.1

2018 Fac PE RVU:1.1

Result: Increase

RUC Recommendation: 6.45

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

31610 Tracheostomy, fenestration procedure with skin flaps

Global: 090

Issue: Tracheostomy

Screen: CMS High Expenditure
Procedural Codes2

Complete? Yes

Most Recent
RUC Meeting: October 2016

Tab 15

Specialty Developing
Recommendation: AAOHNS,
ACS

First
Identified: July 2015

2017 Est.
Medicare
Utilization: 1,839

2007 Work RVU: 9.29

2018 Work RVU: 12.00

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 7.99

2018 Fac PE RVU:7.99

Result: Increase

RUC Recommendation: 12.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

31611 Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom-Singer prosthesis)

Global: 090

Issue: Speech Prosthesis

Screen: Site of Service Anomaly

Complete? Yes

Most Recent
RUC Meeting: February 2008

Tab S

Specialty Developing
Recommendation: AAO-HNS

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 823

2007 Work RVU: 5.92

2018 Work RVU: 6.00

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 6.92

2018 Fac PE RVU:6.92

Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

31620 Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure[s]) **Global:** ZZZ **Issue:** Endobronchial Ultrasound - **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 1.40 **2018 Work RVU:** **2007 NF PE RVU:** 5.73 **2018 NF PE RVU:** 5.73 **2007 Fac PE RVU:** 0.5 **2018 Fac PE RVU:** 0.5 **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

31622 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure) **Global:** 000 **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2017 Est. Medicare Utilization:** 60,563 **2007 Work RVU:** 2.78 **2018 Work RVU:** 2.53 **2007 NF PE RVU:** 5.55 **2018 NF PE RVU:** 5.55 **2007 Fac PE RVU:** 1.02 **2018 Fac PE RVU:** 1.02 **Result:** Maintain

RUC Recommendation: 2.78 **Referred to CPT** October 2014 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

31623 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings **Global:** 000 **Issue:** Diagnostic Bronchoscopy **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 09 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2016 **2017 Est. Medicare Utilization:** 30,317 **2007 Work RVU:** 2.88 **2018 Work RVU:** 2.63 **2007 NF PE RVU:** 6.32 **2018 NF PE RVU:** 6.32 **2007 Fac PE RVU:** 1.02 **2018 Fac PE RVU:** 1.02 **Result:** Maintain

RUC Recommendation: 2.63 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

31624 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage **Global:** 000 **Issue:** Diagnostic Bronchoscopy **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 09 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2017 **2017 Est. Medicare Utilization:** 115,806 **2007 Work RVU:** 2.88 **2018 Work RVU:** 2.63 **2007 NF PE RVU:** 5.67 **2018 NF PE RVU:** 5.67 **2007 Fac PE RVU:** 1.02 **2018 Fac PE RVU:** 1.02 **Result:** Maintain

RUC Recommendation: 2.63 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31625 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites **Global:** 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** April 2013 **2017 Est. Medicare Utilization:** 21,289 **2007 Work RVU:** 3.36 **2018 Work RVU:** 3.11 **2007 NF PE RVU:** 5.73 **2018 NF PE RVU:** 5.73 **2007 Fac PE RVU:** 1.17 **2018 Fac PE RVU:** 1.17 **Result:** Maintain

RUC Recommendation: 3.36 **Referred to CPT** October 2014 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

31626 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple **Global:** 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2017 Est. Medicare Utilization:** 2,245 **2007 Work RVU:** 3.91 **2018 Work RVU:** 3.91 **2007 NF PE RVU:** 7.02 **2018 NF PE RVU:** 7.02 **2007 Fac PE RVU:** 1.26 **2018 Fac PE RVU:** 1.26 **Result:** Maintain

RUC Recommendation: 4.16 **Referred to CPT** October 2014 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

31628 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe **Global:** 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2017 Est. Medicare Utilization:** 33,616 **2007 Work RVU:** 3.80 **2018 Work RVU:** 3.55 **2007 NF PE RVU:** 7.02 **2018 NF PE RVU:** 7.02 **2007 Fac PE RVU:** 1.26 **2018 Fac PE RVU:** 1.26 **Result:** Maintain

RUC Recommendation: 3.80 **Referred to CPT** October 2014 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

31629 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i) **Global:** 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2017 Est. Medicare Utilization:** 14,582 **2007 Work RVU:** 4.09 **2018 Work RVU:** 3.75 **2007 NF PE RVU:** 13.7 **2018 NF PE RVU:** 13.7 **2007 Fac PE RVU:** 1.35 **2018 Fac PE RVU:** 1.35 **Result:** Decrease

RUC Recommendation: 4.00 **Referred to CPT** October 2014 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31632 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015

Tab 05 Specialty Developing Recommendation: ACCP, ATS

First Identified: April 2013

2017 Est. Medicare Utilization: 3,893

2007 Work RVU: 1.03

2018 Work RVU: 1.03

2007 NF PE RVU: 0.83

2018 NF PE RVU: 0.83

2007 Fac PE RVU: 0.3

2018 Fac PE RVU: 0.3

Result: Maintain

RUC Recommendation: 1.03

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

31633 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015

Tab 05 Specialty Developing Recommendation: ACCP, ATS

First Identified: April 2013

2017 Est. Medicare Utilization: 2,114

2007 Work RVU: 1.32

2018 Work RVU: 1.32

2007 NF PE RVU: 0.94

2018 NF PE RVU: 0.94

2007 Fac PE RVU: 0.38

2018 Fac PE RVU: 0.38

Result: Maintain

RUC Recommendation: 1.32

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

31645 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, initial **Global:** 000 **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2016

Tab 08 Specialty Developing Recommendation: ATS, CHEST

First Identified: October 2015

2017 Est. Medicare Utilization: 33,249

2007 Work RVU: 3.16

2018 Work RVU: 2.88

2007 NF PE RVU: 5.05

2018 NF PE RVU: 5.05

2007 Fac PE RVU: 1.09

2018 Fac PE RVU: 1.09

Result: Decrease

RUC Recommendation: 2.88

Referred to CPT May 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31646 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, subsequent, same hospital stay **Global:** 000 **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2016

Tab 08 Specialty Developing Recommendation: ATS, CHEST

First Identified: October 2015

2017 Est. Medicare Utilization: 4,184

2007 Work RVU: 2.72

2018 Work RVU: 2.78

2007 NF PE RVU: 4.76

2018 NF PE RVU: 4.76

2007 Fac PE RVU 0.97

2018 Fac PE RVU: 0.97

Result: Increase

RUC Recommendation: 2.78

Referred to CPT May 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

31652 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures **Global:** 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015

Tab 05 Specialty Developing Recommendation: ATS, ACCP

First Identified:

2017 Est. Medicare Utilization: 23,427

2007 Work RVU:

2018 Work RVU: 4.46

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 5.00

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **Global:** 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015

Tab 05 Specialty Developing Recommendation: ATS, ACCP

First Identified:

2017 Est. Medicare Utilization: 10,545

2007 Work RVU:

2018 Work RVU: 4.96

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 5.50

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31654 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (List separately in addition to code for primary procedure[s]) **Global:** ZZZ **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 05 **Specialty Developing Recommendation:** ATS, ACCP **First Identified:** **2017 Est. Medicare Utilization:** 6,618 **2007 Work RVU:** **2018 Work RVU:** 1.40 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Decrease **2018 Fac PE RVU:**

RUC Recommendation: 1.70 **Referred to CPT** October 2014 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

32201 Pneumonostomy; with percutaneous drainage of abscess or cyst **Global:** 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 3.99 **2018 Work RVU:** **2007 NF PE RVU:** 20.21 **2018 NF PE RVU:** 20.21 **2007 Fac PE RVU** 1.26 **2018 Fac PE RVU:** 1.26 **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

32405 Biopsy, lung or mediastinum, percutaneous needle **Global:** 000 **Issue:** Codes Reported Together **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** No

Most Recent RUC Meeting: January 2018 **Tab** 31 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2017 **2017 Est. Medicare Utilization:** 70,791 **2007 Work RVU:** 1.93 **2018 Work RVU:** 1.68 **2007 NF PE RVU:** 0.64 **2018 NF PE RVU:** 0.64 **2007 Fac PE RVU** 0.61 **2018 Fac PE RVU:** 0.61 **Result:**

RUC Recommendation: Refer to CPT to bundle **Referred to CPT** February 2019 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32420 Pneumocentesis, puncture of lung for aspiration

Global: 000

Issue: Thoracentesis with Tube Insertion

Screen: Harvard Valued - Utilization over 30,000

Complete? Yes

Most Recent
RUC Meeting: September 2011

Tab 17

Specialty Developing
Recommendation:

ACCP, ACR,
ATS, SIR,
SCCM, STS

First
Identified: September 2011

2017 Est.
Medicare
Utilization:

2007 Work RVU: 2.18

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 0.66

2018 Fac PE RVU:0.66

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012

Referred to CPT Asst ☐ Published in CPT Asst:

Result: Deleted from CPT

32421 Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent

Global: 000

Issue: Thoracentesis with Tube Insertion

Screen: Harvard Valued - Utilization over 30,000

Complete? Yes

Most Recent
RUC Meeting: September 2011

Tab 17

Specialty Developing
Recommendation:

ACCP, ACR,
ATS, SIR,
SCCM, STS

First
Identified: September 2011

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012

Referred to CPT Asst ☐ Published in CPT Asst:

Result: Deleted from CPT

32422 Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)

Global: 000

Issue: Thoracentesis with Tube Insertion

Screen: Harvard Valued - Utilization over 30,000

Complete? Yes

Most Recent
RUC Meeting: September 2011

Tab 17

Specialty Developing
Recommendation:

ACCP, ACR,
ATS, SIR,
SCCM, STS

First
Identified: April 2011

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012

Referred to CPT Asst ☐ Published in CPT Asst:

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

32440 Removal of lung, pneumonectomy;

Global: 090

Issue: RAW Review

Screen: CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013

Complete? Yes

Most Recent RUC Meeting: January 2013

Tab 34

Specialty Developing Recommendation:

ACCP, ATS, ACR, ACS, SIR, SCCM, STS

First Identified: November 2011

2017 Est. Medicare Utilization: 381

2007 Work RVU: 27.17

2018 Work RVU: 27.28

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 12.44

2018 Fac PE RVU:12.44

RUC Recommendation: No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures.

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

32480 Removal of lung, other than pneumonectomy; single lobe (lobectomy)

Global: 090

Issue: RAW Review

Screen: CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013

Complete? Yes

Most Recent RUC Meeting: January 2013

Tab 34

Specialty Developing Recommendation:

ACCP, ATS, ACR, ACS, SIR, SCCM, STS

First Identified: November 2011

2017 Est. Medicare Utilization: 6,130

2007 Work RVU: 25.71

2018 Work RVU: 25.82

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 11.63

2018 Fac PE RVU:11.63

RUC Recommendation: No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures.

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32482	Removal of lung, other than pneumonectomy; 2 lobes (bilobectomy)	Global: 090	Issue: RAW Review	Screen: CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013	Complete? Yes
Most Recent RUC Meeting: January 2013	Tab 34	Specialty Developing Recommendation: ACCP, ATS, ACR, ACS, SIR, SCCM, STS	First Identified: November 2011	2017 Est. Medicare Utilization: 463	2007 Work RVU: 27.28 2007 NF PE RVU: NA 2007 Fac PE RVU: 12.48 2018 Work RVU: 27.44 2018 NF PE RVU: NA 2018 Fac PE RVU: 12.48
RUC Recommendation:	No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures.				Result: Remove from Screen
	Referred to CPT				
	Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:				

32491	Removal of lung, other than pneumonectomy; with resection-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, includes any pleural procedure, when performed	Global: 090	Issue: RAW Review	Screen: CMS Request to Re-Review Families of Recently Reviewed CPT Codes	Complete? Yes
Most Recent RUC Meeting: January 2012	Tab 30	Specialty Developing Recommendation: ACCP, ATS, ACR, ACS, SIR, SCCM, STS	First Identified: November 2011	2017 Est. Medicare Utilization: 25	2007 Work RVU: 25.09 2007 NF PE RVU: NA 2007 Fac PE RVU: 12.13 2018 Work RVU: 25.24 2018 NF PE RVU: NA 2018 Fac PE RVU: 12.13
RUC Recommendation:	Request further information from CMS				Result: Remove from Screen
	Referred to CPT				
	Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:				

32551	Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)	Global: 000	Issue: Chest Tube Thoracostomy	Screen: Harvard Valued - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 10	Specialty Developing Recommendation: ACCP, ATS, ACR, ACS, SIR, SCCM, STS	First Identified: April 2011	2017 Est. Medicare Utilization: 34,747	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: 2018 Work RVU: 3.04 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation:	3.50				Result: Increase
	Referred to CPT February 2012				
	Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:				

Status Report: CMS Requests and Relativity Assessment Issues

32554 Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance **Global:** 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012

Tab 04

Specialty Developing Recommendation: ACCP, ACR, ATS, SIR

First Identified:

2017 Est. Medicare Utilization: 16,651

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU: 1.82
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.82

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

32555 Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance **Global:** 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012

Tab 04

Specialty Developing Recommendation: ACCP, ACR, ATS, SIR

First Identified:

2017 Est. Medicare Utilization: 220,892

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU: 2.27
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 2.27

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

32556 Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance **Global:** 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012

Tab 04

Specialty Developing Recommendation: ACCP, ACR, ATS, SIR

First Identified:

2017 Est. Medicare Utilization: 3,330

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU: 2.50
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 2.50

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

32557 Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance **Global:** 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012

Tab 04

Specialty Developing Recommendation: ACCP, ACR, ATS, SIR

First Identified:

2017 Est. Medicare Utilization: 36,948

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU: 3.12
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 3.62

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32663 Thoracoscopy, surgical; with lobectomy (single lobe)

Global: 090

Issue: RAW review

Screen: CMS Fastest Growing

Complete? Yes

Most Recent Tab 34 Specialty Developing STS
RUC Meeting: January 2013 Recommendation:

First Identified: October 2008

2017 Est. Medicare Utilization: 8,268

2007 Work RVU: 24.56 2018 Work RVU: 24.64
2007 NF PE RVU: NA 2018 NF PE RVU: NA
2007 Fac PE RVU 10.44 2018 Fac PE RVU:10.44
Result: Remove from Screen

RUC Recommendation: No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures.

Referred to CPT

Referred to CPT Asst ☐ Published in CPT Asst:

33010 Pericardiocentesis; initial

Global: 000

Issue: Pericardiocentesis and Pericardial Drainage

Screen: Negative IWPUT

Complete? No

Most Recent Tab Specialty Developing
RUC Meeting: Recommendation:

First Identified: September 2018

2017 Est. Medicare Utilization: 5,740

2007 Work RVU: 2.24 2018 Work RVU: 1.99
2007 NF PE RVU: NA 2018 NF PE RVU: NA
2007 Fac PE RVU 0.85 2018 Fac PE RVU:0.85
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018

Referred to CPT Asst ☐ Published in CPT Asst:

33011 Pericardiocentesis; subsequent

Global: 000

Issue: Pericardiocentesis and Pericardial Drainage

Screen: Negative IWPUT

Complete? No

Most Recent Tab Specialty Developing
RUC Meeting: Recommendation:

First Identified: September 2018

2017 Est. Medicare Utilization: 88

2007 Work RVU: 2.24 2018 Work RVU: 1.99
2007 NF PE RVU: NA 2018 NF PE RVU: NA
2007 Fac PE RVU 0.89 2018 Fac PE RVU:0.89
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018

Referred to CPT Asst ☐ Published in CPT Asst:

33015 Tube pericardiostomy

Global: 090

Issue: Pericardiocentesis and Pericardial Drainage

Screen: Negative IWPUT

Complete? No

Most Recent Tab 19 Specialty Developing ACC
RUC Meeting: October 2017 Recommendation:

First Identified: April 2017

2017 Est. Medicare Utilization: 1,154

2007 Work RVU: 8.44 2018 Work RVU: 8.52
2007 NF PE RVU: NA 2018 NF PE RVU: NA
2007 Fac PE RVU 4.98 2018 Fac PE RVU:4.98
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018

Referred to CPT Asst ☐ Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

33020 Pericardiotomy for removal of clot or foreign body (primary procedure) **Global:** 090 **Issue:** Pericardiotomy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 10 **Specialty Developing Recommendation:** AATS, STS **First Identified:** April 2018 **2017 Est. Medicare Utilization:** 153 **2007 Work RVU:** 14.87 **2018 Work RVU:** 14.95
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 6.71 **2018 Fac PE RVU:** 6.71
Result: Decrease

RUC Recommendation: 14.31 **Referred to CPT** May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

33025 Creation of pericardial window or partial resection for drainage **Global:** 090 **Issue:** Pericardiotomy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 10 **Specialty Developing Recommendation:** AATS, STS **First Identified:** April 2017 **2017 Est. Medicare Utilization:** 4,893 **2007 Work RVU:** 13.65 **2018 Work RVU:** 13.70
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 6.25 **2018 Fac PE RVU:** 6.25
Result: Decrease

RUC Recommendation: 13.20 **Referred to CPT** May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

33207 Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular **Global:** 090 **Issue:** Pacemaker or Pacing Cardioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2017 Est. Medicare Utilization:** 15,288 **2007 Work RVU:** 9.05 **2018 Work RVU:** 7.80
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 4.95 **2018 Fac PE RVU:** 4.95
Result: Maintain

RUC Recommendation: 8.05 **Referred to CPT** February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

33208 Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular **Global:** 090 **Issue:** Pacemaker or Pacing Cardioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2017 Est. Medicare Utilization:** 104,518 **2007 Work RVU:** 8.12 **2018 Work RVU:** 8.52
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 4.95 **2018 Fac PE RVU:** 4.95
Result: Maintain

RUC Recommendation: 8.77 **Referred to CPT** February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33212 Insertion of pacemaker pulse generator only; with existing single lead

Global: 090

Issue: Pacemaker or Pacing
Carioverter - Defibrillator

Screen: Codes Reported
Together 75% or More-
Part1

Complete? Yes

**Most Recent
RUC Meeting:** September 2011

Tab 04

**Specialty Developing
Recommendation:** ACC

**First
Identified:** February 2010

**2017 Est.
Medicare
Utilization:** 491

2007 Work RVU: 5.51

2018 Work RVU: 5.01

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.46

2018 Fac PE RVU:3.46

Result: Decrease

RUC Recommendation: 5.26

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

33213 Insertion of pacemaker pulse generator only; with existing dual leads

Global: 090

Issue: Pacemaker or Pacing
Carioverter - Defibrillator

Screen: CMS Fastest Growing /
Codes Reported
Together 75% or More-
Part1

Complete? Yes

**Most Recent
RUC Meeting:** September 2011

Tab 04

**Specialty Developing
Recommendation:** ACC

**First
Identified:** October 2008

**2017 Est.
Medicare
Utilization:** 1,813

2007 Work RVU: 6.36

2018 Work RVU: 5.28

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.87

2018 Fac PE RVU:3.87

Result: Decrease

RUC Recommendation: 5.53

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

33221 Insertion of pacemaker pulse generator only; with existing multiple leads

Global: 090

Issue: Pacemaker or Pacing
Carioverter - Defibrillator

Screen: Codes Reported
Together 75% or More-
Part1

Complete? Yes

**Most Recent
RUC Meeting:** September 2011

Tab 04

**Specialty Developing
Recommendation:** ACC

**First
Identified:** April 2011

**2017 Est.
Medicare
Utilization:** 361

2007 Work RVU:

2018 Work RVU: 5.55

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 5.80

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33227	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system	Global: 090	Issue: Pacemaker or Pacing Carioverter - Defibrillator	Screen: Codes Reported Together 75% or More- Part1	Complete? Yes
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Most Recent
RUC Meeting: September 2011

Tab 04

Specialty Developing ACC
Recommendation:

First
Identified: April 2011

2017 Est.
Medicare
Utilization: 5,216

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU: 5.25
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 5.50

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

33228	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system
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Global: 090

Issue: Pacemaker or Pacing
Carioverter - Defibrillator

Screen: Codes Reported
Together 75% or More-
Part1

Complete? Yes

Most Recent
RUC Meeting: September 2011

Tab 04

Specialty Developing ACC
Recommendation:

First
Identified: April 2011

2017 Est.
Medicare
Utilization: 33,222

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU: 5.52
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 5.77

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

33229	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system
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Global: 090

Issue: Pacemaker or Pacing
Carioverter - Defibrillator

Screen: Codes Reported
Together 75% or More-
Part1

Complete? Yes

Most Recent
RUC Meeting: September 2011

Tab 04

Specialty Developing ACC
Recommendation:

First
Identified: April 2011

2017 Est.
Medicare
Utilization: 4,793

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU: 5.79
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 6.04

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33230	Insertion of implantable defibrillator pulse generator only; with existing dual leads	Global: 090	Issue: Pacemaker or Pacing Carioverter - Defibrillator	Screen: Codes Reported Together 75% or More- Part1	Complete? Yes
Most Recent RUC Meeting: September 2011	Tab 04 Specialty Developing Recommendation: ACC	First Identified: April 2011	2017 Est. Medicare Utilization: 189	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 6.07 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 6.32		Referred to CPT February 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
33231	Insertion of implantable defibrillator pulse generator only; with existing multiple leads	Global: 090	Issue: Pacemaker or Pacing Carioverter - Defibrillator	Screen: Codes Reported Together 75% or More- Part1	Complete? Yes
Most Recent RUC Meeting: September 2011	Tab 04 Specialty Developing Recommendation: ACC	First Identified: April 2011	2017 Est. Medicare Utilization: 190	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 6.34 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 6.59		Referred to CPT February 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
33233	Removal of permanent pacemaker pulse generator only	Global: 090	Issue: Pacemaker or Pacing Carioverter - Defibrillator	Screen: Codes Reported Together 75% or More- Part1	Complete? Yes
Most Recent RUC Meeting: April 2011	Tab 10 Specialty Developing Recommendation: ACC	First Identified: February 2010	2017 Est. Medicare Utilization: 9,103	2007 Work RVU: 3.33 2007 NF PE RVU: NA 2007 Fac PE RVU 3.29 Result: Maintain	2018 Work RVU: 3.14 2018 NF PE RVU: NA 2018 Fac PE RVU: 3.29
RUC Recommendation: 3.39		Referred to CPT February 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

33240	Insertion of implantable defibrillator pulse generator only; with existing single lead	Global: 090	Issue: Pacemaker or Pacing Carioverter - Defibrillator	Screen: Codes Reported Together 75% or More- Part1	Complete? Yes
Most Recent RUC Meeting: September 2011	Tab 04 Specialty Developing Recommendation: ACC	First Identified: February 2010	2017 Est. Medicare Utilization: 462	2007 Work RVU: 7.61 2007 NF PE RVU: NA 2007 Fac PE RVU 4.79 Result: Decrease	2018 Work RVU: 5.80 2018 NF PE RVU: NA 2018 Fac PE RVU: 4.79
RUC Recommendation: 6.06		Referred to CPT February 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
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33241	Removal of implantable defibrillator pulse generator only	Global: 090	Issue: Pacemaker or Pacing Carioverter - Defibrillator	Screen: Codes Reported Together 75% or More- Part1	Complete? Yes
Most Recent RUC Meeting: April 2011	Tab 10 Specialty Developing Recommendation: ACC	First Identified: February 2010	2017 Est. Medicare Utilization: 6,985	2007 Work RVU: 3.26 2007 NF PE RVU: NA 2007 Fac PE RVU 2.99 Result: Maintain	2018 Work RVU: 3.04 2018 NF PE RVU: NA 2018 Fac PE RVU: 2.99
RUC Recommendation: 3.29		Referred to CPT February 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
33249	Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber	Global: 090	Issue: Pacemaker or Pacing Carioverter - Defibrillator	Screen: Codes Reported Together 75% or More- Part1	Complete? Yes
Most Recent RUC Meeting: April 2011	Tab 10 Specialty Developing Recommendation: ACC	First Identified: February 2010	2017 Est. Medicare Utilization: 46,921	2007 Work RVU: 15.02 2007 NF PE RVU: NA 2007 Fac PE RVU 8.89 Result: Maintain	2018 Work RVU: 14.92 2018 NF PE RVU: NA 2018 Fac PE RVU: 8.89
RUC Recommendation: 15.17		Referred to CPT February 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

33262	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system	Global: 090	Issue: Pacemaker or Pacing Carioverter - Defibrillator	Screen: Codes Reported Together 75% or More- Part1	Complete? Yes
Most Recent RUC Meeting: September 2011	Tab 04 Specialty Developing ACC Recommendation:	First Identified: April 2011	2017 Est. Medicare Utilization: 3,692	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 5.81 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 6.06		Referred to CPT February 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
33263	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system	Global: 090	Issue: Pacemaker or Pacing Carioverter - Defibrillator	Screen: Codes Reported Together 75% or More- Part1	Complete? Yes
Most Recent RUC Meeting: September 2011	Tab 04 Specialty Developing ACC Recommendation:	First Identified: April 2011	2017 Est. Medicare Utilization: 12,114	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 6.08 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 6.33		Referred to CPT February 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system	Global: 090	Issue: Pacemaker or Pacing Carioverter - Defibrillator	Screen: Codes Reported Together 75% or More- Part1	Complete? Yes
Most Recent RUC Meeting: September 2011	Tab 04 Specialty Developing ACC Recommendation:	First Identified: April 2011	2017 Est. Medicare Utilization: 16,288	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 6.35 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 6.60		Referred to CPT February 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

33282 Implantation of patient-activated cardiac event recorder

Global: 090

Issue: Implantation and Removal of Patient Activated Cardiac Event Recorder

Screen: CMS Request - Final Rule for 2013

Complete? Yes

Most Recent
RUC Meeting: April 2013

Tab 20

Specialty Developing
Recommendation:

First
Identified: October 2012

2017 Est.
Medicare
Utilization: 42,359

2007 Work RVU: 4.70

2018 Work RVU: 3.25

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 4.1

2018 Fac PE RVU:4.1

Result: Decrease

RUC Recommendation: 3.50

Referred to CPT February 2017

Referred to CPT Asst ☐ Published in CPT Asst:

33284 Removal of an implantable, patient-activated cardiac event recorder

Global: 090

Issue: Implantation and Removal of Patient Activated Cardiac Event Recorder

Screen: CMS Request - Final Rule for 2013

Complete? Yes

Most Recent
RUC Meeting: April 2013

Tab 20

Specialty Developing
Recommendation:

First
Identified: October 2012

2017 Est.
Medicare
Utilization: 11,734

2007 Work RVU: 3.04

2018 Work RVU: 2.75

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.5

2018 Fac PE RVU:3.5

Result: Decrease

RUC Recommendation: 3.00

Referred to CPT February 2017

Referred to CPT Asst ☐ Published in CPT Asst:

33405 Replacement, aortic valve, open, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve

Global: 090

Issue: Valve Replacement and CABG Procedures

Screen: CMS High Expenditure Procedural Codes1

Complete? Yes

Most Recent
RUC Meeting: April 2012

Tab 40

Specialty Developing STS
Recommendation:

First
Identified: September 2011

2017 Est.
Medicare
Utilization: 22,535

2007 Work RVU: 41.19

2018 Work RVU: 41.32

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 17.58

2018 Fac PE RVU:17.58

Result: Maintain

RUC Recommendation: 41.32

Referred to CPT

Referred to CPT Asst ☐ Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

33430 Replacement, mitral valve, with cardiopulmonary bypass

Global: 090

Issue: Valve Replacement and CABG Procedures

Screen: High IWP/UT / CMS High Expenditure Procedural Codes1

Complete? Yes

Most Recent RUC Meeting: April 2012 **Tab** 40 **Specialty Developing Recommendation:** STS

First Identified: February 2008

2017 Est. Medicare Utilization: 8,034

2007 Work RVU: 50.75

2018 Work RVU: 50.93

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 17.71

2018 Fac PE RVU: 17.71

Result: Maintain

RUC Recommendation: 50.93

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

33533 Coronary artery bypass, using arterial graft(s); single arterial graft

Global: 090

Issue: Valve Replacement and CABG Procedures

Screen: CMS High Expenditure Procedural Codes1

Complete? Yes

Most Recent RUC Meeting: April 2012 **Tab** 40 **Specialty Developing Recommendation:** STS

First Identified: September 2011

2017 Est. Medicare Utilization: 63,691

2007 Work RVU: 33.64

2018 Work RVU: 33.75

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 15.55

2018 Fac PE RVU: 15.55

Result: Increase

RUC Recommendation: 34.98

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

33620 Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)

Global: 090

Issue: New Technology Review

Screen: New Technology/New Services / CPT Assistant Analysis 2018

Complete? Yes

Most Recent RUC Meeting: January 2015 **Tab** 35 **Specialty Developing Recommendation:** STS

First Identified: January 2015

2017 Est. Medicare Utilization: 70

2007 Work RVU:

2018 Work RVU: 30.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU:

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: CPT Article published July 2016

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: July 2016

Status Report: CMS Requests and Relativity Assessment Issues

33621	Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)	Global: 090	Issue: New Technology Review	Screen: New Technology/New Services / CPT Assistant Analysis 2018	Complete? Yes
Most Recent RUC Meeting: January 2015	Tab 35 Specialty Developing Recommendation: STS	First Identified: January 2015	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU	2018 Work RVU: 16.18 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: CPT Assistant published July 2016		Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: July 2016	Result: Maintain	
33622	Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)	Global: 090	Issue: New Technology Review	Screen: New Technology/New Services / CPT Assistant Analysis 2018	Complete? Yes
Most Recent RUC Meeting: January 2015	Tab 35 Specialty Developing Recommendation: STS	First Identified: January 2015	2017 Est. Medicare Utilization: 1	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU	2018 Work RVU: 64.00 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: CPT Assistant published July 2016		Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: July 2016	Result: Maintain	
33863	Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)	Global: 090	Issue: Aortic Graft	Screen: High IWPUT	Complete? Yes
Most Recent RUC Meeting: February 2008	Tab S Specialty Developing Recommendation: STS, AATS	First Identified: February 2008	2017 Est. Medicare Utilization: 1,825	2007 Work RVU: 58.71 2007 NF PE RVU: NA 2007 Fac PE RVU 19.01	2018 Work RVU: 58.79 2018 NF PE RVU: NA 2018 Fac PE RVU: 19.01
RUC Recommendation: Remove from screen		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Remove from Screen	

Status Report: CMS Requests and Relativity Assessment Issues

33945	Heart transplant, with or without recipient cardiectomy	Global: 090	Issue: ECMO-ECLS	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 11 Specialty Developing Recommendation: STS, AAP, ACC, SCAI	First Identified:	2017 Est. Medicare Utilization: 681	2007 Work RVU: 89.08 2007 NF PE RVU: NA 2007 Fac PE RVU 23.74 Result: Maintain	2018 Work RVU: 89.50 2018 NF PE RVU: NA 2018 Fac PE RVU:23.74
RUC Recommendation: 16.00		Referred to CPT February 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

33946	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous	Global: XXX	Issue: ECMO-ECLS	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 11 Specialty Developing Recommendation: STS, AAP, ACC, SCAI, ACCP	First Identified:	2017 Est. Medicare Utilization: 426	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain	2018 Work RVU: 6.00 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 6.00		Referred to CPT February 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

33947	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-arterial	Global: XXX	Issue: ECMO-ECLS	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 11 Specialty Developing Recommendation: STS, AAP, ACC, SCAI, ACCP	First Identified: November 2013	2017 Est. Medicare Utilization: 1,051	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain	2018 Work RVU: 6.63 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 6.63		Referred to CPT February 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

33948	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-venous	Global: XXX	Issue: ECMO-ECLS	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 11 Specialty Developing Recommendation: STS, AAP, ACC, SCAI, ACCP	First Identified: November 2013	2017 Est. Medicare Utilization: 2,802	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain	2018 Work RVU: 4.73 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 4.73		Referred to CPT February 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

33949 Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-arterial **Global:** XXX **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 11 Specialty Developing Recommendation: STS, AAP, ACC, SCAI, ACCP

First Identified: November 2013

2017 Est. Medicare Utilization: 3,735

2007 Work RVU:

2018 Work RVU: 4.60

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: 4.60

Referred to CPT February 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

33951 Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed) **Global:** 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 11 Specialty Developing Recommendation: STS, AAP, ACC, SCAI

First Identified: November 2013

2017 Est. Medicare Utilization: 4

2007 Work RVU:

2018 Work RVU: 8.15

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: 8.15

Referred to CPT February 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

33952 Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed) **Global:** 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 11 Specialty Developing Recommendation: STS, AAP, ACC, SCAI

First Identified: November 2013

2017 Est. Medicare Utilization: 1,056

2007 Work RVU:

2018 Work RVU: 8.15

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: 8.43

Referred to CPT February 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

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33953	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	Global: 000	Issue: ECMO-ECLS	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 11	Specialty Developing Recommendation: STS, AAP, ACC, SCAI	First Identified: November 2013	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain 2018 Work RVU: 9.11 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 9.83			Referred to CPT February 2014 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		
33954	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	Global: 000	Issue: ECMO-ECLS	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 11	Specialty Developing Recommendation: STS, AAP, ACC, SCAI	First Identified:	2017 Est. Medicare Utilization: 335	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain 2018 Work RVU: 9.11 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 9.43			Referred to CPT February 2014 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		
33956	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older	Global: 000	Issue: ECMO-ECLS	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 11	Specialty Developing Recommendation: STS, AAP, ACC, SCAI	First Identified:	2017 Est. Medicare Utilization: 374	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain 2018 Work RVU: 16.00 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 16.00			Referred to CPT February 2014 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

33957 Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed) **Global:** 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 11

Specialty Developing Recommendation: STS, AAP, ACC, SCAI

First Identified:

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU: 3.51

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: 4.00

Referred to CPT February 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

33958 Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed) **Global:** 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 11

Specialty Developing Recommendation: STS, AAP, ACC, SCAI

First Identified:

2017 Est. Medicare Utilization: 61

2007 Work RVU:

2018 Work RVU: 3.51

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: 4.05

Referred to CPT February 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

33959 Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes fluoroscopic guidance, when performed) **Global:** 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 11

Specialty Developing Recommendation: STS, AAP, ACC, SCAI

First Identified:

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU: 4.47

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: 4.69

Referred to CPT February 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33960	Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial day	Global: 000	Issue: ECMO-ECLS	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 11	Specialty Developing Recommendation: STS, AAP, ACC, SCAI, ACCP	First Identified: July 2013	2017 Est. Medicare Utilization:	2007 Work RVU: 19.33 2007 NF PE RVU: NA 2007 Fac PE RVU 5.09 Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT February 2014	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
33961	Prolonged extracorporeal circulation for cardiopulmonary insufficiency; each subsequent day	Global: XXX	Issue: ECMO-ECLS	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 11	Specialty Developing Recommendation: STS, AAP, ACC, SCAI, ACCP	First Identified: July 2013	2017 Est. Medicare Utilization:	2007 Work RVU: 10.91 2007 NF PE RVU: NA 2007 Fac PE RVU 3.45 Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT February 2014	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
33962	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)	Global: 000	Issue: ECMO-ECLS	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 11	Specialty Developing Recommendation: STS, AAP, ACC, SCAI	First Identified:	2017 Est. Medicare Utilization: 22	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain
RUC Recommendation: 4.73			Referred to CPT February 2014	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

33963 Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed) **Global:** 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 11 Specialty Developing Recommendation: STS, AAP, ACC, SCAI

First Identified:

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU: 9.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: 9.00

Referred to CPT February 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

33964 Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed) **Global:** 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 11 Specialty Developing Recommendation: STS, AAP, ACC, SCAI

First Identified:

2017 Est. Medicare Utilization: 31

2007 Work RVU:

2018 Work RVU: 9.50

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: 9.50

Referred to CPT February 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

33965 Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age **Global:** 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 11 Specialty Developing Recommendation: STS, AAP, ACC, SCAI

First Identified:

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU: 3.51

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: 3.51

Referred to CPT February 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33966	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older	Global: 000	Issue: ECMO-ECLS	Screen: CMS Request - Final Rule for 2014	Complete? Yes
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Most Recent
RUC Meeting: April 2014

Tab 11 **Specialty Developing**
Recommendation: STS, AAP, ACC, SCAI

First Identified:

2017 Est. Medicare Utilization: 293

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Maintain

2018 Work RVU: 4.50
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.50

Referred to CPT February 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

33969	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	Global: 000	Issue: ECMO-ECLS	Screen: CMS Request - Final Rule for 2014	Complete? Yes
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Most Recent
RUC Meeting: April 2014

Tab 11 **Specialty Developing**
Recommendation: STS, AAP, ACC, SCAI

First Identified:

2017 Est. Medicare Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Maintain

2018 Work RVU: 5.22
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 6.00

Referred to CPT February 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

33984	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	Global: 000	Issue: ECMO-ECLS	Screen: CMS Request - Final Rule for 2014	Complete? Yes
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Most Recent
RUC Meeting: April 2014

Tab 11 **Specialty Developing**
Recommendation: STS, AAP, ACC, SCAI

First Identified:

2017 Est. Medicare Utilization: 392

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Maintain

2018 Work RVU: 5.46
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 6.38

Referred to CPT February 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33985 Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age **Global:** 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent
RUC Meeting: April 2014

Tab 11 **Specialty Developing** STS, AAP, ACC, SCAI
Recommendation:

First
Identified:

2017 Est.
Medicare
Utilization: 1

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Maintain

2018 Work RVU: 9.89
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 9.89

Referred to CPT February 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

33986 Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older **Global:** 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent
RUC Meeting: April 2014

Tab 11 **Specialty Developing** STS, AAP, ACC, SCAI
Recommendation:

First
Identified:

2017 Est.
Medicare
Utilization: 205

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Maintain

2018 Work RVU: 10.00
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 10.00

Referred to CPT February 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

33987 Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent
RUC Meeting: April 2014

Tab 11 **Specialty Developing** STS, AAP, ACC, SCAI
Recommendation:

First
Identified:

2017 Est.
Medicare
Utilization: 50

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Maintain

2018 Work RVU: 4.04
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.08

Referred to CPT February 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33988 Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS **Global:** 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** **2017 Est. Medicare Utilization:** 39 **2007 Work RVU:** **2018 Work RVU:** 15.00
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU: **2018 Fac PE RVU:**
RUC Recommendation: 15.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33989 Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS **Global:** 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2013 **2017 Est. Medicare Utilization:** 14 **2007 Work RVU:** **2018 Work RVU:** 9.50
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU: **2018 Fac PE RVU:**
RUC Recommendation: 9.50 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33X01 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) **Global:** **Issue:** Aortic Graft Procedures **Screen:** New and Revised Service (Not Part of RAW) **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 06 **Specialty Developing Recommendation:** AATS, STS **First Identified:** **2017 Est. Medicare Utilization:** **2007 Work RVU:** **2018 Work RVU:**
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU: **2018 Fac PE RVU:**
RUC Recommendation: 17.75 **Referred to CPT** May 2018 **Result:** Not Part of RAW
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34701 Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 10

Specialty Developing Recommendation: SVS, SIR, STS, AATS, ACS

First Identified: January 2017

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU: 23.71

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 23.71

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

34702 Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 10

Specialty Developing Recommendation: SVS, SIR, STS, AATS, ACS

First Identified: January 2017

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU: 36.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 36.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

34703	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)	Global: 090	Issue: Endovascular Repair Procedures (EVAR)	Screen: Codes Reported Together 75%or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 10	Specialty Developing Recommendation: SVS, SIR, STS, AATS, ACS	First Identified: January 2017	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease
RUC Recommendation: 26.52			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 26.52 2018 NF PE RVU: 2018 Fac PE RVU:

34704	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	Global: 090	Issue: Endovascular Repair Procedures (EVAR)	Screen: Codes Reported Together 75%or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 10	Specialty Developing Recommendation: SVS, SIR, STS, AATS, ACS	First Identified: January 2017	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease
RUC Recommendation: 45.00			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 45.00 2018 NF PE RVU: 2018 Fac PE RVU:

Status Report: CMS Requests and Relativity Assessment Issues

34705	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)	Global: 090	Issue: Endovascular Repair Procedures (EVAR)	Screen: Codes Reported Together 75%or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 10	Specialty Developing Recommendation: SVS, SIR, STS, AATS, ACS	First Identified: January 2017	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease
RUC Recommendation: 29.58			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 29.58 2018 NF PE RVU: 2018 Fac PE RVU:

34706	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	Global: 090	Issue: Endovascular Repair Procedures (EVAR)	Screen: Codes Reported Together 75%or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 10	Specialty Developing Recommendation: SVS, SIR, STS, AATS, ACS	First Identified: January 2017	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease
RUC Recommendation: 45.00			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 45.00 2018 NF PE RVU: 2018 Fac PE RVU:

Status Report: CMS Requests and Relativity Assessment Issues

34707	Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation)	Global: 090	Issue: Endovascular Repair Procedures (EVAR)	Screen: Codes Reported Together 75%or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 10	Specialty Developing Recommendation: SVS, SIR, STS, AATS, ACS	First Identified: January 2017	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease
RUC Recommendation: 22.28			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 22.28 2018 NF PE RVU: 2018 Fac PE RVU:

34708	Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)	Global: 090	Issue: Endovascular Repair Procedures (EVAR)	Screen: Codes Reported Together 75%or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 10	Specialty Developing Recommendation: SVS, SIR, STS, AATS, ACS	First Identified: January 2017	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease
RUC Recommendation: 36.50			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 36.50 2018 NF PE RVU: 2018 Fac PE RVU:

Status Report: CMS Requests and Relativity Assessment Issues

34709	Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Endovascular Repair Procedures (EVAR)	Screen: Codes Reported Together 75%or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 10 Specialty Developing Recommendation: SVS, SIR, STS, AATS, ACS	First Identified: January 2017	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 6.50 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 6.50		Referred to CPT Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
34710	Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed; initial vessel treated	Global: 090	Issue: Endovascular Repair Procedures (EVAR)	Screen: Codes Reported Together 75%or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 10 Specialty Developing Recommendation: SVS, SIR, STS, AATS, ACS	First Identified: January 2017	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 15.00 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 15.00		Referred to CPT Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			

Status Report: CMS Requests and Relativity Assessment Issues

34711	Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed; each additional vessel treated (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Endovascular Repair Procedures (EVAR)	Screen: Codes Reported Together 75%or More-Part3	Complete? Yes		
Most Recent RUC Meeting:	January 2017	Tab 10	Specialty Developing Recommendation: SVS, SIR, STS, AATS, ACS	First Identified: January 2017	2017 Est. Medicare Utilization:	2007 Work RVU:	2018 Work RVU: 6.00
						2007 NF PE RVU:	2018 NF PE RVU:
						2007 Fac PE RVU Result: Decrease	2018 Fac PE RVU:
RUC Recommendation: 6.00		Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:			
34712	Transcatheter delivery of enhanced fixation device(s) to the endograft (eg, anchor, screw, tack) and all associated radiological supervision and interpretation	Global: 090	Issue: Endovascular Repair Procedures (EVAR)	Screen: Codes Reported Together 75%or More-Part3	Complete? Yes		
Most Recent RUC Meeting:	January 2017	Tab 10	Specialty Developing Recommendation: SVS, SIR, STS, AATS, ACS	First Identified: January 2017	2017 Est. Medicare Utilization:	2007 Work RVU:	2018 Work RVU: 12.00
						2007 NF PE RVU:	2018 NF PE RVU:
						2007 Fac PE RVU Result: Decrease	2018 Fac PE RVU:
RUC Recommendation: 12.00		Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:			
34713	Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Endovascular Repair Procedures (EVAR)	Screen: Codes Reported Together 75%or More-Part3	Complete? Yes		
Most Recent RUC Meeting:	January 2017	Tab 10	Specialty Developing Recommendation: SVS, SIR, STS, AATS, ACS	First Identified: January 2017	2017 Est. Medicare Utilization:	2007 Work RVU:	2018 Work RVU: 2.50
						2007 NF PE RVU:	2018 NF PE RVU:
						2007 Fac PE RVU Result: Decrease	2018 Fac PE RVU:
RUC Recommendation: 2.50		Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:			

Status Report: CMS Requests and Relativity Assessment Issues

34714 Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 10

Specialty Developing Recommendation: SVS, SIR, STS, AATS, ACS

First Identified: January 2017

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU: 5.25

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 5.25

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

34715 Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 10

Specialty Developing Recommendation: SVS, SIR, STS, AATS, ACS

First Identified: January 2017

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU: 6.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 6.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

34716 Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 10

Specialty Developing Recommendation: SVS, SIR, STS, AATS, ACS

First Identified: January 2017

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU: 7.19

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 7.19

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

34800	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis	Global: 090	Issue: Endovascular Repair Procedures (EVAR)	Screen: Codes Reported Together 75%or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 10	Specialty Developing Recommendation: AAOHNS	First Identified: October 2015	2017 Est. Medicare Utilization: 420	2007 Work RVU: 21.46 2007 NF PE RVU: NA 2007 Fac PE RVU 8.72 Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 8.72
34802	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)	Global: 090	Issue: Endovascular Repair Procedures (EVAR)	Screen: Pre-Time Analysis / Codes Reported Together 75%or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 10	Specialty Developing Recommendation: SVS, SIR, STS, AATS	First Identified: January 2014	2017 Est. Medicare Utilization: 8,798	2007 Work RVU: 23.71 2007 NF PE RVU: NA 2007 Fac PE RVU 9.38 Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT September 2016 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 9.38
34803	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (2 docking limbs)	Global: 090	Issue: Endovascular Repair Procedures (EVAR)	Screen: Codes Reported Together 75%or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 10	Specialty Developing Recommendation: SVS, SIR, STS, AATS	First Identified: October 2015	2017 Est. Medicare Utilization: 5,480	2007 Work RVU: 24.74 2007 NF PE RVU: NA 2007 Fac PE RVU 9.68 Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 9.68

Status Report: CMS Requests and Relativity Assessment Issues

34804 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using unibody bifurcated prosthesis **Global:** 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 10

Specialty Developing Recommendation: SVS, SIR, STS, AATS

First Identified: October 2015

2017 Est. Medicare Utilization: 2,013

2007 Work RVU: 23.71

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 9.37

2018 Fac PE RVU:9.37

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

34805 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-uniiliac or aorto-unifemoral prosthesis

Global: 090

Issue: Endovascular Repair Procedures (EVAR)

Screen: Codes Reported Together 75%or More-Part3

Complete? Yes

Most Recent RUC Meeting: January 2017

Tab 10

Specialty Developing Recommendation: SVS, SIR, STS, AATS

First Identified: January 2017

2017 Est. Medicare Utilization: 556

2007 Work RVU: 22.59

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 9.04

2018 Fac PE RVU:9.04

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

34806 Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration, and collection of pressure data (List separately in addition to code for primary procedure)

Global: ZZZ

Issue: Endovascular Repair Procedures (EVAR)

Screen: Codes Reported Together 75%or More-Part3

Complete? Yes

Most Recent RUC Meeting: January 2017

Tab 10

Specialty Developing Recommendation: SVS, SIR, STS, AATS

First Identified: January 2017

2017 Est. Medicare Utilization: 3

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Endovascular Repair Procedures (EVAR)	Screen: Pre-Time Analysis	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 10	Specialty Developing Recommendation: SVS, SIR, STS, AATS	First Identified: January 2014	2017 Est. Medicare Utilization: 18,015	2007 Work RVU: 6.74 2007 NF PE RVU: NA 2007 Fac PE RVU: 2.1 Result: Decrease
RUC Recommendation: 4.13			Referred to CPT September 2016 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:	2018 Work RVU: 4.13	2018 NF PE RVU: NA
				2018 Fac PE RVU: 2.1	
<hr/>					
34820	Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Endovascular Repair Procedures (EVAR)	Screen: Codes Reported Together 75%or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 10	Specialty Developing Recommendation: SVS, SIR, STS, AATS	First Identified: January 2017	2017 Est. Medicare Utilization: 183	2007 Work RVU: 9.74 2007 NF PE RVU: NA 2007 Fac PE RVU: 3.04 Result: Decrease
RUC Recommendation: 7.00			Referred to CPT Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:	2018 Work RVU: 7.00	2018 NF PE RVU: NA
				2018 Fac PE RVU: 3.04	
<hr/>					
34825	Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel	Global: 090	Issue: Endovascular Repair Procedures (EVAR)	Screen: Pre-Time Analysis / Codes Reported Together 75%or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 10	Specialty Developing Recommendation: SVS, SIR, STS, AATS	First Identified: January 2014	2017 Est. Medicare Utilization: 9,934	2007 Work RVU: 12.72 2007 NF PE RVU: NA 2007 Fac PE RVU: 5.89 Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT September 2016 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:	2018 Work RVU:	2018 NF PE RVU: NA
				2018 Fac PE RVU: 5.89	

Status Report: CMS Requests and Relativity Assessment Issues

34826	Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Endovascular Repair Procedures (EVAR)	Screen: Codes Reported Together 75%or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 10	Specialty Developing Recommendation: SVS, SIR, STS, AATS	First Identified: January 2017	2017 Est. Medicare Utilization: 3,294	2007 Work RVU: 4.12 2007 NF PE RVU: NA 2007 Fac PE RVU 1.31 Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 1.31
34833	Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Endovascular Repair Procedures (EVAR)	Screen: Codes Reported Together 75%or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 10	Specialty Developing Recommendation: SVS, SIR, STS, AATS	First Identified: January 2017	2017 Est. Medicare Utilization: 91	2007 Work RVU: 11.98 2007 NF PE RVU: NA 2007 Fac PE RVU 4.15 Result: Decrease
RUC Recommendation: 8.16			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 8.16 2018 NF PE RVU: NA 2018 Fac PE RVU: 4.15
34834	Open brachial artery exposure for delivery of endovascular prosthesis, unilateral (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Endovascular Repair Procedures (EVAR)	Screen: Codes Reported Together 75%or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 10	Specialty Developing Recommendation: SVS, SIR, STS, AATS	First Identified: January 2017	2017 Est. Medicare Utilization: 696	2007 Work RVU: 5.34 2007 NF PE RVU: NA 2007 Fac PE RVU 2.04 Result: Decrease
RUC Recommendation: 2.65			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2.65 2018 NF PE RVU: NA 2018 Fac PE RVU: 2.04

Status Report: CMS Requests and Relativity Assessment Issues

34900 Endovascular repair of iliac artery (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) using ilio-iliac tube endoprosthesis **Global:** 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 10

Specialty Developing Recommendation: SVS, SIR, STS, AATS

First Identified: January 2017

2017 Est. Medicare Utilization: 787

2007 Work RVU: 16.77

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 7.24

2018 Fac PE RVU: 7.24

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

35301 Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision **Global:** 090 **Issue:** Thromboendarterectomy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013

Tab 21

Specialty Developing Recommendation: SVS

First Identified: September 2011

2017 Est. Medicare Utilization: 40,593

2007 Work RVU: 19.53

2018 Work RVU: 21.16

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 8.04

2018 Fac PE RVU: 8.04

Result: Increase

RUC Recommendation: 21.16

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

35450 Transluminal balloon angioplasty, open; renal or other visceral artery **Global:** 000 **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 15

Specialty Developing Recommendation: ACR, SIR, SVS

First Identified:

2017 Est. Medicare Utilization:

2007 Work RVU: 10.05

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 3.47

2018 Fac PE RVU: 3.47

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

35452 Transluminal balloon angioplasty, open; aortic

Global: 000

Issue: Open and Percutaneous
Transluminal Angioplasty

Screen: Codes Reported
Together 75% or More-
Part3

Complete? Yes

**Most Recent
RUC Meeting:** January 2016

Tab 15

**Specialty Developing
Recommendation:** ACR, SIR,
SVS

**First
Identified:**

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 6.90

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 2.48

2018 Fac PE RVU:2.48

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

35454 Deleted from CPT

Global: 000

Issue: Endovascular
Revascularization

Screen: CMS Fastest Growing

Complete? Yes

**Most Recent
RUC Meeting:** April 2010

Tab 07

**Specialty Developing
Recommendation:** ACC, ACR,
SIR, SVS

**First
Identified:** February 2010

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 6.03

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 2.19

2018 Fac PE RVU:2.19

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐

Published in CPT Asst:

35456 Deleted from CPT

Global: 000

Issue: Endovascular
Revascularization

Screen: CMS Fastest Growing

Complete? Yes

**Most Recent
RUC Meeting:** April 2010

Tab 07

**Specialty Developing
Recommendation:** ACC, ACR,
SIR, SVS

**First
Identified:** February 2010

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 7.34

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 2.64

2018 Fac PE RVU:2.64

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

35458 Transluminal balloon angioplasty, open; brachiocephalic trunk or branches, each vessel **Global:** 000 **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 15

Specialty Developing Recommendation: ACR, SIR, SVS

First Identified:

2017 Est. Medicare Utilization:

2007 Work RVU: 9.48

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.33

2018 Fac PE RVU:3.33

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35459 Deleted from CPT

Global: 000

Issue: Endovascular Revascularization

Screen: CMS Fastest Growing

Complete? Yes

Most Recent RUC Meeting: April 2010

Tab 07

Specialty Developing Recommendation: ACC, ACR, SIR, SVS

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 8.62

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.01

2018 Fac PE RVU:3.01

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

35460 Transluminal balloon angioplasty, open; venous

Global: 000

Issue: Open and Percutaneous Transluminal Angioplasty

Screen: Codes Reported Together 75% or More-Part3

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab 15

Specialty Developing Recommendation: ACR, SIR, SVS

First Identified:

2017 Est. Medicare Utilization:

2007 Work RVU: 6.03

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 2.15

2018 Fac PE RVU:2.15

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35470 Deleted from CPT

Global: 000

Issue: Endovascular
Revascularization

Screen: CMS Fastest Growing

Complete? Yes

**Most Recent
RUC Meeting:** April 2010

Tab 07

**Specialty Developing
Recommendation:** ACC, ACR,
SIR, SVS

**First
Identified:** October 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 8.62

2018 Work RVU:

2007 NF PE RVU: 81.78

2018 NF PE RVU: 81.78

2007 Fac PE RVU 3.37

2018 Fac PE RVU:3.37

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

35471 Transluminal balloon angioplasty, percutaneous; renal or visceral artery

Global: 000

Issue: Open and Percutaneous
Transluminal Angioplasty

Screen: CMS Fastest Growing /
Codes Reported
Together 75% or More-
Part3

Complete? Yes

**Most Recent
RUC Meeting:** January 2016

Tab 15

**Specialty Developing
Recommendation:** ACR, SIR,
SVS

**First
Identified:** October 2009

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 10.05

2018 Work RVU:

2007 NF PE RVU: 91.6

2018 NF PE RVU: 91.6

2007 Fac PE RVU 4.13

2018 Fac PE RVU:4.13

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

35472 Transluminal balloon angioplasty, percutaneous; aortic

Global: 000

Issue: Open and Percutaneous
Transluminal Angioplasty

Screen: CMS Fastest Growing /
Codes Reported
Together 75% or More-
Part3

Complete? Yes

**Most Recent
RUC Meeting:** January 2016

Tab 15

**Specialty Developing
Recommendation:** ACR, SIR,
SVS

**First
Identified:** October 2009

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 6.90

2018 Work RVU:

2007 NF PE RVU: 60.05

2018 NF PE RVU: 60.05

2007 Fac PE RVU 2.75

2018 Fac PE RVU:2.75

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT Removed from CPT referral

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35473 Deleted from CPT

Global: 000

Issue: Endovascular
Revascularization

Screen: CMS Fastest Growing

Complete? Yes

**Most Recent
RUC Meeting:** April 2010

Tab 07

**Specialty Developing
Recommendation:** ACC, ACR,
SIR, SVS

**First
Identified:** February 2010

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 6.03

2018 Work RVU:

2007 NF PE RVU: 56.4

2018 NF PE RVU: 56.4

2007 Fac PE RVU 2.43

2018 Fac PE RVU:2.43

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

35474 Deleted from CPT

Global: 000

Issue: Endovascular
Revascularization

Screen: CMS Fastest Growing

Complete? Yes

**Most Recent
RUC Meeting:** April 2010

Tab 07

**Specialty Developing
Recommendation:** ACC, ACR,
SIR, SVS

**First
Identified:** October 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 7.35

2018 Work RVU:

2007 NF PE RVU: 80.7

2018 NF PE RVU: 80.7

2007 Fac PE RVU 2.9

2018 Fac PE RVU:2.9

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

35475 Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel

Global: 000

Issue: Open and Percutaneous
Transluminal Angioplasty

Screen: CMS Fastest Growing /
CMS High Expenditure
Procedural Codes1 /
Codes Reported
Together 75% or More-
Part3 / High Volume
Growth3

Complete? Yes

**Most Recent
RUC Meeting:** January 2016

Tab 15

**Specialty Developing
Recommendation:** ACR, SIR,
SVS

**First
Identified:** September 2011

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 9.48

2018 Work RVU:

2007 NF PE RVU: 53.95

2018 NF PE RVU: 53.95

2007 Fac PE RVU 3.48

2018 Fac PE RVU:3.48

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35476 Transluminal balloon angioplasty, percutaneous; venous

Global: 000

Issue: Open and Percutaneous
Transluminal Angioplasty

Screen: CMS Fastest Growing /
CMS High Expenditure
Procedural Codes1 /
Codes Reported
Together 75% or More-
Part3

Complete? Yes

**Most Recent
RUC Meeting:** January 2016

Tab 15

**Specialty Developing
Recommendation:** ACR, SIR,
SVS

**First
Identified:** September 2011

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 6.03

2018 Work RVU:

2007 NF PE RVU: 42.45

2018 NF PE RVU: 42.45

2007 Fac PE RVU 2.26

2018 Fac PE RVU:2.26

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

35490 Deleted from CPT

Global: 000

Issue: Endovascular
Revascularization

Screen: High Volume Growth1

Complete? Yes

**Most Recent
RUC Meeting:** April 2010

Tab 07

**Specialty Developing
Recommendation:** SIR, ACR,
SVS

**First
Identified:** April 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 11.06

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 5.11

2018 Fac PE RVU:5.11

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

35491 Deleted from CPT

Global: 000

Issue: Endovascular
Revascularization

Screen: High Volume Growth1

Complete? Yes

**Most Recent
RUC Meeting:** April 2010

Tab 07

**Specialty Developing
Recommendation:** SIR, ACR,
SVS

**First
Identified:** April 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 7.60

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.46

2018 Fac PE RVU:3.46

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35492 Deleted from CPT

Global: 000

Issue: Endovascular
Revascularization

Screen: High Volume Growth1

Complete? Yes

Most Recent
RUC Meeting: April 2010

Tab 07

Specialty Developing
Recommendation: SIR, ACR,
SVS

First
Identified: April 2008

2017 Est.
Medicare
Utilization:

2007 Work RVU: 6.64

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.3

2018 Fac PE RVU:3.3

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

35493 Deleted from CPT

Global: 000

Issue: Endovascular
Revascularization

Screen: High Volume Growth1

Complete? Yes

Most Recent
RUC Meeting: April 2010

Tab 07

Specialty Developing
Recommendation: SIR, ACR,
SVS

First
Identified: February 2008

2017 Est.
Medicare
Utilization:

2007 Work RVU: 8.09

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.89

2018 Fac PE RVU:3.89

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

35494 Deleted from CPT

Global: 000

Issue: Endovascular
Revascularization

Screen: High Volume Growth1

Complete? Yes

Most Recent
RUC Meeting: April 2010

Tab 07

Specialty Developing
Recommendation: SIR, ACR,
SVS

First
Identified: April 2008

2017 Est.
Medicare
Utilization:

2007 Work RVU: 10.42

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 4.64

2018 Fac PE RVU:4.64

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

35495 Deleted from CPT

Global: 000

Issue: Endovascular
Revascularization

Screen: High Volume Growth1

Complete? Yes

Most Recent
RUC Meeting: April 2010

Tab 07

Specialty Developing
Recommendation: SIR, ACR,
SVS

First
Identified: February 2008

2017 Est.
Medicare
Utilization:

2007 Work RVU: 9.48

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 4.45

2018 Fac PE RVU:4.45

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35701 Exploration (not followed by surgical repair), with or without lysis of artery; carotid artery **Global:** 090 **Issue:** Exploration of Major Artery **Screen:** Negative IWPUT **Complete?** No

Most Recent RUC Meeting: January 2018 **Tab** 22 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** January 2018 **2017 Est. Medicare Utilization:** 649 **2007 Work RVU:** 9.11 **2018 Work RVU:** 9.19 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 4.93 **2018 Fac PE RVU:** 4.93 **RUC Recommendation:** Refer to CPT **Referred to CPT** September 2018 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:**

35721 Exploration (not followed by surgical repair), with or without lysis of artery; femoral artery **Global:** 090 **Issue:** Exploration of Major Artery **Screen:** Negative IWPUT **Complete?** No

Most Recent RUC Meeting: January 2018 **Tab** 22 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** January 2018 **2017 Est. Medicare Utilization:** 574 **2007 Work RVU:** 7.66 **2018 Work RVU:** 7.72 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 4.26 **2018 Fac PE RVU:** 4.26 **RUC Recommendation:** Deleted from CPT **Referred to CPT** September 2018 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

35741 Exploration (not followed by surgical repair), with or without lysis of artery; popliteal artery **Global:** 090 **Issue:** Exploration of Major Artery **Screen:** Negative IWPUT **Complete?** No

Most Recent RUC Meeting: January 2018 **Tab** 22 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** January 2018 **2017 Est. Medicare Utilization:** 210 **2007 Work RVU:** 8.61 **2018 Work RVU:** 8.69 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 4.49 **2018 Fac PE RVU:** 4.49 **RUC Recommendation:** Deleted from CPT **Referred to CPT** September 2018 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

35761 Exploration (not followed by surgical repair), with or without lysis of artery; other vessels **Global:** 090 **Issue:** Exploration of Major Artery **Screen:** Negative IWPUT **Complete?** No

Most Recent RUC Meeting: January 2018 **Tab** 22 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** April 2017 **2017 Est. Medicare Utilization:** 1,789 **2007 Work RVU:** 5.84 **2018 Work RVU:** 5.93 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 3.88 **2018 Fac PE RVU:** 3.88 **RUC Recommendation:** Deleted from CPT **Referred to CPT** September 2018 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

35X00				Global:	Issue: Exploration of Major Artery	Screen: Negative IWPUT	Complete? No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:		First Identified: September 2018	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation:				Referred to CPT September 2018 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

35X01				Global:	Issue: Exploration of Major Artery	Screen: Negative IWPUT	Complete? No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:		First Identified: September 2018	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation:				Referred to CPT September 2018 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

36000	Introduction of needle or intracatheter, vein			Global: XXX	Issue: Introduction of Needle or Intracatheter	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 45	Specialty Developing Recommendation:	ACC, AUR, AAP, AAFP, ACRh	First Identified: October 2009	2017 Est. Medicare Utilization:	2007 Work RVU: 0.18 2007 NF PE RVU: 0.54 2007 Fac PE RVU Result: Maintain	2018 Work RVU: 0.18 2018 NF PE RVU: 0.54 2018 Fac PE RVU: 0.05
RUC Recommendation: CMS consider a bundled status for this code				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

36010	Introduction of catheter, superior or inferior vena cava			Global: XXX	Issue: Introduction of Catheter	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: October 2013	Tab 18	Specialty Developing Recommendation:	ACR, SIR, SVS	First Identified: February 2010	2017 Est. Medicare Utilization: 14,893	2007 Work RVU: 2.43 2007 NF PE RVU: 17.17 2007 Fac PE RVU Result: Remove from screen	2018 Work RVU: 2.18 2018 NF PE RVU: 17.17 2018 Fac PE RVU: 0.77
RUC Recommendation: Remove from re-review.				Referred to CPT February 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

36140 Introduction of needle or intracatheter, upper or lower extremity artery

Global: XXX

Issue: Introduction of Needle or Intracatheter

Screen: Harvard Valued - Utilization over 30,000

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab 18

Specialty Developing Recommendation: SVS, SIR, ACR, ACRO

First Identified: April 2011

2017 Est. Medicare Utilization: 19,528

2007 Work RVU: 2.01

2018 Work RVU: 1.76

2007 NF PE RVU: 12.15

2018 NF PE RVU: 12.15

2007 Fac PE RVU 0.65

2018 Fac PE RVU:0.65

Result: Remove from Screen

RUC Recommendation: Remove from re-review

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

36145 Deleted from CPT

Global: XXX

Issue: Arteriovenous Shunt Imaging

Screen: Codes Reported Together 95% or More / Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: April 2009

Tab 9

Specialty Developing Recommendation:

First Identified: February 2008

2017 Est. Medicare Utilization:

2007 Work RVU: 2.01

2018 Work RVU:

2007 NF PE RVU: 11.87

2018 NF PE RVU: 11.87

2007 Fac PE RVU 0.64

2018 Fac PE RVU:0.64

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2009

Referred to CPT Asst ☐

Published in CPT Asst:

36147 Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)

Global: XXX

Issue: Dialysis Circuit -1

Screen: Codes Reported Together 95% or More

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab 14

Specialty Developing Recommendation: ACR, RPA, SIR, SVS

First Identified: February 2008

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2008

Referred to CPT Asst ☐

Published in CPT Asst:

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36148	Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Dialysis Circuit -1	Screen: Codes Reported Together 95% or More	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 14	Specialty Developing Recommendation: ACR, RPA, SIR, SVS	First Identified: February 2008	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT October 2008	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
36215	Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family	Global: 000	Issue: Selective Catheter Placement	Screen: Codes Reported Together 75% or More- Part1 / Harvard-Valued Annual Allowed Charges Greater than \$10 million / Harvard Valued - Utilization greater than 30,000-Part2 / CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 23	Specialty Developing Recommendation: ACR, RPA, SIR, SVS	First Identified: February 2010	2017 Est. Medicare Utilization: 47,379	2007 Work RVU: 4.67 2007 NF PE RVU: 26.59 2007 Fac PE RVU 1.65 Result: Decrease
RUC Recommendation: 4.17			Referred to CPT	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
36216	Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family	Global: 000	Issue: Selective Catheter Placement	Screen: Codes Reported Together 75% or More- Part1 / CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 23	Specialty Developing Recommendation: ACR, SIR, SVS	First Identified: February 2010	2017 Est. Medicare Utilization: 4,390	2007 Work RVU: 5.27 2007 NF PE RVU: 28.57 2007 Fac PE RVU 1.82 Result: Maintain
RUC Recommendation: 5.27			Referred to CPT	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

36217	Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family	Global: 000	Issue: Selective Catheter Placement	Screen: Harvard Valued - Utilization over 30,000 / CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 23	Specialty Developing Recommendation: ACR, SIR, SVS	First Identified: April 2011	2017 Est. Medicare Utilization: 3,970	2007 Work RVU: 6.29 2007 NF PE RVU: 52.65 2007 Fac PE RVU: 2.17 Result: Maintain
RUC Recommendation: 6.29			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 6.29 2018 NF PE RVU: 52.65 2018 Fac PE RVU: 2.17
36218	Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	Global: ZZZ	Issue: Selective Catheter Placement	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 23	Specialty Developing Recommendation: ACR, SIR, SVS	First Identified: July 2015	2017 Est. Medicare Utilization: 1,408	2007 Work RVU: 1.01 2007 NF PE RVU: 4.72 2007 Fac PE RVU: 0.34 Result: Maintain
RUC Recommendation: 1.01			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.01 2018 NF PE RVU: 4.72 2018 Fac PE RVU: 0.34
36221	Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed	Global: 000	Issue: Cervicocerebral Angiography	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 14	Specialty Developing Recommendation: AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS	First Identified: February 2010	2017 Est. Medicare Utilization: 2,537	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU:
RUC Recommendation: 4.51			Referred to CPT February 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 3.92 2018 NF PE RVU: 2018 Fac PE RVU:
					Result: Decrease

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36222 Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed **Global:** 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab 14** **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2017 Est. Medicare Utilization:** 9,083 **2007 Work RVU:** **2018 Work RVU:** 5.28 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:**

RUC Recommendation: 6.00

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

36223 Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed **Global:** 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab 14** **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2017 Est. Medicare Utilization:** 29,857 **2007 Work RVU:** **2018 Work RVU:** 5.75 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:**

RUC Recommendation: 6.50

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

36224 Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed **Global:** 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab 14** **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2017 Est. Medicare Utilization:** 33,196 **2007 Work RVU:** **2018 Work RVU:** 6.25 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:**

RUC Recommendation: 7.55

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

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36225 Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed **Global:** 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2017 Est. Medicare Utilization:** 11,337 **2007 Work RVU:** **2018 Work RVU:** 5.75 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:**

RUC Recommendation: 6.50

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

36226 Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed **Global:** 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2017 Est. Medicare Utilization:** 30,704 **2007 Work RVU:** **2018 Work RVU:** 6.25 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:**

RUC Recommendation: 7.55

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

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) **Global:** ZZZ **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2017 Est. Medicare Utilization:** 11,539 **2007 Work RVU:** **2018 Work RVU:** 2.09 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:**

RUC Recommendation: 2.32

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

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36228 Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent **Tab** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2017 Est. Medicare Utilization:** 2,089 **2007 Work RVU:** **2018 Work RVU:** 4.25 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU** **2018 Fac PE RVU:**

RUC Recommendation: 4.25

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

36245 Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family **Global:** XXX **Issue:** Selective Catheter Placement **Screen:** Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More-Part1 / Harvard-Valued Annual Allowed Charges Greater than \$10 million **Complete?** Yes

Most Recent **Tab** 22 **Specialty Developing Recommendation:** ACC, ACR, SIR, SCAI, SVS **First Identified:** October 2009 **2017 Est. Medicare Utilization:** 42,234 **2007 Work RVU:** 4.67 **2018 Work RVU:** 4.65 **2007 NF PE RVU:** 31.17 **2018 NF PE RVU:** 31.17 **2007 Fac PE RVU** 1.78 **2018 Fac PE RVU:** 1.78

RUC Recommendation: 4.90

Referred to CPT February 2010 and February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

36246 Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family **Global:** 000 **Issue:** Vascular Injection Procedures **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent **Tab** 27 **Specialty Developing Recommendation:** SVS, SIR, ACR, ACC **First Identified:** February 2010 **2017 Est. Medicare Utilization:** 38,079 **2007 Work RVU:** 5.27 **2018 Work RVU:** 5.02 **2007 NF PE RVU:** 29.18 **2018 NF PE RVU:** 29.18 **2007 Fac PE RVU** 1.84 **2018 Fac PE RVU:** 1.84

RUC Recommendation: 5.27

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

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36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	Global: 000	Issue: Vascular Injection Procedures	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: October 2012	Tab 27 Specialty Developing Recommendation: SVS, SIR, ACR, ACC	First Identified: February 2010	2017 Est. Medicare Utilization: 65,178	2007 Work RVU: 6.29 2007 NF PE RVU: 48.22 2007 Fac PE RVU: 2.17 Result: Increase	2018 Work RVU: 6.04 2018 NF PE RVU: 48.22 2018 Fac PE RVU: 2.17
RUC Recommendation: 7.00		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
36248	Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	Global: ZZZ	Issue: Catheter Placement	Screen: CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: October 2009	Tab 40 Specialty Developing Recommendation: ACR, SIR	First Identified: October 2008	2017 Est. Medicare Utilization: 24,806	2007 Work RVU: 1.01 2007 NF PE RVU: 3.81 2007 Fac PE RVU: 0.35 Result: Remove from Screen	2018 Work RVU: 1.01 2018 NF PE RVU: 3.81 2018 Fac PE RVU: 0.35
RUC Recommendation: Remove from screen		Referred to CPT February 2010 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
36251	Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral	Global: 000	Issue: Renal Angiography	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2011	Tab 11 Specialty Developing Recommendation: ACR, SIR	First Identified:	2017 Est. Medicare Utilization: 3,817	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Decrease	2018 Work RVU: 5.10 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 5.45		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

36252	Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral	Global: 000	Issue: Renal Angiography	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2011	Tab 11 Specialty Developing Recommendation: ACR, SIR	First Identified:	2017 Est. Medicare Utilization: 9,408	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 6.74 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 7.38		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
36253	Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral	Global: 000	Issue: Renal Angiography	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2011	Tab 11 Specialty Developing Recommendation: ACR, SIR	First Identified:	2017 Est. Medicare Utilization: 1,302	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 7.30 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 7.55		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
36254	Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral	Global: 000	Issue: Renal Angiography	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2011	Tab 11 Specialty Developing Recommendation: ACR, SIR	First Identified:	2017 Est. Medicare Utilization: 213	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 7.90 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 8.15		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

36410	Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)	Global: XXX	Issue: Venipuncture	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 36 Specialty Developing Recommendation: ACP	First Identified: October 2009	2017 Est. Medicare Utilization: 155,437	2007 Work RVU: 0.18 2007 NF PE RVU: 0.3 2007 Fac PE RVU: 0.05 Result: Maintain	2018 Work RVU: 0.18 2018 NF PE RVU: 0.3 2018 Fac PE RVU: 0.05
RUC Recommendation: 0.18		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	Global: 000	Issue: Endovenous Ablation	Screen: High Volume Growth2	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 38 Specialty Developing Recommendation: ACC, ACR, ACS, SCAI, SIR, SVS	First Identified: April 2013	2017 Est. Medicare Utilization: 127,660	2007 Work RVU: 6.72 2007 NF PE RVU: 47.57 2007 Fac PE RVU: 2.39 Result: Decrease	2018 Work RVU: 5.30 2018 NF PE RVU: 47.57 2018 Fac PE RVU: 2.39
RUC Recommendation: 5.30		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
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)	Global: ZZZ	Issue: Endovenous Ablation	Screen: High Volume Growth2	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 38 Specialty Developing Recommendation: ACC, ACR, ACS, SCAI, SIR, SVS	First Identified: October 2013	2017 Est. Medicare Utilization: 9,885	2007 Work RVU: 3.38 2007 NF PE RVU: 7.39 2007 Fac PE RVU: 1.08 Result: Decrease	2018 Work RVU: 2.65 2018 NF PE RVU: 7.39 2018 Fac PE RVU: 1.08
RUC Recommendation: 2.65		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

36478 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated **Global:** 000 **Issue:** Endovenous Ablation **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 38 Specialty Developing Recommendation: ACC, ACR, ACS, SCAI, SIR, SVS

First Identified: April 2013

2017 Est. Medicare Utilization: 84,473

2007 Work RVU: 6.72

2018 Work RVU: 5.30

2007 NF PE RVU: 42.85

2018 NF PE RVU: 42.85

2007 Fac PE RVU: 2.41

2018 Fac PE RVU: 2.41

Result: Decrease

RUC Recommendation: 5.30

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

36479 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Endovenous Ablation **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 38 Specialty Developing Recommendation: ACC, ACR, ACS, SCAI, SIR, SVS

First Identified: April 2013

2017 Est. Medicare Utilization: 8,471

2007 Work RVU: 3.38

2018 Work RVU: 2.65

2007 NF PE RVU: 7.59

2018 NF PE RVU: 7.59

2007 Fac PE RVU: 1.1

2018 Fac PE RVU: 1.1

Result: Decrease

RUC Recommendation: 2.65

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

36481 Percutaneous portal vein catheterization by any method **Global:** 000 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009

Tab 21 Specialty Developing Recommendation: ACR, SIR

First Identified: NA

2017 Est. Medicare Utilization: 727

2007 Work RVU: 6.98

2018 Work RVU: 6.73

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 2.46

2018 Fac PE RVU: 2.46

Result: PE Only

RUC Recommendation: New PE Inputs

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

36511 Therapeutic apheresis; for white blood cells

Global: 000

Issue: Therapeutic Apheresis

Screen: CMS Request - Final Rule for 2016

Complete? Yes

Most Recent
RUC Meeting: January 2017

Tab 12

Specialty Developing
Recommendation: CAP, RPA

First
Identified: January 2017

2017 Est.
Medicare
Utilization: 223

2007 Work RVU: 1.74
2007 NF PE RVU: NA
2007 Fac PE RVU 0.69

2018 Work RVU: 2.00
2018 NF PE RVU: NA
2018 Fac PE RVU:0.69

RUC Recommendation: 2.00. Refer to CPT Assistant.

Referred to CPT September 2016

Referred to CPT Asst ☒

Published in CPT Asst: May 2018

Result: Increase

36512 Therapeutic apheresis; for red blood cells

Global: 000

Issue: Therapeutic Apheresis

Screen: CMS Request - Final Rule for 2016

Complete? Yes

Most Recent
RUC Meeting: January 2017

Tab 12

Specialty Developing
Recommendation: CAP, RPA

First
Identified: January 2017

2017 Est.
Medicare
Utilization: 1,677

2007 Work RVU: 1.74
2007 NF PE RVU: NA
2007 Fac PE RVU 0.71

2018 Work RVU: 2.00
2018 NF PE RVU: NA
2018 Fac PE RVU:0.71

RUC Recommendation: 2.00. Refer to CPT Assistant.

Referred to CPT September 2016

Referred to CPT Asst ☒

Published in CPT Asst: May 2018

Result: Increase

36513 Therapeutic apheresis; for platelets

Global: 000

Issue: Therapeutic Apheresis

Screen: CMS Request - Final Rule for 2016

Complete? Yes

Most Recent
RUC Meeting: January 2017

Tab 12

Specialty Developing
Recommendation: CAP, RPA

First
Identified: January 2017

2017 Est.
Medicare
Utilization: 232

2007 Work RVU: 1.74
2007 NF PE RVU: NA
2007 Fac PE RVU 0.68

2018 Work RVU: 2.00
2018 NF PE RVU: NA
2018 Fac PE RVU:0.68

RUC Recommendation: 2.00. Refer to CPT Assistant.

Referred to CPT September 2016

Referred to CPT Asst ☒

Published in CPT Asst: May 2018

Result: Increase

36514 Therapeutic apheresis; for plasma pheresis

Global: 000

Issue: Therapeutic Apheresis

Screen: CMS Request - Final Rule for 2016

Complete? Yes

Most Recent
RUC Meeting: January 2017

Tab 12

Specialty Developing
Recommendation: CAP, RPA

First
Identified: January 2017

2017 Est.
Medicare
Utilization: 28,945

2007 Work RVU: 1.74
2007 NF PE RVU: 15.33
2007 Fac PE RVU 0.67

2018 Work RVU: 1.81
2018 NF PE RVU: 15.33
2018 Fac PE RVU:0.67

RUC Recommendation: 1.81. Refer to CPT Assistant

Referred to CPT September 2016

Referred to CPT Asst ☒

Published in CPT Asst: May 2018

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

36515 Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion **Global:** 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2017 Est. Medicare Utilization:** 1 **2007 Work RVU:** 1.74 **2018 Work RVU:** **2007 NF PE RVU:** 60.92 **2018 NF PE RVU:** 60.92 **2007 Fac PE RVU:** 0.63 **2018 Fac PE RVU:** 0.63

RUC Recommendation: Deleted from CPT **Referred to CPT:** September 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☒ **Published in CPT Asst:** May 2018

36516 Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion **Global:** 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Fastest Growing / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** October 2008 **2017 Est. Medicare Utilization:** 1,481 **2007 Work RVU:** 1.22 **2018 Work RVU:** 1.56 **2007 NF PE RVU:** 75.37 **2018 NF PE RVU:** 75.37 **2007 Fac PE RVU:** 0.46 **2018 Fac PE RVU:** 0.46

RUC Recommendation: 1.56. Refer to CPT Assistant **Referred to CPT:** September 2016 **Result:** Increase
Referred to CPT Asst ☒ **Published in CPT Asst:** Sep 2009

36522 Photopheresis, extracorporeal **Global:** 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2017 Est. Medicare Utilization:** 9,320 **2007 Work RVU:** 1.67 **2018 Work RVU:** 1.75 **2007 NF PE RVU:** 33.02 **2018 NF PE RVU:** 33.02 **2007 Fac PE RVU:** 0.94 **2018 Fac PE RVU:** 0.94

RUC Recommendation: 1.75. Refer to CPT Assistant **Referred to CPT:** September 2016 **Result:** Increase
Referred to CPT Asst ☒ **Published in CPT Asst:** May 2018

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36555	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age	Global: 000	Issue: Insertion of Catheter	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 16	Specialty Developing Recommendation: ACR, ASA	First Identified: July 2015	2017 Est. Medicare Utilization: 38	2007 Work RVU: 2.68 2007 NF PE RVU: 5.34 2007 Fac PE RVU: 0.76 Result: Decrease
RUC Recommendation: 1.93			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.93 2018 NF PE RVU: 5.34 2018 Fac PE RVU: 0.76
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	Global: 000	Issue: Insertion of Catheter	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 16	Specialty Developing Recommendation: ACR, ASA	First Identified: July 2015	2017 Est. Medicare Utilization: 450,710	2007 Work RVU: 2.50 2007 NF PE RVU: 4.93 2007 Fac PE RVU: 0.7 Result: Decrease
RUC Recommendation: 1.75			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.75 2018 NF PE RVU: 4.93 2018 Fac PE RVU: 0.7
36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; younger than 5 years of age	Global: 000	Issue: PICC Line Procedures	Screen: Identified in RUC review of other services	Complete? Yes
Most Recent RUC Meeting: January 2018	Tab 09	Specialty Developing Recommendation: ACR, SIR	First Identified: October 2016	2017 Est. Medicare Utilization: 9	2007 Work RVU: 1.92 2007 NF PE RVU: 7.03 2007 Fac PE RVU: 0.57 Result: Decrease
RUC Recommendation: 2.11			Referred to CPT September 2017 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.67 2018 NF PE RVU: 7.03 2018 Fac PE RVU: 0.57
36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older	Global: 000	Issue: PICC Line Procedures	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2018	Tab 09	Specialty Developing Recommendation: ACR, SIR	First Identified: July 2015	2017 Est. Medicare Utilization: 148,430	2007 Work RVU: 1.82 2007 NF PE RVU: 6.55 2007 Fac PE RVU: 0.57 Result: Decrease
RUC Recommendation: 1.90. Review at RAW in October 2021.			Referred to CPT September 2017 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.70 2018 NF PE RVU: 6.55 2018 Fac PE RVU: 0.57

Status Report: CMS Requests and Relativity Assessment Issues

36584 Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access **Global:** 000 **Issue:** PICC Line Procedures **Screen:** Identified in RUC review of other services **Complete?** Yes

Most Recent RUC Meeting: January 2018

Tab 09 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2016

2017 Est. Medicare Utilization: 5,630

2007 Work RVU: 1.20

2018 Work RVU: 1.20

2007 NF PE RVU: 6.16

2018 NF PE RVU: 6.16

2007 Fac PE RVU 0.54

2018 Fac PE RVU:0.54

Result: Decrease

RUC Recommendation: 1.47

Referred to CPT September 2017

Referred to CPT Asst ☐ **Published in CPT Asst:**

36620 Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous

Global: 000

Issue: Insertion of Catheter

Screen: CMS High Expenditure Procedural Codes2 / Codes Reported Together 75%or More-Part4 / Modifier -51 Exempt

Complete? Yes

Most Recent RUC Meeting: April 2018

Tab 33 **Specialty Developing Recommendation:** ACR, ASA

First Identified: July 2015

2017 Est. Medicare Utilization: 577,293

2007 Work RVU: 1.15

2018 Work RVU: 1.00

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 0.22

2018 Fac PE RVU:0.22

Result: Decrease

RUC Recommendation: 1.00

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

36818 Arteriovenous anastomosis, open; by upper arm cephalic vein transposition

Global: 090

Issue: Arteriovenous Anastomosis

Screen: CMS Request - Final Rule for 2013

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab 10 **Specialty Developing Recommendation:** ACS, SVS

First Identified: November 2012

2017 Est. Medicare Utilization: 6,042

2007 Work RVU: 11.81

2018 Work RVU: 12.39

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 5.73

2018 Fac PE RVU:5.73

Result: Increase

RUC Recommendation: 13.00

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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36819 Arteriovenous anastomosis, open; by upper arm basilic vein transposition **Global:** 090 **Issue:** Arteriovenous Anastomosis **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** November 2012 **2017 Est. Medicare Utilization:** 8,857 **2007 Work RVU:** 14.39 **2018 Work RVU:** 13.29 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 6.08 **2018 Fac PE RVU:** 6.08 **Result:** Increase

RUC Recommendation: 15.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

36820 Arteriovenous anastomosis, open; by forearm vein transposition **Global:** 090 **Issue:** Arteriovenous Anastomosis **Screen:** Site of Service Anomaly / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 1,874 **2007 Work RVU:** 14.39 **2018 Work RVU:** 13.07 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 6.11 **2018 Fac PE RVU:** 6.11 **Result:** Decrease

RUC Recommendation: 13.99

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

36821 Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure) **Global:** 090 **Issue:** Arteriovenous Anastomosis **Screen:** Site of Service Anomaly / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 31,982 **2007 Work RVU:** 9.15 **2018 Work RVU:** 11.90 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 4.49 **2018 Fac PE RVU:** 4.49 **Result:** Decrease

RUC Recommendation: 11.90

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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36822 Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (separate procedure) **Global:** 090 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI

First Identified:

2017 Est. Medicare Utilization:

2007 Work RVU: 5.51

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 4.23

2018 Fac PE RVU: 4.23

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

36825 Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft **Global:** 090 **Issue:** Arteriovenous Anastomosis **Screen:** Site of Service Anomaly / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013

Tab 10 **Specialty Developing Recommendation:** ACS, SVS

First Identified: September 2007

2017 Est. Medicare Utilization: 2,627

2007 Work RVU: 10.00

2018 Work RVU: 14.17

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 4.87

2018 Fac PE RVU: 4.87

RUC Recommendation: 15.93

Referred to CPT

Result: Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

36830 Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft) **Global:** 090 **Issue:** Arteriovenous Anastomosis **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013

Tab 10 **Specialty Developing Recommendation:** ACS, SVS

First Identified: November 2012

2017 Est. Medicare Utilization: 22,134

2007 Work RVU: 12.00

2018 Work RVU: 12.03

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 4.98

2018 Fac PE RVU: 4.98

RUC Recommendation: 11.90

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36834 Deleted from CPT

Global: 090

Issue: Aneurysm Repair

Screen: Site of Service Anomaly

Complete? Yes

Most Recent RUC Meeting: September 2007

Tab 16

Specialty Developing Recommendation: AVA, ACS

First Identified: September 2007

2017 Est. Medicare Utilization:

2007 Work RVU: 11.11

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 4.68

2018 Fac PE RVU:4.68

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

36870 Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)

Global: 090

Issue: Dialysis Circuit -1

Screen: Site of Service Anomaly (99238-Only) / CMS High Expenditure Procedural Codes / Codes Reported Together 75% or More-Part3

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab 14

Specialty Developing Recommendation: ACR, SIR, SVS

First Identified: September 2007

2017 Est. Medicare Utilization:

2007 Work RVU: 5.17

2018 Work RVU:

2007 NF PE RVU: 49.54

2018 NF PE RVU: 49.54

2007 Fac PE RVU 2.99

2018 Fac PE RVU:2.99

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

36901 Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report;

Global: 000

Issue: Dialysis Circuit -1

Screen: Codes Reported Together 75% or More-Part3

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab 14

Specialty Developing Recommendation: ACR, RPA, SIR, SVS

First Identified: October 2015

2017 Est. Medicare Utilization: 74,000

2007 Work RVU:

2018 Work RVU: 3.36

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 3.36

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

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36902 Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 14 Specialty Developing Recommendation: ACR, RPA, SIR, SVS

First Identified: October 2015

2017 Est. Medicare Utilization: 206,381

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 4.83
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.83

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

36903 Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 14 Specialty Developing Recommendation: ACR, RPA, SIR, SVS

First Identified: October 2015

2017 Est. Medicare Utilization: 20,187

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 6.39
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 6.39

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

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36904	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s);	Global: 000	Issue: Dialysis Circuit -1	Screen: Codes Reported Together 75% or More-Part3	Complete? Yes	
Most Recent RUC Meeting: January 2016	Tab 14	Specialty Developing Recommendation: ACR, RPA, SIR, SVS	First Identified: October 2015	2017 Est. Medicare Utilization: 5,123	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 7.50 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 7.50			Referred to CPT October 2015 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			

36905	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	Global: 000	Issue: Dialysis Circuit -1	Screen: Codes Reported Together 75% or More-Part3	Complete? Yes	
Most Recent RUC Meeting: January 2016	Tab 14	Specialty Developing Recommendation: ACR, RPA, SIR, SVS	First Identified: October 2015	2017 Est. Medicare Utilization: 43,448	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 9.00 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 9.00			Referred to CPT October 2015 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			

Status Report: CMS Requests and Relativity Assessment Issues

36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit	Global: 000	Issue: Dialysis Circuit -1	Screen: Codes Reported Together 75% or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 14	Specialty Developing Recommendation: ACR, RPA, SIR, SVS	First Identified: October 2015	2017 Est. Medicare Utilization: 13,355	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease
RUC Recommendation: 10.42			Referred to CPT October 2015 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 10.42 2018 NF PE RVU: 2018 Fac PE RVU:
36907	Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Dialysis Circuit -1	Screen: Codes Reported Together 75% or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 14	Specialty Developing Recommendation: ACR, RPA, SIR, SVS	First Identified: October 2015	2017 Est. Medicare Utilization: 65,148	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease
RUC Recommendation: 3.00			Referred to CPT October 2015 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 3.00 2018 NF PE RVU: 2018 Fac PE RVU:
36908	Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Dialysis Circuit -1	Screen: Codes Reported Together 75% or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 14	Specialty Developing Recommendation: ACR, RPA, SIR, SVS	First Identified: October 2015	2017 Est. Medicare Utilization: 5,424	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease
RUC Recommendation: 4.25			Referred to CPT October 2015 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 4.25 2018 NF PE RVU: 2018 Fac PE RVU:

Status Report: CMS Requests and Relativity Assessment Issues

36909	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Dialysis Circuit -1	Screen: Codes Reported Together 75% or More-Part3	Complete? Yes
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Most Recent RUC Meeting: January 2016	Tab 14	Specialty Developing Recommendation: ACR, RPA, SIR, SVS	First Identified: October 2015	2017 Est. Medicare Utilization: 5,531	2007 Work RVU:	2018 Work RVU: 4.12
RUC Recommendation: 4.12			Referred to CPT October 2015		2007 NF PE RVU:	2018 NF PE RVU:
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU	2018 Fac PE RVU:
					Result: Decrease	

36X72		Global:	Issue: PICC Line Procedures	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
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Most Recent RUC Meeting: January 2018	Tab 09	Specialty Developing Recommendation:	First Identified: September 2017	2017 Est. Medicare Utilization:	2007 Work RVU:	2018 Work RVU:
RUC Recommendation: 2.00			Referred to CPT		2007 NF PE RVU:	2018 NF PE RVU:
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU	2018 Fac PE RVU:
					Result: Decrease	

36X73		Global:	Issue: PICC Line Procedures	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
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Most Recent RUC Meeting: January 2018	Tab 09	Specialty Developing Recommendation:	First Identified: September 2017	2017 Est. Medicare Utilization:	2007 Work RVU:	2018 Work RVU:
RUC Recommendation: 1.90			Referred to CPT		2007 NF PE RVU:	2018 NF PE RVU:
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU	2018 Fac PE RVU:
					Result: Decrease	

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37183	Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilatation, stent placement and all associated imaging guidance and documentation)	Global: 000	Issue: Interventional Radiology Procedures	Screen: CMS Request - Practice Expense Review	Complete? Yes
Most Recent RUC Meeting: February 2009	Tab 21 Specialty Developing Recommendation: ACR, SIR	First Identified: NA	2017 Est. Medicare Utilization: 847	2007 Work RVU: 7.99 2007 NF PE RVU: NA 2007 Fac PE RVU: 2.89 Result: PE Only	2018 Work RVU: 7.74 2018 NF PE RVU: NA 2018 Fac PE RVU: 2.89
RUC Recommendation: New PE inputs		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
37191	Insertion 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	Global: 000	Issue: IVC Transcatheter Procedure	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2011	Tab 12 Specialty Developing Recommendation: ACR, SIR, SVS	First Identified:	2017 Est. Medicare Utilization: 32,181	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Decrease	2018 Work RVU: 4.46 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 4.71		Referred to CPT February 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
37192	Repositioning 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	Global: 000	Issue: IVC Transcatheter Procedure	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2011	Tab 12 Specialty Developing Recommendation: ACR, SIR, SVS	First Identified:	2017 Est. Medicare Utilization: 42	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Decrease	2018 Work RVU: 7.10 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 8.00		Referred to CPT February 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

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	Global: 000	Issue: IVC Transcatheter Procedure	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes		
Most Recent RUC Meeting:	April 2011	Tab 12	Specialty Developing Recommendation: ACR, SIR, SVS	First Identified:	2017 Est. Medicare Utilization: 7,704	2007 Work RVU:	2018 Work RVU: 7.10
						2007 NF PE RVU:	2018 NF PE RVU:
						2007 Fac PE RVU	2018 Fac PE RVU:
RUC Recommendation:	8.00			Referred to CPT February 2011	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
37201	Transcatheter therapy, infusion for thrombolysis other than coronary	Global: 000	Issue: Bundle Thrombolysis	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes		
Most Recent RUC Meeting:	April 2012	Tab 15	Specialty Developing Recommendation: ACR, SIR, SVS	First Identified: February 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 4.99	2018 Work RVU:
						2007 NF PE RVU: NA	2018 NF PE RVU: NA
						2007 Fac PE RVU 2.43	2018 Fac PE RVU:2.43
RUC Recommendation:	Deleted from CPT			Referred to CPT October 2011	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
37203	Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter)	Global: 000	Issue: Transcatheter Procedures	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes		
Most Recent RUC Meeting:	September 2011	Tab 07	Specialty Developing Recommendation: ACC, ACR, SIR, SVS	First Identified: February 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 5.02	2018 Work RVU:
						2007 NF PE RVU: 31.87	2018 NF PE RVU: 31.87
						2007 Fac PE RVU 1.98	2018 Fac PE RVU:1.98
RUC Recommendation:	Deleted from CPT			Referred to CPT June 2011	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

37204	Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	Global: 000	Issue: Embolization and Occlusion Procedures	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 08	Specialty Developing Recommendation: ACC, ACR, SIR, SVS	First Identified: February 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 18.11 2007 NF PE RVU: NA 2007 Fac PE RVU: 5.75 Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT February 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 5.75
37205	Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel	Global: 000	Issue: Endovascular Revascularization	Screen: High Volume Growth1 / Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 07	Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC	First Identified: February 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 8.27 2007 NF PE RVU: NA 2007 Fac PE RVU: 3.77 Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT February 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 3.77
37206	Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Endovascular Revascularization	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 07	Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC	First Identified: February 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 4.12 2007 NF PE RVU: NA 2007 Fac PE RVU: 1.46 Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT February 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 1.46

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37207 Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel **Global:** 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 07 Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 8.27

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 2.98

2018 Fac PE RVU: 2.98

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

37208 Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 07 Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 4.12

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 1.3

2018 Fac PE RVU: 1.3

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

37209 Exchange of a previously placed intravascular catheter during thrombolytic therapy **Global:** 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012

Tab 15 Specialty Developing Recommendation: ACR, SIR, SVS

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 2.27

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 0.72

2018 Fac PE RVU: 0.72

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

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37210	Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure	Global: 000	Issue: Embolization and Occlusion Procedures	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 08	Specialty Developing Recommendation: ACR, SIR, SVS	First Identified: February 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 10.60 2007 NF PE RVU: 46.03 2007 Fac PE RVU: 3.13 Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT February 2013	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day	Global: 000	Issue: Bundle Thrombolysis	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 15	Specialty Developing Recommendation: ACR, SIR, SVS	First Identified: February 2010	2017 Est. Medicare Utilization: 10,284	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Decrease
RUC Recommendation: 8.00			Referred to CPT	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
37212	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	Global: 000	Issue: Bundle Thrombolysis	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 15	Specialty Developing Recommendation: ACR, SIR, SVS	First Identified: February 2010	2017 Est. Medicare Utilization: 3,525	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Decrease
RUC Recommendation: 7.06			Referred to CPT	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:

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37213 Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; **Global:** 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012

Tab 15 Specialty Developing Recommendation: ACR, SIR, SVS

First Identified: February 2010

2017 Est. Medicare Utilization: 2,818

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 4.75
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 5.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

37214 Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method **Global:** 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012

Tab 15 Specialty Developing Recommendation: ACR, SIR, SVS

First Identified: February 2010

2017 Est. Medicare Utilization: 6,584

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 2.49
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 3.04

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

37220 Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty **Global:** 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 07 Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC

First Identified: February 2010

2017 Est. Medicare Utilization: 12,542

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 7.90
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 8.15

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37221 Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed **Global:** 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 07 Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC

First Identified: February 2010

2017 Est. Medicare Utilization: 38,796

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 9.75
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 10.00

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

37222 Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 07 Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC

First Identified: February 2010

2017 Est. Medicare Utilization: 3,297

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 3.73
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 3.73

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

37223 Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 07 Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC

First Identified: February 2010

2017 Est. Medicare Utilization: 5,384

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 4.25
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.25

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

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37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	Global: 000	Issue: Endovascular Revascularization	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 07 Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC	First Identified: February 2010	2017 Est. Medicare Utilization: 34,564	2007 Work RVU:	2018 Work RVU: 8.75
RUC Recommendation: 9.00		Referred to CPT February 2010		2007 NF PE RVU:	2018 NF PE RVU:
		Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU	2018 Fac PE RVU:
				Result: Decrease	

37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	Global: 000	Issue: Endovascular Revascularization	Screen: High Volume Growth1 / PE Screen - High Cost Supplies	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 07 Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC	First Identified: February 2010	2017 Est. Medicare Utilization: 41,794	2007 Work RVU:	2018 Work RVU: 11.75
RUC Recommendation: Review action plan. 12.00		Referred to CPT February 2010		2007 NF PE RVU:	2018 NF PE RVU:
		Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU	2018 Fac PE RVU:
				Result: Decrease	

37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	Global: 000	Issue: Endovascular Revascularization	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 07 Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC	First Identified: February 2010	2017 Est. Medicare Utilization: 26,087	2007 Work RVU:	2018 Work RVU: 10.24
RUC Recommendation: 10.49		Referred to CPT February 2010		2007 NF PE RVU:	2018 NF PE RVU:
		Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU	2018 Fac PE RVU:
				Result: Decrease	

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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** **Global:** 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 / PE Screen - High Cost Supplies **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 07

Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC

First Identified: February 2010

2017 Est. Medicare Utilization: 21,041

2007 Work RVU:

2018 Work RVU: 14.25

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: Review action plan. 14.50

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

37228 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty** **Global:** 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 07

Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC

First Identified: February 2010

2017 Est. Medicare Utilization: 30,672

2007 Work RVU:

2018 Work RVU: 10.75

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 11.00

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

37229 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed** **Global:** 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 / PE Screen - High Cost Supplies / High Volume Growth5 **Complete?** No

Most Recent RUC Meeting: April 2010

Tab 07

Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC

First Identified: February 2010

2017 Est. Medicare Utilization: 32,833

2007 Work RVU:

2018 Work RVU: 13.80

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: Review action plan. 14.05

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

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37230 Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed **Global:** 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 07 Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC

First Identified: February 2010

2017 Est. Medicare Utilization: 2,870

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 13.55
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 13.80

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

37231 Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed **Global:** 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 07 Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC

First Identified: February 2010

2017 Est. Medicare Utilization: 2,126

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 14.75
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 15.00

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

37232 Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 07 Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC

First Identified: February 2010

2017 Est. Medicare Utilization: 11,447

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 4.00
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.00

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

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37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Endovascular Revascularization	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 07	Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC	First Identified: February 2010	2017 Est. Medicare Utilization: 7,810	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease 2018 Work RVU: 6.50 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 6.50			Referred to CPT February 2010 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Endovascular Revascularization	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 07	Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC	First Identified: February 2010	2017 Est. Medicare Utilization: 329	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease 2018 Work RVU: 5.50 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 5.50			Referred to CPT February 2010 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Endovascular Revascularization	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 07	Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC	First Identified: February 2010	2017 Est. Medicare Utilization: 148	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease 2018 Work RVU: 7.80 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 7.80			Referred to CPT February 2010 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

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37236 Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery

Global: 000 **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 09 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** **2017 Est. Medicare Utilization:** 13,270 **2007 Work RVU:** **2018 Work RVU:** 8.75 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** 9.00 **Referred to CPT** February 2013 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **2007 Fac PE RVU Result:** Decrease

37237 Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)

Global: ZZZ **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 09 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** **2017 Est. Medicare Utilization:** 1,427 **2007 Work RVU:** **2018 Work RVU:** 4.25 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** 4.25 **Referred to CPT** February 2013 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **2007 Fac PE RVU Result:** Decrease

37238 Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein

Global: 000 **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 09 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** **2017 Est. Medicare Utilization:** 10,248 **2007 Work RVU:** **2018 Work RVU:** 6.04 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** 6.29 **Referred to CPT** February 2013 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **2007 Fac PE RVU Result:** Decrease

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37239 Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 09

Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC

First Identified:

2017 Est. Medicare Utilization: 4,771

2007 Work RVU:

2018 Work RVU: 2.97

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 3.34

Referred to CPT February 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

37241 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)

Global: 000

Issue: Embolization and Occlusion Procedures

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2013

Tab 08

Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC

First Identified: February 2010

2017 Est. Medicare Utilization: 2,261

2007 Work RVU:

2018 Work RVU: 8.75

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 9.00

Referred to CPT February 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

37242 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)

Global: 000

Issue: Embolization and Occlusion Procedures

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2013

Tab 08

Specialty Developing Recommendation: SVS, ACS, SIR, ACR, ACC

First Identified: February 2010

2017 Est. Medicare Utilization: 9,288

2007 Work RVU:

2018 Work RVU: 9.80

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 11.98

Referred to CPT February 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

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37243 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction **Global:** 000 **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 08 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2017 Est. Medicare Utilization:** 14,939 **2007 Work RVU:** **2018 Work RVU:** 11.74 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Decrease **2018 Fac PE RVU:**

RUC Recommendation: 14.00 **Referred to CPT** February 2013 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

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 **Global:** 000 **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 08 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2017 Est. Medicare Utilization:** 10,941 **2007 Work RVU:** **2018 Work RVU:** 13.75 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Decrease **2018 Fac PE RVU:**

RUC Recommendation: 14.00 **Referred to CPT** February 2013 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

37246 Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery **Global:** 000 **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 9,000 **2007 Work RVU:** **2018 Work RVU:** 7.00 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Decrease **2018 Fac PE RVU:**

RUC Recommendation: 7.00 **Referred to CPT** October 2015 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

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37247 Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (List separately in addition to code for primary procedure)

Global: ZZZ **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 680 **2007 Work RVU:** **2018 Work RVU:** 3.50 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** 3.50 **Referred to CPT** October 2015 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **2007 Fac PE RVU Result:** Decrease

37248 Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein

Global: 000 **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 15,388 **2007 Work RVU:** **2018 Work RVU:** 6.00 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** 6.00 **Referred to CPT** October 2015 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **2007 Fac PE RVU Result:** Decrease

37249 Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein (List separately in addition to code for primary procedure)

Global: ZZZ **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 3,545 **2007 Work RVU:** **2018 Work RVU:** 2.97 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** 2.97 **Referred to CPT** October 2015 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **2007 Fac PE RVU Result:** Decrease

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37250 Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2015

Tab 07 Specialty Developing Recommendation: ACC, SCAI, SIR, SVS

First Identified: July 2014

2017 Est. Medicare Utilization:

2007 Work RVU: 2.10

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 0.77

2018 Fac PE RVU: 0.77

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

37251 Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2015

Tab 07 Specialty Developing Recommendation: ACC, SCAI, SIR, SVS

First Identified: July 2014

2017 Est. Medicare Utilization:

2007 Work RVU: 1.60

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 0.54

2018 Fac PE RVU: 0.54

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

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) **Global:** ZZZ **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 / Work Neutrality (CPT 2016) **Complete?** Yes

Most Recent RUC Meeting: October 2018

Tab 14 Specialty Developing Recommendation: ACC, SCAI, SIR, SVS

First Identified: July 2014

2017 Est. Medicare Utilization: 32,209

2007 Work RVU:

2018 Work RVU: 1.80

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 1.80

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

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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) **Global:** ZZZ **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 / Work Neutrality (CPT 2016) **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 14 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2017 Est. Medicare Utilization:** 38,310 **2007 Work RVU:** **2018 Work RVU:** 1.44 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Decrease **2018 Fac PE RVU:**

RUC Recommendation: 1.44 **Referred to CPT** October 2014 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

37609 Ligation or biopsy, temporal artery **Global:** 010 **Issue:** Ligation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** SVS, ACS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 15,358 **2007 Work RVU:** 3.02 **2018 Work RVU:** 3.05 **2007 NF PE RVU:** 4.43 **2018 NF PE RVU:** 4.43 **2007 Fac PE RVU Result:** PE Only **2018 Fac PE RVU:** 1.93

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

37619 Ligation of inferior vena cava **Global:** 090 **Issue:** Ligation of Inferior Vena Cava **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 13 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** **2017 Est. Medicare Utilization:** 38 **2007 Work RVU:** **2018 Work RVU:** 30.00 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Increase **2018 Fac PE RVU:**

RUC Recommendation: 37.60 **Referred to CPT** February 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

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37620 Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device) **Global:** 090 **Issue:** Major Vein Revision **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 45

Specialty Developing Recommendation: ACR, SIR, SVS

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 11.49

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 5.52

2018 Fac PE RVU:5.52

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

37760 Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg

Global: 090

Issue: Perorator Vein Ligation

Screen: Site of Service Anomaly

Complete? Yes

Most Recent RUC Meeting: April 2009

Tab 10

Specialty Developing Recommendation: SVS, ACS

First Identified: September 2007

2017 Est. Medicare Utilization: 108

2007 Work RVU: 10.69

2018 Work RVU: 10.78

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 5.14

2018 Fac PE RVU:5.14

Result: Maintain

RUC Recommendation: 10.69

Referred to CPT February 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

37761 Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg

Global: 090

Issue: Perforator Vein Ligation

Screen: Site of Service Anomaly

Complete? Yes

Most Recent RUC Meeting: April 2009

Tab 10

Specialty Developing Recommendation: SVS, ACS

First Identified:

2017 Est. Medicare Utilization: 422

2007 Work RVU:

2018 Work RVU: 9.13

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 9.00

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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37765 Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions				Global: 090	Issue: Stab Phlebectomy of Varicose Veins	Screen: High Volume Growth1 / CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 12	Specialty Developing Recommendation:	ACS, SIR, SVS	First Identified: February 2008	2017 Est. Medicare Utilization: 16,368	2007 Work RVU: 7.63 2007 NF PE RVU: NA 2007 Fac PE RVU 4.36 Result: Decrease	2018 Work RVU: 7.71 2018 NF PE RVU: NA 2018 Fac PE RVU:4.36
RUC Recommendation: 4.80				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
37766 Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions				Global: 090	Issue: Stab Phlebectomy of Varicose Veins	Screen: High Volume Growth1 / CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 12	Specialty Developing Recommendation:	ACS, SIR, SVS	First Identified: February 2008	2017 Est. Medicare Utilization: 12,684	2007 Work RVU: 9.58 2007 NF PE RVU: NA 2007 Fac PE RVU 5.01 Result: Decrease	2018 Work RVU: 9.66 2018 NF PE RVU: NA 2018 Fac PE RVU:5.01
RUC Recommendation: 6.00				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
37785 Ligation, division, and/or excision of varicose vein cluster(s), 1 leg				Global: 090	Issue: Ligation	Screen: Site of Service Anomaly (99238-Only)	Complete? Yes
Most Recent RUC Meeting: September 2007	Tab 16	Specialty Developing Recommendation:	APMA, SVS, ACS	First Identified: September 2007	2017 Est. Medicare Utilization: 1,317	2007 Work RVU: 3.87 2007 NF PE RVU: 5.12 2007 Fac PE RVU 2.69 Result: PE Only	2018 Work RVU: 3.93 2018 NF PE RVU: 5.12 2018 Fac PE RVU:2.69
RUC Recommendation: Reduce 99238 to 0.5				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
38220 Diagnostic bone marrow; aspiration(s)				Global: XXX	Issue: Diagnostic Bone Marrow Aspiration and Biopsy	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 06	Specialty Developing Recommendation:	ASCO, ASH, CAP ASBMT	First Identified: February 2016	2017 Est. Medicare Utilization: 32,046	2007 Work RVU: 1.08 2007 NF PE RVU: 3.46 2007 Fac PE RVU 0.5 Result: Decrease	2018 Work RVU: 1.20 2018 NF PE RVU: 3.46 2018 Fac PE RVU:0.5
RUC Recommendation: 1.20				Referred to CPT February 2016 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

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38221 Diagnostic bone marrow; biopsy(ies) **Global:** XXX **Issue:** Diagnostic Bone Marrow Aspiration and Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 06 **Specialty Developing Recommendation:** ASCO, ASH, CAP ASBMT **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 126,980 **2007 Work RVU:** 1.37 **2018 Work RVU:** 1.28
2007 NF PE RVU: 3.64 **2018 NF PE RVU:** 3.64
2007 Fac PE RVU: 0.63 **2018 Fac PE RVU:** 0.63
Result: Decrease

RUC Recommendation: 1.28 **Referred to CPT** February 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

38222 Diagnostic bone marrow; biopsy(ies) and aspiration(s) **Global:** XXX **Issue:** Diagnostic Bone Marrow Aspiration and Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 06 **Specialty Developing Recommendation:** ASCO, ASH, CAP ASBMT **First Identified:** February 2016 **2017 Est. Medicare Utilization:** **2007 Work RVU:** **2018 Work RVU:** 1.44
2007 NF PE RVU: **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 1.44 **Referred to CPT** February 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

38542 Dissection, deep jugular node(s) **Global:** 090 **Issue:** Jugular Node Dissection **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 40 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 648 **2007 Work RVU:** 6.08 **2018 Work RVU:** 7.95
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 4.3 **2018 Fac PE RVU:** 4.3
Result: Increase

RUC Recommendation: 7.85 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

38570 Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple **Global:** 010 **Issue:** Laparoscopy Lymphadenectomy **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 12 **Specialty Developing Recommendation:** AUA **First Identified:** January 2014 **2017 Est. Medicare Utilization:** 3,148 **2007 Work RVU:** 9.28 **2018 Work RVU:** 8.49
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 3.98 **2018 Fac PE RVU:** 3.98
Result: Maintain

RUC Recommendation: 9.34 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

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38571	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy	Global: 010	Issue: Laparoscopy Lymphadenectomy	Screen: CMS Fastest Growing / 010-Day Global Post- Operative Visits	Complete? Yes
Most Recent RUC Meeting: September 2014	Tab 12 Specialty Developing AUA Recommendation:	First Identified: October 2008	2017 Est. Medicare Utilization: 15,991	2007 Work RVU: 14.70 2007 NF PE RVU: NA 2007 Fac PE RVU 5.97 Result: Decrease	2018 Work RVU: 12.00 2018 NF PE RVU: NA 2018 Fac PE RVU: 5.97
RUC Recommendation: 12.00		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
38572	Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple	Global: 010	Issue: Laparoscopy Lymphadenectomy	Screen: 010-Day Global Post- Operative Visits	Complete? Yes
Most Recent RUC Meeting: September 2014	Tab 12 Specialty Developing ACOG Recommendation:	First Identified: January 2014	2017 Est. Medicare Utilization: 2,806	2007 Work RVU: 16.86 2007 NF PE RVU: NA 2007 Fac PE RVU 6.86 Result: Decrease	2018 Work RVU: 15.60 2018 NF PE RVU: NA 2018 Fac PE RVU: 6.86
RUC Recommendation: 15.60		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
38792	Injection procedure; radioactive tracer for identification of sentinel node	Global: 000	Issue: Radioactive Tracer	Screen: Negative IWPUT	Complete? Yes
Most Recent RUC Meeting: January 2018	Tab 23 Specialty Developing Recommendation:	First Identified: April 2017	2017 Est. Medicare Utilization: 33,101	2007 Work RVU: 0.52 2007 NF PE RVU: NA 2007 Fac PE RVU 0.45 Result: Increase	2018 Work RVU: 0.52 2018 NF PE RVU: NA 2018 Fac PE RVU: 0.45
RUC Recommendation: 0.65		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
39400	Mediastinoscopy, includes biopsy(ies), when performed	Global: 010	Issue: Mediastinoscopy with Biopsy	Screen: Pre-Time Analysis	Complete? Yes
Most Recent RUC Meeting: January 2015	Tab 08 Specialty Developing STS Recommendation:	First Identified: January 2014	2017 Est. Medicare Utilization:	2007 Work RVU: 8.00 2007 NF PE RVU: NA 2007 Fac PE RVU 4.68 Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 4.68
RUC Recommendation: Deleted from CPT		Referred to CPT October 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

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39401 Mediastinoscopy; includes biopsy(ies) of mediastinal mass (eg, lymphoma), when performed **Global:** 000 **Issue:** Mediastinoscopy with Biopsy **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent **Tab** 08 **Specialty Developing** STS
RUC Meeting: January 2015 **Recommendation:**

First Identified: October 2014 **2017 Est. Medicare Utilization:** 824

2007 Work RVU: **2018 Work RVU:** 5.44
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU **2018 Fac PE RVU:**
Result: Decrease

RUC Recommendation: 5.44

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

39402 Mediastinoscopy; with lymph node biopsy(ies) (eg, lung cancer staging) **Global:** 000 **Issue:** Mediastinoscopy with Biopsy **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent **Tab** 08 **Specialty Developing** STS
RUC Meeting: January 2015 **Recommendation:**

First Identified: October 2014 **2017 Est. Medicare Utilization:** 5,301

2007 Work RVU: **2018 Work RVU:** 7.25
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU **2018 Fac PE RVU:**
Result: Increase

RUC Recommendation: 7.50

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

3X000 **Global:** **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** No

Most Recent **Tab** **Specialty Developing**
RUC Meeting: **Recommendation:**

First Identified: September 2018 **2017 Est. Medicare Utilization:**

2007 Work RVU: **2018 Work RVU:**
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU **2018 Fac PE RVU:**
Result:

RUC Recommendation:

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

3X001 **Global:** **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** No

Most Recent **Tab** **Specialty Developing**
RUC Meeting: **Recommendation:**

First Identified: September 2018 **2017 Est. Medicare Utilization:**

2007 Work RVU: **2018 Work RVU:**
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU **2018 Fac PE RVU:**
Result:

RUC Recommendation:

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

3X002

Global:

Issue: Pericardiocentesis and Pericardial Drainage

Screen: Negative IWPUT

Complete? No

Most Recent RUC Meeting:

Tab

Specialty Developing Recommendation:

First Identified: September 2018

2017 Est. Medicare Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result:

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation:

Referred to CPT September 2018

Referred to CPT Asst ☐ **Published in CPT Asst:**

3X003

Global:

Issue: Pericardiocentesis and Pericardial Drainage

Screen: Negative IWPUT

Complete? No

Most Recent RUC Meeting:

Tab

Specialty Developing Recommendation:

First Identified: September 2018

2017 Est. Medicare Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result:

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation:

Referred to CPT September 2018

Referred to CPT Asst ☐ **Published in CPT Asst:**

40490 Biopsy of lip

Global: 000

Issue: Biopsy of Lip

Screen: Harvard Valued - Utilization over 30,000

Complete? Yes

Most Recent RUC Meeting: September 2011

Tab 21

Specialty Developing Recommendation: AAO-HNS, AAD

First Identified: April 2011

2017 Est. Medicare Utilization: 34,141

2007 Work RVU: 1.22
2007 NF PE RVU: 1.75
2007 Fac PE RVU Result: 0.61 Maintain

2018 Work RVU: 1.22
2018 NF PE RVU: 1.75
2018 Fac PE RVU: 0.61

RUC Recommendation: 1.22

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

40650 Repair lip, full thickness; vermillion only

Global: 090

Issue: PE Subcommittee

Screen: Emergent Procedures

Complete? Yes

Most Recent RUC Meeting: April 2016

Tab 46

Specialty Developing Recommendation: AAOS, ACEP, and orthopaedic subspecialties

First Identified: October 2015

2017 Est. Medicare Utilization: 363

2007 Work RVU: 3.69
2007 NF PE RVU: 6.58
2007 Fac PE RVU: 3.26

2018 Work RVU: 3.78
2018 NF PE RVU: 6.58
2018 Fac PE RVU: 3.26

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT

Referred to CPT Asst ☒ **Published in CPT Asst:** Nov 2016

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

40800	Drainage of abscess, cyst, hematoma, vestibule of mouth; simple	Global: 010	Issue: RAW	Screen: 010-Day Global Post-Operative Visits	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 52	Specialty Developing Recommendation:	First Identified: January 2014	2017 Est. Medicare Utilization: 1,731	2007 Work RVU: 1.19 2007 NF PE RVU: 3.18 2007 Fac PE RVU: 1.8 Result: Maintain
RUC Recommendation: Maintain			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.23 2018 NF PE RVU: 3.18 2018 Fac PE RVU: 1.8

40808	Biopsy, vestibule of mouth	Global: 010	Issue: Biopsy of Mouth Lesion	Screen: Negative IWPUT	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 13	Specialty Developing Recommendation: AAOHNS, AAOMS	First Identified: April 2017	2017 Est. Medicare Utilization: 10,804	2007 Work RVU: 0.98 2007 NF PE RVU: 2.87 2007 Fac PE RVU: 1.51 Result: Increase
RUC Recommendation: 1.05			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.01 2018 NF PE RVU: 2.87 2018 Fac PE RVU: 1.51

40812	Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair	Global: 010	Issue: RAW	Screen: 010-Day Global Post-Operative Visits	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 52	Specialty Developing Recommendation:	First Identified: January 2014	2017 Est. Medicare Utilization: 6,060	2007 Work RVU: 2.33 2007 NF PE RVU: 3.92 2007 Fac PE RVU: 2.37 Result: Maintain
RUC Recommendation: Maintain			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2.37 2018 NF PE RVU: 3.92 2018 Fac PE RVU: 2.37

40820	Destruction of lesion or scar of vestibule of mouth by physical methods (eg, laser, thermal, cryo, chemical)	Global: 010	Issue: RAW	Screen: 010-Day Global Post-Operative Visits	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 52	Specialty Developing Recommendation:	First Identified: January 2014	2017 Est. Medicare Utilization: 1,360	2007 Work RVU: 1.30 2007 NF PE RVU: 4.23 2007 Fac PE RVU: 2.54 Result: Maintain
RUC Recommendation: Maintain			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.34 2018 NF PE RVU: 4.23 2018 Fac PE RVU: 2.54

Status Report: CMS Requests and Relativity Assessment Issues

41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session			Global: 000	Issue: Submucosal ablation of tongue base	Screen: Final Rule for 2015	Complete? Yes	
Most Recent RUC Meeting:	April 2015	Tab 26	Specialty Developing Recommendation:	AAO-HNS	First Identified: July 2014	2017 Est. Medicare Utilization: 1,344	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 3.50 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 3.50					Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
42145	Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)			Global: 090	Issue: Palatopharyngoplasty	Screen: Site of Service Anomaly	Complete? Yes	
Most Recent RUC Meeting:	April 2008	Tab 41	Specialty Developing Recommendation:	AAO-HNS	First Identified: September 2007	2017 Est. Medicare Utilization: 741	2007 Work RVU: 9.63 2007 NF PE RVU: NA 2007 Fac PE RVU 7.33 2007 Result: Maintain	2018 Work RVU: 9.78 2018 NF PE RVU: NA 2018 Fac PE RVU:7.33
RUC Recommendation: 9.63					Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
42415	Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve			Global: 090	Issue: Excise Parotid Gland/Lesion	Screen: Site of Service Anomaly	Complete? Yes	
Most Recent RUC Meeting:	February 2011	Tab 27	Specialty Developing Recommendation:	ACS, AAO-HNS	First Identified: September 2007	2017 Est. Medicare Utilization: 5,215	2007 Work RVU: 17.99 2007 NF PE RVU: NA 2007 Fac PE RVU 10.11 2007 Result: Maintain	2018 Work RVU: 17.16 2018 NF PE RVU: NA 2018 Fac PE RVU:10.11
RUC Recommendation: 18.12					Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve			Global: 090	Issue: Excise Parotid Gland/Lesion	Screen: Site of Service Anomaly	Complete? Yes	
Most Recent RUC Meeting:	February 2011	Tab 27	Specialty Developing Recommendation:	ACS, AAO-HNS	First Identified: September 2007	2017 Est. Medicare Utilization: 1,673	2007 Work RVU: 20.87 2007 NF PE RVU: NA 2007 Fac PE RVU 11.46 2007 Result: Maintain	2018 Work RVU: 19.53 2018 NF PE RVU: NA 2018 Fac PE RVU:11.46
RUC Recommendation: 21.00					Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

42440 Excision of submandibular (submaxillary) gland **Global:** 090 **Issue:** Submandibular Gland Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 64 **Specialty Developing Recommendation:** AAO-HNS, ACS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 1,822 **2007 Work RVU:** 7.05 **2018 Work RVU:** 6.14 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 4.48 **2018 Fac PE RVU:** 4.48 **RUC Recommendation:** 7.13 **Result:** Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43191 Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure) **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 2,936 **2007 Work RVU:** **2018 Work RVU:** 2.49 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** 2.78 **Result:** Increase

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43192 Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 202 **2007 Work RVU:** **2018 Work RVU:** 2.79 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** 3.21 **Result:** Increase

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43193 Esophagoscopy, rigid, transoral; with biopsy, single or multiple **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 333 **2007 Work RVU:** **2018 Work RVU:** 2.79 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** 3.36 **Result:** Increase

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43194	Esophagoscopy, rigid, transoral; with removal of foreign body(s)	Global: 000	Issue: Esophagoscopy	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: October 2012	Tab 10	Specialty Developing Recommendation: AAO-HNS, ASGE, SAGES	First Identified: September 2011	2017 Est. Medicare Utilization: 171	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase 2018 Work RVU: 3.51 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 3.99			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

43195	Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter)	Global: 000	Issue: Esophagoscopy	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: October 2012	Tab 10	Specialty Developing Recommendation: AAO-HNS, ASGE, SAGES	First Identified: September 2011	2017 Est. Medicare Utilization: 535	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase 2018 Work RVU: 3.07 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 3.21			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

43196	Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire	Global: 000	Issue: Esophagoscopy	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: October 2012	Tab 10	Specialty Developing Recommendation: AAO-HNS, ASGE, SAGES	First Identified: September 2011	2017 Est. Medicare Utilization: 382	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase 2018 Work RVU: 3.31 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 3.36			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

43197	Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	Global: 000	Issue: Esophagoscopy	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: October 2012	Tab 10	Specialty Developing Recommendation: AAO-HNS, ASGE, SAGES, AGA	First Identified: September 2011	2017 Est. Medicare Utilization: 1,541	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain 2018 Work RVU: 1.52 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.59			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

43198 Esophagoscopy, flexible, transnasal; with biopsy, single or multiple **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent **Tab** 10 **Specialty Developing** AAO-HNS, **First** **2017 Est.** **2007 Work RVU:** **2018 Work RVU:** 1.82
RUC Meeting: October 2012 **Recommendation:** ASGE, **Identified:** September 2011 **Medicare** **2007 NF PE RVU:** **2018 NF PE RVU:**
Utilization: 236 **2007 Fac PE RVU** **2018 Fac PE RVU:**
RUC Recommendation: 1.89 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Maintain

43200 Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure) **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent **Tab** 10 **Specialty Developing** AAO-HNS, **First** **2017 Est.** **2007 Work RVU:** 1.59 **2018 Work RVU:** 1.42
RUC Meeting: October 2012 **Recommendation:** AGA, ASGE, **Identified:** September 2011 **Medicare** **2007 NF PE RVU:** 3.98 **2018 NF PE RVU:** 3.98
Utilization: 6,488 **2007 Fac PE RVU** 1.04 **2018 Fac PE RVU:** 1.04
RUC Recommendation: 1.59 **Referred to CPT** May 2012
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Maintain

43201 Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent **Tab** 10 **Specialty Developing** AGA, ASGE, **First** **2017 Est.** **2007 Work RVU:** 2.09 **2018 Work RVU:** 1.72
RUC Meeting: October 2012 **Recommendation:** SAGES **Identified:** September 2011 **Medicare** **2007 NF PE RVU:** 4.86 **2018 NF PE RVU:** 4.86
Utilization: 240 **2007 Fac PE RVU** 1.12 **2018 Fac PE RVU:** 1.12
RUC Recommendation: 1.90 **Referred to CPT** May 2012
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Decrease

43202 Esophagoscopy, flexible, transoral; with biopsy, single or multiple **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent **Tab** 10 **Specialty Developing** AAO-HNS, **First** **2017 Est.** **2007 Work RVU:** 1.89 **2018 Work RVU:** 1.72
RUC Meeting: October 2012 **Recommendation:** AGA, ASGE, **Identified:** September 2011 **Medicare** **2007 NF PE RVU:** 5.44 **2018 NF PE RVU:** 5.44
Utilization: 2,369 **2007 Fac PE RVU** 0.95 **2018 Fac PE RVU:** 0.95
RUC Recommendation: 1.89 **Referred to CPT** May 2012
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Maintain

Status Report: CMS Requests and Relativity Assessment Issues

43204 Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 26 **2007 Work RVU:** 3.76 **2018 Work RVU:** 2.33 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 1.63 **2018 Fac PE RVU:** 1.63 **RUC Recommendation:** 2.89 **Result:** Decrease

Referred to CPT May 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

43205 Esophagoscopy, flexible, transoral; with band ligation of esophageal varices **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 222 **2007 Work RVU:** 3.78 **2018 Work RVU:** 2.44 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 1.66 **2018 Fac PE RVU:** 1.66 **RUC Recommendation:** 3.00 **Result:** Decrease

Referred to CPT May 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

43206 Esophagoscopy, flexible, transoral; with optical endomicroscopy **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 65 **2007 Work RVU:** **2018 Work RVU:** 2.29 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** 2.39 **Result:** Decrease

Referred to CPT **Referred to CPT Asst** ☐ **Published in CPT Asst:**

43211 Esophagoscopy, flexible, transoral; with endoscopic mucosal resection **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 109 **2007 Work RVU:** **2018 Work RVU:** 4.20 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** 4.58 **Result:** Decrease

Referred to CPT **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43212 Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed) **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012

Tab 10

Specialty Developing Recommendation:

AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 558

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 3.40
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 3.73

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43213 Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed) **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012

Tab 10

Specialty Developing Recommendation:

AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 305

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 4.63
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 5.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43214 Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed) **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012

Tab 10

Specialty Developing Recommendation:

AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 287

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 3.40
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 3.78

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43215 Esophagoscopy, flexible, transoral; with removal of foreign body(s) **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012

Tab 10

Specialty Developing Recommendation:

AAO-HNS, AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 984

2007 Work RVU: 2.60
2007 NF PE RVU: NA
2007 Fac PE RVU Result: Maintain

2018 Work RVU: 2.44
2018 NF PE RVU: NA
2018 Fac PE RVU: 1.22

RUC Recommendation: 2.60

Referred to CPT May 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43216 Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 83 **2007 Work RVU:** 2.40 **2018 Work RVU:** 2.30 **2007 NF PE RVU:** 1.55 **2018 NF PE RVU:** 1.55 **2007 Fac PE RVU:** 1.1 **2018 Fac PE RVU:** 1.1 **Result:** Maintain

RUC Recommendation: 2.40 **Referred to CPT** May 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

43217 Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 89 **2007 Work RVU:** 2.90 **2018 Work RVU:** 2.80 **2007 NF PE RVU:** 6.85 **2018 NF PE RVU:** 6.85 **2007 Fac PE RVU:** 1.25 **2018 Fac PE RVU:** 1.25 **Result:** Maintain

RUC Recommendation: 2.90 **Referred to CPT** May 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

43219 Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 2.80 **2018 Work RVU:** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 1.4 **2018 Fac PE RVU:** 1.4 **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

43220 Esophagoscopy, flexible, transoral; with transendoscopic balloon dilation (less than 30 mm diameter) **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 2,195 **2007 Work RVU:** 2.10 **2018 Work RVU:** 2.00 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 1.01 **2018 Fac PE RVU:** 1.01 **Result:** Maintain

RUC Recommendation: 2.10 **Referred to CPT** May 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43226 Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012

Tab 10

Specialty Developing Recommendation:

AAO-HNS, AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 1,621

2007 Work RVU: 2.34

2018 Work RVU: 2.24

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 1.1

2018 Fac PE RVU:1.1

Result: Maintain

RUC Recommendation: 2.34

Referred to CPT May 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

43227 Esophagoscopy, flexible, transoral; with control of bleeding, any method **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012

Tab 10

Specialty Developing Recommendation:

AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 232

2007 Work RVU: 3.59

2018 Work RVU: 2.89

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 1.55

2018 Fac PE RVU:1.55

Result: Decrease

RUC Recommendation: 3.26

Referred to CPT May 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

43228 Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012

Tab 10

Specialty Developing Recommendation:

AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization:

2007 Work RVU: 3.76

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 1.63

2018 Fac PE RVU:1.63

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT May 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

43229 Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed) **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012

Tab 10

Specialty Developing Recommendation:

AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 3,177

2007 Work RVU:

2018 Work RVU: 3.49

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 3.72

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43231 Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent **Tab** 10 **Specialty Developing** AGA, ASGE, **First** **2017 Est.**
RUC Meeting: April 2013 **Recommendation:** SAGES **Identified:** September 2011 **Medicare**
Utilization: 625

RUC Recommendation: 3.19 **Referred to CPT** May 2012 **2007 Work RVU:** 3.19 **2018 Work RVU:** 2.80
Referred to CPT Asst ☐ **Published in CPT Asst:** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 1.42 **2018 Fac PE RVU:** 1.42
Result: Maintain

43232 Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent **Tab** 10 **Specialty Developing** AGA, ASGE, **First** **2017 Est.**
RUC Meeting: April 2013 **Recommendation:** SAGES **Identified:** September 2011 **Medicare**
Utilization: 539

RUC Recommendation: 3.83 **Referred to CPT** May 2012 **2007 Work RVU:** 4.47 **2018 Work RVU:** 3.59
Referred to CPT Asst ☐ **Published in CPT Asst:** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 1.96 **2018 Fac PE RVU:** 1.96
Result: Decrease

43233 Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed) **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent **Tab** 08 **Specialty Developing** AGA, ASGE, **First** **2017 Est.**
RUC Meeting: January 2013 **Recommendation:** SAGES **Identified:** **Medicare**
Utilization: 1,883

RUC Recommendation: 4.45 **Referred to CPT** October 2012 **2007 Work RVU:** **2018 Work RVU:** 4.07
Referred to CPT Asst ☐ **Published in CPT Asst:** **2007 NF PE RVU:** **2018 NF PE RVU:**
2007 Fac PE RVU **2018 Fac PE RVU:**
Result: Decrease

43234 Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope) (separate procedure) **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent **Tab** 10 **Specialty Developing** AGA, ASGE, **First** **2017 Est.**
RUC Meeting: April 2013 **Recommendation:** SAGES **Identified:** September 2011 **Medicare**
Utilization:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **2007 Work RVU:** 2.01 **2018 Work RVU:**
Referred to CPT Asst ☐ **Published in CPT Asst:** **2007 NF PE RVU:** 5.23 **2018 NF PE RVU:** 5.23
2007 Fac PE RVU 0.91 **2018 Fac PE RVU:** 0.91
Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

43235 Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure) **Global:** 000 **Issue:** EGD **Screen:** MPC List / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013

Tab 08

Specialty Developing Recommendation:

AGA, ASGE, SAGES

First Identified: October 2010

2017 Est. Medicare Utilization: 344,612

2007 Work RVU: 2.39

2018 Work RVU: 2.09

2007 NF PE RVU: 5.19

2018 NF PE RVU: 5.19

2007 Fac PE RVU 1.11

2018 Fac PE RVU:1.11

Result: Decrease

RUC Recommendation: 2.26

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

43236 Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance

Global: 000

Issue: EGD

Screen: CMS Fastest Growing / MPC List

Complete? Yes

Most Recent RUC Meeting: January 2013

Tab 08

Specialty Developing Recommendation:

AGA, ASGE, SAGES

First Identified: October 2008

2017 Est. Medicare Utilization: 15,985

2007 Work RVU: 2.92

2018 Work RVU: 2.39

2007 NF PE RVU: 6.47

2018 NF PE RVU: 6.47

2007 Fac PE RVU 1.33

2018 Fac PE RVU:1.33

Result: Decrease

RUC Recommendation: 2.57

Referred to CPT October 2012

Referred to CPT Asst ☒ **Published in CPT Asst:** Apr 2009 and Jun 2010

43237 Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures

Global: 000

Issue: EGD

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: April 2013

Tab 11

Specialty Developing Recommendation:

AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 15,905

2007 Work RVU: 3.98

2018 Work RVU: 3.47

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 1.74

2018 Fac PE RVU:1.74

Result: Decrease

RUC Recommendation: 3.85

Referred to CPT February 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43238 Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures) **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 11,963 **2007 Work RVU:** 5.02 **2018 Work RVU:** 4.16 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 2.11 **2018 Fac PE RVU:** 2.11 **Result:** Decrease

RUC Recommendation: 4.50 **Referred to CPT** February 2013 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

43239 Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2010 **2017 Est. Medicare Utilization:** 1,441,019 **2007 Work RVU:** 2.87 **2018 Work RVU:** 2.39 **2007 NF PE RVU:** 5.79 **2018 NF PE RVU:** 5.79 **2007 Fac PE RVU:** 1.29 **2018 Fac PE RVU:** 1.29 **Result:** Decrease

RUC Recommendation: 2.56 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

43240 Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed) **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 782 **2007 Work RVU:** 6.85 **2018 Work RVU:** 7.15 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 2.82 **2018 Fac PE RVU:** 2.82 **Result:** Increase

RUC Recommendation: 7.25 **Referred to CPT** February 2013 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43241 Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube or catheter **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 4,030 **2007 Work RVU:** 2.59 **2018 Work RVU:** 2.49 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 1.18 **2018 Fac PE RVU:** 1.18 **RUC Recommendation:** 2.59 **Referred to CPT** October 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

43242 Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis) **Global:** 000 **Issue:** EGD **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 11 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** October 2008 **2017 Est. Medicare Utilization:** 25,289 **2007 Work RVU:** 7.30 **2018 Work RVU:** 4.73 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 2.98 **2018 Fac PE RVU:** 2.98 **RUC Recommendation:** 5.39 **Referred to CPT** February 2013 **Referred to CPT Asst** ☒ **Published in CPT Asst:** Mar 2009 **Result:** Decrease

43243 Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 1,007 **2007 Work RVU:** 4.56 **2018 Work RVU:** 4.27 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 1.94 **2018 Fac PE RVU:** 1.94 **RUC Recommendation:** 4.37 **Referred to CPT** October 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

Status Report: CMS Requests and Relativity Assessment Issues

43244 Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent **Tab** 08 **Specialty Developing** AGA, ASGE, **First** **2017 Est.** **2007 Work RVU:** 5.04 **2018 Work RVU:** 4.40
RUC Meeting: January 2013 **Recommendation:** SAGES **Identified:** September 2011 **Medicare** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA
Utilization: 21,700 **2007 Fac PE RVU** 2.14 **2018 Fac PE RVU:**2.14
RUC Recommendation: 4.50 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43245 Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie) **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent **Tab** 08 **Specialty Developing** AGA, ASGE, **First** **2017 Est.** **2007 Work RVU:** 3.18 **2018 Work RVU:** 3.08
RUC Meeting: January 2013 **Recommendation:** SAGES **Identified:** September 2011 **Medicare** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA
Utilization: 15,165 **2007 Fac PE RVU** 1.39 **2018 Fac PE RVU:**1.39
RUC Recommendation: 3.18 **Referred to CPT** October 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43246 Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent **Tab** 11 **Specialty Developing** AGA, ASGE, **First** **2017 Est.** **2007 Work RVU:** 4.32 **2018 Work RVU:** 3.56
RUC Meeting: April 2013 **Recommendation:** SAGES **Identified:** September 2011 **Medicare** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA
Utilization: 81,957 **2007 Fac PE RVU** 1.8 **2018 Fac PE RVU:**1.8
RUC Recommendation: 4.32 **Referred to CPT** October 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43247 Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s) **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent **Tab** 08 **Specialty Developing** AGA, ASGE, **First** **2017 Est.** **2007 Work RVU:** 3.38 **2018 Work RVU:** 3.11
RUC Meeting: January 2013 **Recommendation:** SAGES **Identified:** September 2011 **Medicare** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA
Utilization: 28,840 **2007 Fac PE RVU** 1.48 **2018 Fac PE RVU:**1.48
RUC Recommendation: 3.27 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43248 Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent
RUC Meeting: January 2013

Tab 08

Specialty Developing
Recommendation:

AGA, ASGE,
SAGES

First
Identified: September 2011

2017 Est.
Medicare
Utilization: 110,596

2007 Work RVU: 3.15
2007 NF PE RVU: NA
2007 Fac PE RVU 1.43
Result: Decrease

2018 Work RVU: 2.91
2018 NF PE RVU: NA
2018 Fac PE RVU:1.43

RUC Recommendation: 3.01

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

43249 Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)

Global: 000 **Issue:** EGD

Screen: MPC List

Complete? Yes

Most Recent
RUC Meeting: January 2013

Tab 08

Specialty Developing
Recommendation:

AGA, ASGE,
SAGES

First
Identified: September 2011

2017 Est.
Medicare
Utilization: 114,903

2007 Work RVU: 2.90
2007 NF PE RVU: NA
2007 Fac PE RVU 1.32
Result: Decrease

2018 Work RVU: 2.67
2018 NF PE RVU: NA
2018 Fac PE RVU:1.32

RUC Recommendation: 2.77

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

43250 Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps

Global: 000 **Issue:** EGD

Screen: MPC List

Complete? Yes

Most Recent
RUC Meeting: January 2013

Tab 08

Specialty Developing
Recommendation:

AGA, ASGE,
SAGES

First
Identified: September 2011

2017 Est.
Medicare
Utilization: 4,475

2007 Work RVU: 3.20
2007 NF PE RVU: NA
2007 Fac PE RVU 1.4
Result: Decrease

2018 Work RVU: 2.97
2018 NF PE RVU: NA
2018 Fac PE RVU:1.4

RUC Recommendation: 3.07

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

43251 Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

Global: 000 **Issue:** EGD

Screen: MPC List

Complete? Yes

Most Recent
RUC Meeting: April 2013

Tab 11

Specialty Developing
Recommendation:

AGA, ASGE,
SAGES

First
Identified: September 2011

2017 Est.
Medicare
Utilization: 32,016

2007 Work RVU: 3.69
2007 NF PE RVU: NA
2007 Fac PE RVU 1.6
Result: Decrease

2018 Work RVU: 3.47
2018 NF PE RVU: NA
2018 Fac PE RVU:1.6

RUC Recommendation: 3.57

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43253	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)	Global: 000	Issue: EGD	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 11	Specialty Developing Recommendation: AGA, ASGE, SAGES	First Identified:	2017 Est. Medicare Utilization: 1,898	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease 2018 Work RVU: 4.73 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 5.39			Referred to CPT February 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
<hr/>					
43254	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection	Global: 000	Issue: EGD	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2013	Tab 08	Specialty Developing Recommendation: AGA, ASGE, SAGES	First Identified:	2017 Est. Medicare Utilization: 5,110	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease 2018 Work RVU: 4.87 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 5.25			Referred to CPT October 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
<hr/>					
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method	Global: 000	Issue: EGD	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2013	Tab 08	Specialty Developing Recommendation: AGA, ASGE, SAGES	First Identified: September 2011	2017 Est. Medicare Utilization: 60,113	2007 Work RVU: 4.81 2007 NF PE RVU: NA 2007 Fac PE RVU 2.05 Result: Decrease 2018 Work RVU: 3.56 2018 NF PE RVU: NA 2018 Fac PE RVU: 2.05
RUC Recommendation: 4.20			Referred to CPT October 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

43256 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic stent placement (includes predilation) **Global:** 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013

Tab 08

Specialty Developing Recommendation:

AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization:

2007 Work RVU: 4.34

2007 NF PE RVU: NA

2007 Fac PE RVU 1.85

Result: Deleted from CPT

2018 Work RVU:

2018 NF PE RVU: NA

2018 Fac PE RVU:1.85

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

43257 Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease

Global: 000

Issue: EGD

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: January 2013

Tab 08

Specialty Developing Recommendation:

AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 239

2007 Work RVU: 5.50

2007 NF PE RVU: NA

2007 Fac PE RVU 2.16

Result: Decrease

2018 Work RVU: 4.15

2018 NF PE RVU: NA

2018 Fac PE RVU:2.16

RUC Recommendation: 4.25

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

43258 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique

Global: 000

Issue: EGD

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: January 2013

Tab 08

Specialty Developing Recommendation:

AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization:

2007 Work RVU: 4.54

2007 NF PE RVU: NA

2007 Fac PE RVU 1.94

Result: Deleted from CPT

2018 Work RVU:

2018 NF PE RVU: NA

2018 Fac PE RVU:1.94

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43259	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis	Global: 000	Issue: EGD	Screen: CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 11	Specialty Developing Recommendation: AGA, ASGE, ACG	First Identified: October 2008	2017 Est. Medicare Utilization: 33,873	2007 Work RVU: 5.19 2007 NF PE RVU: NA 2007 Fac PE RVU: 2.17 2018 Work RVU: 4.04 2018 NF PE RVU: NA 2018 Fac PE RVU: 2.17
RUC Recommendation: 4.74			Referred to CPT February 2013 Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Mar 2009	Result: Decrease
43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	Global: 000	Issue: ERCP	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 12	Specialty Developing Recommendation: AGA, ASGE, SAGES	First Identified: September 2011	2017 Est. Medicare Utilization: 5,680	2007 Work RVU: 5.95 2007 NF PE RVU: NA 2007 Fac PE RVU: 2.49 2018 Work RVU: 5.85 2018 NF PE RVU: NA 2018 Fac PE RVU: 2.49
RUC Recommendation: 5.95			Referred to CPT February 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain
43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	Global: 000	Issue: ERCP	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 12	Specialty Developing Recommendation: AGA, ASGE, SAGES	First Identified: September 2011	2017 Est. Medicare Utilization: 8,114	2007 Work RVU: 6.26 2007 NF PE RVU: NA 2007 Fac PE RVU: 2.61 2018 Work RVU: 6.15 2018 NF PE RVU: NA 2018 Fac PE RVU: 2.61
RUC Recommendation: 6.25			Referred to CPT January 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

43262 Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy **Global:** 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 12 Specialty Developing Recommendation: AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 32,502

2007 Work RVU: 7.38

2018 Work RVU: 6.50

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.03

2018 Fac PE RVU:3.03

Result: Decrease

RUC Recommendation: 6.60

Referred to CPT January 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

43263 Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi **Global:** 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 12 Specialty Developing Recommendation: AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 169

2007 Work RVU: 7.28

2018 Work RVU: 6.50

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.02

2018 Fac PE RVU:3.02

Result: Maintain

RUC Recommendation: 7.28

Referred to CPT February 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

43264 Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s) **Global:** 000 **Issue:** ERCP **Screen:** Harvard Valued - Utilization over 30,000 / MPC List / Harvard-Valued Annual Allowed Charges Greater than \$10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 12 Specialty Developing Recommendation: AGA, ASGE, SAGES

First Identified: April 2011

2017 Est. Medicare Utilization: 52,622

2007 Work RVU: 8.89

2018 Work RVU: 6.63

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.61

2018 Fac PE RVU:3.61

Result: Decrease

RUC Recommendation: 6.73

Referred to CPT February 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43265 Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy) **Global:** 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 2,724

2007 Work RVU: 10.00

2018 Work RVU: 7.93

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 4.03

2018 Fac PE RVU: 4.03

Result: Decrease

RUC Recommendation: 8.03

Referred to CPT February 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

43266 Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)

Global: 000 **Issue:** EGD

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: January 2013

Tab 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES

First Identified:

2017 Est. Medicare Utilization: 5,382

2007 Work RVU:

2018 Work RVU: 3.92

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 4.40

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

43267 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube

Global: 000 **Issue:** ERCP

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: April 2013

Tab 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization:

2007 Work RVU: 7.38

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.01

2018 Fac PE RVU: 3.01

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43268 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct **Global:** 000 **Issue:** ERCP **Screen:** Harvard Valued - Utilization over 30,000 / MPC List **Complete?** Yes

Most Recent
RUC Meeting: April 2013

Tab 12

Specialty Developing
Recommendation: AGA, ASGE, SAGES

First Identified: April 2011

2017 Est. Medicare Utilization:

2007 Work RVU: 7.38

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.15

2018 Fac PE RVU:3.15

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

43269 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent **Global:** 000 **Issue:** ERCP

Screen: MPC List

Complete? Yes

Most Recent
RUC Meeting: April 2013

Tab 12

Specialty Developing
Recommendation: AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization:

2007 Work RVU: 8.20

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.35

2018 Fac PE RVU:3.35

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

43270 Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed) **Global:** 000 **Issue:** EGD

Screen: MPC List

Complete? Yes

Most Recent
RUC Meeting: January 2013

Tab 08

Specialty Developing
Recommendation: AGA, ASGE, SAGES

First Identified:

2017 Est. Medicare Utilization: 19,288

2007 Work RVU:

2018 Work RVU: 4.01

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 4.39

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43271 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s) **Global:** 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 12 Specialty Developing Recommendation: AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization:

2007 Work RVU: 7.38

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 3.03

2018 Fac PE RVU: 3.03

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

43272 Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique **Global:** 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 12 Specialty Developing Recommendation: AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization:

2007 Work RVU: 7.38

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 3.05

2018 Fac PE RVU: 3.05

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

43273 Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure) **Global:** ZZZ **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 12 Specialty Developing Recommendation: AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 7,595

2007 Work RVU:

2018 Work RVU: 2.24

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: 2.24

Referred to CPT February 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43274	Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent	Global: 000	Issue: ERCP	Screen: MPC List	Complete? Yes	
Most Recent RUC Meeting: April 2013	Tab 12	Specialty Developing Recommendation: AGA, ASGE, SAGES	First Identified: September 2011	2017 Est. Medicare Utilization: 41,004	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 8.48 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 8.74			Referred to CPT February 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
43275	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)	Global: 000	Issue: ERCP	Screen: MPC List	Complete? Yes	
Most Recent RUC Meeting: April 2013	Tab 12	Specialty Developing Recommendation: AGA, ASGE, SAGES	First Identified: September 2011	2017 Est. Medicare Utilization: 13,393	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 6.86 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 6.96			Referred to CPT February 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
43276	Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged	Global: 000	Issue: ERCP	Screen: MPC List	Complete? Yes	
Most Recent RUC Meeting: April 2013	Tab 12	Specialty Developing Recommendation: AGA, ASGE, SAGES	First Identified: September 2011	2017 Est. Medicare Utilization: 13,865	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 8.84 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 9.10			Referred to CPT February 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

43277 Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct **Global:** 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 12 Specialty Developing Recommendation: AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 6,237

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 6.90
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 7.11

Referred to CPT February 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

43278 Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed

Global: 000 **Issue:** ERCP

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: April 2013

Tab 12 Specialty Developing Recommendation: AGA, ASGE, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 488

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 7.92
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 8.08

Referred to CPT February 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

43450 Dilation of esophagus, by unguided sound or bougie, single or multiple passes **Global:** 000 **Issue:** Dilation of Esophagus

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: October 2012

Tab 17 Specialty Developing Recommendation: AGA, ASGE, SAGES, AAO-HNS

First Identified: September 2011

2017 Est. Medicare Utilization: 72,504

2007 Work RVU: 1.38
2007 NF PE RVU: 2.64
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 1.28
2018 NF PE RVU: 2.64
2018 Fac PE RVU: 0.75

RUC Recommendation: 1.30

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43453 Dilation of esophagus, over guide wire

Global: 000 **Issue:** Dilation of Esophagus

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: October 2012

Tab 17 Specialty Developing Recommendation: AGA, ASGE, SAGES, AAO-HNS

First Identified: September 2011

2017 Est. Medicare Utilization: 1,861

2007 Work RVU: 1.51
2007 NF PE RVU: 6.12
2007 Fac PE RVU Result: Maintain

2018 Work RVU: 1.41
2018 NF PE RVU: 6.12
2018 Fac PE RVU: 0.8

RUC Recommendation: 1.51

Referred to CPT May 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43456	Dilation of esophagus, by balloon or dilator, retrograde	Global: 000	Issue: Dilation of Esophagus	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: October 2012	Tab 17	Specialty Developing Recommendation: AGA, ASGE, SAGES, AAO-HNS	First Identified: September 2011	2017 Est. Medicare Utilization:	2007 Work RVU: 2.57 2007 NF PE RVU: 13.55 2007 Fac PE RVU: 1.2 Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT October 2012	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: 13.55 2018 Fac PE RVU: 1.2

43458	Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia	Global: 000	Issue: Dilation of Esophagus	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: October 2012	Tab 17	Specialty Developing Recommendation: AGA, ASGE, SAGES, AAO-HNS	First Identified: September 2011	2017 Est. Medicare Utilization:	2007 Work RVU: 3.06 2007 NF PE RVU: 6.72 2007 Fac PE RVU: 1.37 Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT October 2012	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: 6.72 2018 Fac PE RVU: 1.37

43760	Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance	Global: 000	Issue: Gastrostomy Tube Replacement	Screen: CMS 000-Day Global Typically Reported with an E/M	Complete? Yes
Most Recent RUC Meeting: January 2018	Tab 11	Specialty Developing Recommendation: ACEP, ACG, ACS, AGA, ASGE	First Identified: July 2016	2017 Est. Medicare Utilization: 54,095	2007 Work RVU: 1.10 2007 NF PE RVU: 4.77 2007 Fac PE RVU: 0.44 Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT September 2017	Published in CPT Asst:	2018 Work RVU: 0.90 2018 NF PE RVU: 4.77 2018 Fac PE RVU: 0.44

43X63		Global:	Issue: Gastrostomy Tube Replacement	Screen: CMS 000-Day Global Typically Reported with an E/M	Complete? Yes
Most Recent RUC Meeting: January 2018	Tab 11	Specialty Developing Recommendation: ACEP, ACG, ACS, AGA, ASGE	First Identified: September 2017	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Decrease
RUC Recommendation: 0.75. Flag for Re-review.			Referred to CPT	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:

Status Report: CMS Requests and Relativity Assessment Issues

43X64				Global:	Issue: Gastrostomy Tube Replacement	Screen: CMS 000-Day Global Typically Reported with an E/M	Complete?	Yes				
Most Recent RUC Meeting:	January 2018	Tab 11	Specialty Developing Recommendation:	ACEP, ACG, ACS, AGA, ASGE	First Identified:	September 2017	2017 Est. Medicare Utilization:	2007 Work RVU:	2018 Work RVU:			
								2007 NF PE RVU:	2018 NF PE RVU:			
								2007 Fac PE RVU Result:	2018 Fac PE RVU:			
RUC Recommendation:				1.41. Flag for Re-review.		Referred to CPT	Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:			
44143 Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)				Global:	090	Issue:	RAW	Screen:	High Level E/M in Global Period	Complete?	Yes	
Most Recent RUC Meeting:	January 2016	Tab 54	Specialty Developing Recommendation:		First Identified:	October 2015	2017 Est. Medicare Utilization:	10,236	2007 Work RVU:	27.63	2018 Work RVU:	27.79
									2007 NF PE RVU:	NA	2018 NF PE RVU:	NA
									2007 Fac PE RVU	10.6	2018 Fac PE RVU:	10.6
RUC Recommendation:				99214 visit appropriate. Remove from screen.		Referred to CPT	Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	Result:	Remove from screen	
44205 Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy				Global:	090	Issue:	Laprosopic Procedures	Screen:	CMS Fastest Growing	Complete?	Yes	
Most Recent RUC Meeting:	October 2008	Tab 26	Specialty Developing Recommendation:	ACS, ASCRS	First Identified:	October 2008	2017 Est. Medicare Utilization:	11,915	2007 Work RVU:	22.86	2018 Work RVU:	22.95
									2007 NF PE RVU:	NA	2018 NF PE RVU:	NA
									2007 Fac PE RVU	8.6	2018 Fac PE RVU:	8.6
RUC Recommendation:				Remove from screen		Referred to CPT	Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	Result:	Remove from Screen	

Status Report: CMS Requests and Relativity Assessment Issues

44207 Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) **Global:** 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** ACS, ASCRS **First Identified:** February 2008 **2017 Est. Medicare Utilization:** 9,270

2007 Work RVU: 31.79 **2018 Work RVU:** 31.92
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 11.17 **2018 Fac PE RVU:** 11.17
Result: Remove from Screen

RUC Recommendation: Remove from screen **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

44380 Ileoscopy, through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure) **Global:** 000 **Issue:** Ileoscopy
Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 2,119

2007 Work RVU: 1.05 **2018 Work RVU:** 0.87
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 0.6 **2018 Fac PE RVU:** 0.6
Result: Decrease

RUC Recommendation: 0.97 **Referred to CPT** May 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

44381 Ileoscopy, through stoma; with transendoscopic balloon dilation **Global:** 000 **Issue:** Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** May 2013 **2017 Est. Medicare Utilization:** 149

2007 Work RVU: **2018 Work RVU:** 1.38
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU: **2018 Fac PE RVU:**
Result: Decrease

RUC Recommendation: 1.48 **Referred to CPT** May 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

44382 Ileoscopy, through stoma; with biopsy, single or multiple **Global:** 000 **Issue:** Ileoscopy
Ileoscopy
Ileoscopy
Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 1,520

2007 Work RVU: 1.27 **2018 Work RVU:** 1.17
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 0.67 **2018 Fac PE RVU:** 0.67
Result: Maintain

RUC Recommendation: 1.27 **Referred to CPT** May 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44383	Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation)	Global: 000	Issue: Ileoscopy	Screen: MPC List	Complete? Yes
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Most Recent RUC Meeting: October 2013

Tab 04

Specialty Developing Recommendation:

AGA, ASGE, ACG

First Identified: September 2011

2017 Est. Medicare Utilization:

2007 Work RVU: 2.94

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 1.36

2018 Fac PE RVU:1.36

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT May 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

44384 Ileoscopy, through stoma; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)

Global: 000

Issue: Ileoscopy

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab 04

Specialty Developing Recommendation:

AGA, ASGE, ACG

First Identified: May 2013

2017 Est. Medicare Utilization: 114

2007 Work RVU:

2018 Work RVU: 2.85

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 3.11

Referred to CPT May 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

44385 Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or JJ]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

Global: 000

Issue: Pouchoscopy

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab 05

Specialty Developing Recommendation:

ACG, ACS, AGA, ASGE, ASCRS, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 1,359

2007 Work RVU: 1.82

2018 Work RVU: 1.20

2007 NF PE RVU: 3.73

2018 NF PE RVU: 3.73

2007 Fac PE RVU 0.79

2018 Fac PE RVU:0.79

Result: Decrease

RUC Recommendation: 1.30

Referred to CPT May 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44386 Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); with biopsy, single or multiple **Global:** 000 **Issue:** Pouchoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013

Tab 05

Specialty Developing Recommendation:

ACG, ACS, AGA, ASGE, ASCRS, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 1,583

2007 Work RVU: 2.12
2007 NF PE RVU: 6.66
2007 Fac PE RVU 0.93

2018 Work RVU: 1.50
2018 NF PE RVU: 6.66
2018 Fac PE RVU:0.93

RUC Recommendation: 1.60

Referred to CPT May 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

44388 Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

Global: 000

Issue: Colonoscopy through stoma

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: January 2014

Tab 08

Specialty Developing Recommendation:

ASCRS, ACS, SAGES, AGA, ASGE, ACG

First Identified: September 2011

2017 Est. Medicare Utilization: 4,398

2007 Work RVU: 2.82
2007 NF PE RVU: 5.34
2007 Fac PE RVU 1.21

2018 Work RVU: 2.72
2018 NF PE RVU: 5.34
2018 Fac PE RVU:1.21

RUC Recommendation: 2.82

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

44389 Colonoscopy through stoma; with biopsy, single or multiple

Global: 000

Issue: Colonoscopy through stoma

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: January 2014

Tab 08

Specialty Developing Recommendation:

ASCRS, ACS, SAGES, AGA, ASGE, ACG

First Identified: September 2011

2017 Est. Medicare Utilization: 2,501

2007 Work RVU: 3.13
2007 NF PE RVU: 6.73
2007 Fac PE RVU 1.35

2018 Work RVU: 3.02
2018 NF PE RVU: 6.73
2018 Fac PE RVU:1.35

RUC Recommendation: 3.12

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

44390	Colonoscopy through stoma; with removal of foreign body(s)	Global: 000	Issue: Colonoscopy through stoma	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 08 Specialty Developing Recommendation: ASCRS, ACS, SAGES, AGA, ASGE, ACG	First Identified: September 2011	2017 Est. Medicare Utilization: 34	2007 Work RVU: 3.82 2007 NF PE RVU: 7.32 2007 Fac PE RVU: 1.57	2018 Work RVU: 3.74 2018 NF PE RVU: 7.32 2018 Fac PE RVU: 1.57
RUC Recommendation: 3.82		Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain	
44391	Colonoscopy through stoma; with control of bleeding, any method	Global: 000	Issue: Colonoscopy through stoma	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 08 Specialty Developing Recommendation: ASCRS, ACS, SAGES, AGA, ASGE, ACG	First Identified: September 2011	2017 Est. Medicare Utilization: 169	2007 Work RVU: 4.31 2007 NF PE RVU: 8.78 2007 Fac PE RVU: 1.83	2018 Work RVU: 4.12 2018 NF PE RVU: 8.78 2018 Fac PE RVU: 1.83
RUC Recommendation: 4.22		Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease	
44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	Global: 000	Issue: Colonoscopy through stoma	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 08 Specialty Developing Recommendation: ASCRS, ACS, SAGES, AGA, ASGE, ACG	First Identified: September 2011	2017 Est. Medicare Utilization: 412	2007 Work RVU: 3.81 2007 NF PE RVU: 6.78 2007 Fac PE RVU: 1.55	2018 Work RVU: 3.53 2018 NF PE RVU: 6.78 2018 Fac PE RVU: 1.55
RUC Recommendation: 3.63		Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease	

Status Report: CMS Requests and Relativity Assessment Issues

44393 Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique **Global:** 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014

Tab 08

Specialty Developing Recommendation:

ASCRS,
ACS,
SAGES,
AGA, ASGE,
ACG

First Identified: September 2011

2017 Est. Medicare Utilization:

2007 Work RVU: 4.83
2007 NF PE RVU: 7.14
2007 Fac PE RVU 1.91

2018 Work RVU:
2018 NF PE RVU: 7.14
2018 Fac PE RVU:1.91

RUC Recommendation: Deleted from CPT

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

44394 Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique **Global:** 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014

Tab 08

Specialty Developing Recommendation:

ASCRS,
ACS,
SAGES,
AGA, ASGE,
ACG

First Identified: September 2011

2017 Est. Medicare Utilization: 1,720

2007 Work RVU: 4.42
2007 NF PE RVU: 7.97
2007 Fac PE RVU 1.81

2018 Work RVU: 4.03
2018 NF PE RVU: 7.97
2018 Fac PE RVU:1.81

RUC Recommendation: 4.13

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

44397 Colonoscopy through stoma; with transendoscopic stent placement (includes predilation) **Global:** 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014

Tab 08

Specialty Developing Recommendation:

ASCRS,
ACS,
SAGES,
AGA, ASGE,
ACG

First Identified: September 2011

2017 Est. Medicare Utilization:

2007 Work RVU: 4.70
2007 NF PE RVU: NA
2007 Fac PE RVU 1.93

2018 Work RVU:
2018 NF PE RVU: NA
2018 Fac PE RVU:1.93

RUC Recommendation: Deleted from CPT

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

44401 Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed) **Global:** 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014

Tab 08

Specialty Developing Recommendation:

ASCRS, ACS, SAGES, AGA, ASGE, ACG

First Identified: September 2011

2017 Est. Medicare Utilization: 64

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 4.34
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.44

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

44402 Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed) **Global:** 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014

Tab 08

Specialty Developing Recommendation:

ASCRS, ACS, SAGES, AGA, ASGE, ACG

First Identified: January 2014

2017 Est. Medicare Utilization: 14

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 4.70
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.96

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

44403 Colonoscopy through stoma; with endoscopic mucosal resection **Global:** 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014

Tab 08

Specialty Developing Recommendation:

ASCRS, ACS, SAGES, AGA, ASGE, ACG

First Identified: January 2014

2017 Est. Medicare Utilization: 63

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 5.50
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 5.81

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

44404 Colonoscopy through stoma; with directed submucosal injection(s), any substance **Global:** 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014

Tab 08

Specialty Developing Recommendation:

ASCRS,
ACS,
SAGES,
AGA, ASGE,
ACG

First Identified: January 2014

2017 Est. Medicare Utilization: 180

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 3.02
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 3.13

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

44405 Colonoscopy through stoma; with transendoscopic balloon dilation

Global: 000

Issue: Colonoscopy through stoma

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: January 2014

Tab 08

Specialty Developing Recommendation:

ASCRS,
ACS,
SAGES,
AGA, ASGE,
ACG

First Identified: January 2014

2017 Est. Medicare Utilization: 49

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 3.23
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 3.33

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

44406 Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures

Global: 000

Issue: Colonoscopy through stoma

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: January 2014

Tab 08

Specialty Developing Recommendation:

ASCRS,
ACS,
SAGES,
AGA, ASGE,
ACG

First Identified: January 2014

2017 Est. Medicare Utilization: 4

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 4.10
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.41

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

44407 Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures **Global:** 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014

Tab 08

Specialty Developing Recommendation:

ASCRS,
ACS,
SAGES,
AGA, ASGE,
ACG

First Identified: January 2014

2017 Est. Medicare Utilization: 1

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 4.96
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 5.06

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

44408 Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed **Global:** 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014

Tab 08

Specialty Developing Recommendation:

ASCRS,
ACS,
SAGES,
AGA, ASGE,
ACG

First Identified: January 2014

2017 Est. Medicare Utilization: 60

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 4.14
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.24

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

44901 Incision and drainage of appendiceal abscess; percutaneous **Global:** 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013

Tab 04

Specialty Developing Recommendation:

First Identified: January 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 3.37
2007 NF PE RVU: 25.61
2007 Fac PE RVU 1.07

2018 Work RVU:
2018 NF PE RVU: 25.61
2018 Fac PE RVU: 1.07

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

44970 Laparoscopy, surgical, appendectomy

Global: 090

Issue: Laproscopic Procedures

Screen: CMS Fastest Growing

Complete? Yes

Most Recent
RUC Meeting: October 2008

Tab 26

Specialty Developing
Recommendation: ACS

First
Identified: October 2008

2017 Est.
Medicare
Utilization: 21,428

2007 Work RVU: 9.35

2018 Work RVU: 9.45

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 4.11

2018 Fac PE RVU:4.11

Result: Remove from Screen

RUC Recommendation: Remove from screen

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

45170 Deleted from CPT

Global: 090

Issue: Rectal Tumor Excision

Screen: Site of Service Anomaly

Complete? Yes

Most Recent
RUC Meeting: February 2009

Tab 11

Specialty Developing
Recommendation: ACS,
ASCRS,
ASGS

First
Identified: September 2007

2017 Est.
Medicare
Utilization:

2007 Work RVU: 12.48

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 5.28

2018 Fac PE RVU:5.28

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2008

Referred to CPT Asst ☐

Published in CPT Asst:

45171 Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)

Global: 090

Issue: Rectal Tumor Excision

Screen: Site of Service Anomaly

Complete? Yes

Most Recent
RUC Meeting: February 2009

Tab 11

Specialty Developing
Recommendation: ACS,
ASCRS,
ASGS

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 2,646

2007 Work RVU:

2018 Work RVU: 8.13

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 8.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

45172 Excision of rectal tumor, transanal approach; including muscularis propria (ie, full thickness)

Global: 090

Issue: Rectal Tumor Excision

Screen: Site of Service Anomaly

Complete? Yes

Most Recent
RUC Meeting: February 2009

Tab 11

Specialty Developing
Recommendation: ACS,
ASCRS,
ASGS

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 2,140

2007 Work RVU:

2018 Work RVU: 12.13

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 12.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

45300 Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) **Global:** 000 **Issue:** Diagnostic Proctosigmoidoscopy - Rigid **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017

Tab 13

Specialty Developing Recommendation:

ACS, ASCRS, SAGES

First Identified: July 2016

2017 Est. Medicare Utilization: 27,742

2007 Work RVU: 0.38

2018 Work RVU: 0.80

2007 NF PE RVU: 1.63

2018 NF PE RVU: 1.63

2007 Fac PE RVU 0.3

2018 Fac PE RVU:0.3

Result: Maintain

RUC Recommendation: 0.80

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

45330 Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

Global: 000

Issue: Flexible Sigmoidoscopy

Screen: Harvard Valued - Utilization over 30,000 / MPC List

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab 06

Specialty Developing Recommendation:

ACG, ACS, AGA, ASGE, ASCRS, SAGES

First Identified: April 2011

2017 Est. Medicare Utilization: 54,322

2007 Work RVU: 0.96

2018 Work RVU: 0.84

2007 NF PE RVU: 2.33

2018 NF PE RVU: 2.33

2007 Fac PE RVU 0.53

2018 Fac PE RVU:0.53

Result: Decrease

RUC Recommendation: 0.84

Referred to CPT May 2013

Referred to CPT Asst ☐

Published in CPT Asst:

45331 Sigmoidoscopy, flexible; with biopsy, single or multiple

Global: 000

Issue: Flexible Sigmoidoscopy

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab 06

Specialty Developing Recommendation:

ACG, ACS, AGA, ASGE, ASCRS, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 36,331

2007 Work RVU: 1.15

2018 Work RVU: 1.14

2007 NF PE RVU: 3.11

2018 NF PE RVU: 3.11

2007 Fac PE RVU 0.64

2018 Fac PE RVU:0.64

Result: Decrease

RUC Recommendation: 1.14

Referred to CPT May 2013

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

45332 Sigmoidoscopy, flexible; with removal of foreign body(s) **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013	Tab 06	Specialty Developing Recommendation: ACG, ACS, AGA, ASGE, ASCRS, SAGES	First Identified: September 2011	2017 Est. Medicare Utilization: 314	2007 Work RVU: 1.79 2007 NF PE RVU: 5.15 2007 Fac PE RVU 0.86	2018 Work RVU: 1.76 2018 NF PE RVU: 5.15 2018 Fac PE RVU: 0.86
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RUC Recommendation: 1.85

Referred to CPT May 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

45333 Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013	Tab 06	Specialty Developing Recommendation: ACG, ACS, AGA, ASGE, ASCRS, SAGES	First Identified: September 2011	2017 Est. Medicare Utilization: 1,052	2007 Work RVU: 1.79 2007 NF PE RVU: 5.06 2007 Fac PE RVU 0.85	2018 Work RVU: 1.55 2018 NF PE RVU: 5.06 2018 Fac PE RVU: 0.85
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RUC Recommendation: 1.65

Referred to CPT May 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

45334 Sigmoidoscopy, flexible; with control of bleeding, any method **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013	Tab 06	Specialty Developing Recommendation: ACG, ACS, AGA, ASGE, ASCRS, SAGES	First Identified: September 2011	2017 Est. Medicare Utilization: 3,274	2007 Work RVU: 2.73 2007 NF PE RVU: NA 2007 Fac PE RVU 1.24	2018 Work RVU: 2.00 2018 NF PE RVU: NA 2018 Fac PE RVU: 1.24
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RUC Recommendation: 2.10

Referred to CPT May 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

45335 Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent **Tab** 06 **Specialty Developing** ACG, ACS, **First** **2017 Est.** **2007 Work RVU:** 1.46 **2018 Work RVU:** 1.04
RUC Meeting: October 2013 **Recommendation:** AGA, ASGE, **Identified:** September 2011 **Medicare** **2007 NF PE RVU:** 3.74 **2018 NF PE RVU:** 3.74
 ASCRS, **Utilization:** 3,140 **2007 Fac PE RVU** 0.75 **2018 Fac PE RVU:**0.75
 SAGES

RUC Recommendation: 1.15

Referred to CPT May 2013

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

45337 Sigmoidoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent **Tab** 06 **Specialty Developing** ACG, ACS, **First** **2017 Est.** **2007 Work RVU:** 2.36 **2018 Work RVU:** 2.10
RUC Meeting: October 2013 **Recommendation:** AGA, ASGE, **Identified:** September 2011 **Medicare** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA
 ASCRS, **Utilization:** 1,385 **2007 Fac PE RVU** 1.06 **2018 Fac PE RVU:**1.06
 SAGES

RUC Recommendation: 2.20

Referred to CPT May 2013

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

45338 Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent **Tab** 06 **Specialty Developing** ACG, ACS, **First** **2017 Est.** **2007 Work RVU:** 2.34 **2018 Work RVU:** 2.05
RUC Meeting: October 2013 **Recommendation:** AGA, ASGE, **Identified:** September 2011 **Medicare** **2007 NF PE RVU:** 5.37 **2018 NF PE RVU:** 5.37
 ASCRS, **Utilization:** 4,884 **2007 Fac PE RVU** 1.07 **2018 Fac PE RVU:**1.07
 SAGES

RUC Recommendation: 2.15

Referred to CPT May 2013

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45339 Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 3.14 **2018 Work RVU:** **2007 NF PE RVU:** 4.03 **2018 NF PE RVU:** 4.03 **2007 Fac PE RVU:** 1.38 **2018 Fac PE RVU:** 1.38

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45340 Sigmoidoscopy, flexible; with transendoscopic balloon dilation **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 1,308 **2007 Work RVU:** 1.89 **2018 Work RVU:** 1.25 **2007 NF PE RVU:** 7.18 **2018 NF PE RVU:** 7.18 **2007 Fac PE RVU:** 0.89 **2018 Fac PE RVU:** 0.89

RUC Recommendation: 1.35 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45341 Sigmoidoscopy, flexible; with endoscopic ultrasound examination **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 09 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 3,199 **2007 Work RVU:** 2.60 **2018 Work RVU:** 2.12 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 1.17 **2018 Fac PE RVU:** 1.17

RUC Recommendation: 2.43 **Referred to CPT** October 2013 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45342 Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or Global: 000 Issue: Flexible Sigmoidoscopy Screen: MPC List Complete? Yes
transmural fine needle aspiration/biopsy(s)

Most Recent Tab 09 Specialty Developing AGA, ASGE, First 2017 Est. 2007 Work RVU: 4.05 2018 Work RVU: 2.98
RUC Meeting: January 2014 Recommendation: ACG, Identified: September 2011 Medicare 2007 NF PE RVU: NA 2018 NF PE RVU: NA
ASCERS, Utilization: 429 2007 Fac PE RVU 1.71 2018 Fac PE RVU:1.71
SAGES, ACS

RUC Recommendation: 3.08

Referred to CPT October 2013

Result: Decrease

Referred to CPT Asst ☐ Published in CPT Asst:

45345 Sigmoidoscopy, flexible; with transendoscopic stent placement (includes Global: 000 Issue: Flexible Sigmoidoscopy Screen: MPC List Complete? Yes
predilation)

Most Recent Tab 06 Specialty Developing ACG, ACS, First 2017 Est. 2007 Work RVU: 2.92 2018 Work RVU:
RUC Meeting: October 2013 Recommendation: AGA, ASGE, Identified: September 2011 Medicare 2007 NF PE RVU: NA 2018 NF PE RVU: NA
ASCERS, Utilization: 2007 Fac PE RVU 1.26 2018 Fac PE RVU:1.26
SAGES

RUC Recommendation: Deleted from CPT

Referred to CPT May 2013

Result: Deleted from CPT

Referred to CPT Asst ☐ Published in CPT Asst:

45346 Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) Global: 000 Issue: Flexible Sigmoidoscopy Screen: MPC List Complete? Yes
(includes pre- and post-dilation and guide wire passage, when performed)

Most Recent Tab 06 Specialty Developing ACG, ACS, First 2017 Est. 2007 Work RVU: 2.81
RUC Meeting: October 2013 Recommendation: AGA, ASGE, Identified: Medicare 2007 NF PE RVU: 2018 NF PE RVU:
ASCERS, Utilization: 1,111 2007 Fac PE RVU 2018 Fac PE RVU:
SAGES

RUC Recommendation: 2.97

Referred to CPT May 2013

Result: Decrease

Referred to CPT Asst ☐ Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

45347	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	Global: 000	Issue: Flexible Sigmoidoscopy	Screen: MPC List	Complete? Yes
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Most Recent RUC Meeting: October 2013

Tab 06

Specialty Developing Recommendation:

ACG, ACS, AGA, ASGE, ASCRS, SAGES

First Identified:

2017 Est. Medicare Utilization: 616

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 2.72
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 2.98

Referred to CPT May 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

45349 Sigmoidoscopy, flexible; with endoscopic mucosal resection

Global: 000

Issue: Flexible Sigmoidoscopy

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: April 2014

Tab 13

Specialty Developing Recommendation:

AGA, ASGE, ACG, ASCRS, SAGES, ACS

First Identified: January 2014

2017 Est. Medicare Utilization: 501

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 3.52
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 3.83

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

45350 Sigmoidoscopy, flexible; with band ligation(s) (eg, hemorrhoids)

Global: 000

Issue: Flexible Sigmoidoscopy

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: April 2014

Tab 13

Specialty Developing Recommendation:

AGA, ASGE, ACG, ASCRS, SAGES, ACS

First Identified: January 2014

2017 Est. Medicare Utilization: 1,038

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 1.68
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.78

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

45355 Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple **Global:** 000 **Issue:** Colonoscopy via stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014	Tab 08	Specialty Developing Recommendation: AGA, ASGE, ACG, ASCRS, SAGES, ACS	First Identified: September 2011	2017 Est. Medicare Utilization:	2007 Work RVU: 3.51	2018 Work RVU:
					2007 NF PE RVU: NA	2018 NF PE RVU: NA
					2007 Fac PE RVU 1.43	2018 Fac PE RVU: 1.43

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45378 Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure) **Global:** 000 **Issue:** Colonoscopy **Screen:** CMS High Expenditure Procedural Codes1 / MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014	Tab 10	Specialty Developing Recommendation: AGA, ASGE, ACG, ASCRS, ACS, SAGES	First Identified: September 2011	2017 Est. Medicare Utilization: 398,625	2007 Work RVU: 3.69	2018 Work RVU: 3.26
					2007 NF PE RVU: 6.20	2018 NF PE RVU: 6.20
					2007 Fac PE RVU 1.57	2018 Fac PE RVU: 1.57

RUC Recommendation: 3.36 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45379 Colonoscopy, flexible; with removal of foreign body(s) **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014	Tab 10	Specialty Developing Recommendation: AGA, ASGE, ACG, ASCRS, ACS, SAGES	First Identified: September 2011	2017 Est. Medicare Utilization: 892	2007 Work RVU: 4.68	2018 Work RVU: 4.28
					2007 NF PE RVU: 7.78	2018 NF PE RVU: 7.78
					2007 Fac PE RVU 1.92	2018 Fac PE RVU: 1.92

RUC Recommendation: 4.37 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45380	Colonoscopy, flexible; with biopsy, single or multiple	Global: 000	Issue: Colonoscopy	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 10	Specialty Developing Recommendation: AGA, ASGE, ACG, ASCRS, ACS, SAGES	First Identified: October 2010	2017 Est. Medicare Utilization: 1,038,308	2007 Work RVU: 4.43 2007 NF PE RVU: 7.33 2007 Fac PE RVU: 1.87 2018 Work RVU: 3.56 2018 NF PE RVU: 7.33 2018 Fac PE RVU: 1.87
RUC Recommendation: 3.66			Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease

45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance	Global: 000	Issue: Colonoscopy	Screen: CMS Fastest Growing / MPC List / Codes Reported Together 75%or More-Part4	Complete? Yes
Most Recent RUC Meeting: January 2018	Tab 31	Specialty Developing Recommendation: AGA, ASGE, ACG, ASCRS, ACS, SAGES	First Identified: October 2008	2017 Est. Medicare Utilization: 80,245	2007 Work RVU: 4.19 2007 NF PE RVU: 7.26 2007 Fac PE RVU: 1.79 2018 Work RVU: 3.56 2018 NF PE RVU: 7.26 2018 Fac PE RVU: 1.79
RUC Recommendation: 3.67			Referred to CPT October 2013 Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Jun 2010	Result: Decrease

45382	Colonoscopy, flexible; with control of bleeding, any method	Global: 000	Issue: Colonoscopy	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 10	Specialty Developing Recommendation: AGA, ASGE, ACG, ASCRS, ACS, SAGES	First Identified: September 2011	2017 Est. Medicare Utilization: 24,211	2007 Work RVU: 5.68 2007 NF PE RVU: 10.04 2007 Fac PE RVU: 2.37 2018 Work RVU: 4.66 2018 NF PE RVU: 10.04 2018 Fac PE RVU: 2.37
RUC Recommendation: 4.76			Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

45383 Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014

Tab 10

Specialty Developing Recommendation:

AGA, ASGE, ACG, ASCRS, ACS, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization:

2007 Work RVU: 5.86

2007 NF PE RVU: 8.08

2007 Fac PE RVU 2.34

2018 Work RVU:

2018 NF PE RVU: 8.08

2018 Fac PE RVU:2.34

RUC Recommendation: Deleted from CPT

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

45384 Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014

Tab 10

Specialty Developing Recommendation:

AGA, ASGE, ACG, ASCRS, ACS, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 103,201

2007 Work RVU: 4.69

2007 NF PE RVU: 6.9

2007 Fac PE RVU 1.93

2018 Work RVU: 4.07

2018 NF PE RVU: 6.9

2018 Fac PE RVU:1.93

RUC Recommendation: 4.17

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

45385 Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List / Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2018

Tab 31

Specialty Developing Recommendation:

AGA, ASGE, ACG, ASCRS, ACS, SAGES

First Identified: October 2010

2017 Est. Medicare Utilization: 881,753

2007 Work RVU: 5.30

2007 NF PE RVU: 7.94

2007 Fac PE RVU 2.18

2018 Work RVU: 4.57

2018 NF PE RVU: 7.94

2018 Fac PE RVU:2.18

RUC Recommendation: 4.67

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

45386	Colonoscopy, flexible; with transendoscopic balloon dilation	Global: 000	Issue: Colonoscopy	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 10	Specialty Developing Recommendation: AGA, ASGE, ACG, ASCRS, ACS, SAGES	First Identified: September 2011	2017 Est. Medicare Utilization: 2,165	2007 Work RVU: 4.57 2007 NF PE RVU: 12.37 2007 Fac PE RVU: 1.89 2018 Work RVU: 3.77 2018 NF PE RVU: 12.37 2018 Fac PE RVU: 1.89
RUC Recommendation: 3.87			Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease

45387	Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)	Global: 000	Issue: Colonoscopy	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 10	Specialty Developing Recommendation: AGA, ASGE, ACG, ASCRS, ACS, SAGES	First Identified: September 2011	2017 Est. Medicare Utilization:	2007 Work RVU: 5.90 2007 NF PE RVU: NA 2007 Fac PE RVU: 2.49 2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 2.49
RUC Recommendation: Deleted from CPT			Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Deleted from CPT

45388	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	Global: 000	Issue: Colonoscopy	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 10	Specialty Developing Recommendation: AGA, ASGE, ACG, ASCRS, ACS, SAGES	First Identified: January 2014	2017 Est. Medicare Utilization: 29,540	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: 2018 Work RVU: 4.88 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 4.98			Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

45389 Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed) **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014

Tab 10

Specialty Developing Recommendation:

AGA, ASGE, ACG, ASCRS, ACS, SAGES

First Identified: January 2014

2017 Est. Medicare Utilization: 489

2007 Work RVU:

2007 NF PE RVU:

2007 Fac PE RVU

2018 Work RVU: 5.24

2018 NF PE RVU:

2018 Fac PE RVU:

RUC Recommendation: 5.50

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

45390 Colonoscopy, flexible; with endoscopic mucosal resection

Global: 000

Issue: Colonoscopy

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: January 2014

Tab 10

Specialty Developing Recommendation:

AGA, ASGE, ACG, ASCRS, ACS, SAGES

First Identified: January 2014

2017 Est. Medicare Utilization: 15,874

2007 Work RVU:

2007 NF PE RVU:

2007 Fac PE RVU

2018 Work RVU: 6.04

2018 NF PE RVU:

2018 Fac PE RVU:

RUC Recommendation: 6.35

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

45391 Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures

Global: 000

Issue: Colonoscopy

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: January 2014

Tab 10

Specialty Developing Recommendation:

AGA, ASGE, ACG, ASCRS, ACS, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 922

2007 Work RVU: 5.09

2007 NF PE RVU: NA

2007 Fac PE RVU 2.13

2018 Work RVU: 4.64

2018 NF PE RVU: NA

2018 Fac PE RVU: 2.13

RUC Recommendation: 4.95

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

45392	Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures	Global: 000	Issue: Colonoscopy	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 10	Specialty Developing Recommendation: AGA, ASGE, ACG, ASCRS, ACS, SAGES	First Identified: September 2011	2017 Est. Medicare Utilization: 172	2007 Work RVU: 6.54 2007 NF PE RVU: NA 2007 Fac PE RVU: 2.65 2018 Work RVU: 5.50 2018 NF PE RVU: NA 2018 Fac PE RVU: 2.65
RUC Recommendation: 5.60			Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:	Result: Decrease	
45393	Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed	Global: 000	Issue: Colonoscopy	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 10	Specialty Developing Recommendation: AGA, ASGE, ACG, ASCRS, ACS, SAGES	First Identified: January 2014	2017 Est. Medicare Utilization: 2,026	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: 2018 Work RVU: 4.68 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 4.78			Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:	Result: Decrease	
45398	Colonoscopy, flexible; with band ligation(s) (eg, hemorrhoids)	Global: 000	Issue: Colonoscopy	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 10	Specialty Developing Recommendation: AGA, ASGE, ACG, ASCRS, ACS, SAGES	First Identified: January 2014	2017 Est. Medicare Utilization: 2,788	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: 2018 Work RVU: 4.20 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 4.30			Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:	Result: Decrease	

Status Report: CMS Requests and Relativity Assessment Issues

46200 Fissurectomy, including sphincterotomy, when performed

Global: 090

Issue: Fissurectomy

Screen: Site of Service Anomaly
(99238-Only)

Complete? Yes

Most Recent **Tab** 16 **Specialty Developing** ACS
RUC Meeting: September 2007 **Recommendation:**

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 1,064

2007 Work RVU: 3.48

2018 Work RVU: 3.59

2007 NF PE RVU: 4.46

2018 NF PE RVU: 4.46

2007 Fac PE RVU 3.08

2018 Fac PE RVU:3.08

Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

46500 Injection of sclerosing solution, hemorrhoids

Global: 010

Issue: Hemorrhoid Injection

Screen: 010-Day Global Post-
Operative Visits /
Negative IWPUT

Complete? Yes

Most Recent **Tab** 24 **Specialty Developing** ACS, ASCRS
RUC Meeting: January 2018 **Recommendation:** (colon)

First
Identified: January 2014

2017 Est.
Medicare
Utilization: 13,188

2007 Work RVU: 1.64

2018 Work RVU: 1.42

2007 NF PE RVU: 2.48

2018 NF PE RVU: 2.48

2007 Fac PE RVU 1.18

2018 Fac PE RVU:1.18

Result: Increase

RUC Recommendation: 2.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

47011 Hepatotomy; for percutaneous drainage of abscess or cyst, 1 or 2 stages

Global: 000

Issue: Drainage of Abscess

Screen: Codes Reported
Together 75% or More-
Part2

Complete? Yes

Most Recent **Tab** 04 **Specialty Developing**
RUC Meeting: January 2013 **Recommendation:**

First
Identified: January 2012

2017 Est.
Medicare
Utilization:

2007 Work RVU: 3.69

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 1.17

2018 Fac PE RVU:1.17

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

47135	Liver allotransplantation, orthotopic, partial or whole, from cadaver or living donor, any age	Global: 090	Issue: Liver Allotransplantation	Screen: 090-Day Global Post-Operative Visits	Complete? Yes
Most Recent RUC Meeting: September 2014	Tab 14	Specialty Developing Recommendation: ACS, ASTS	First Identified: January 2014	2017 Est. Medicare Utilization: 1,514	2007 Work RVU: 83.29 2007 NF PE RVU: NA 2007 Fac PE RVU: 30.59 Result: Increase
RUC Recommendation: 91.78			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 90.00 2018 NF PE RVU: NA 2018 Fac PE RVU: 30.59

47136	Liver allotransplantation; heterotopic, partial or whole, from cadaver or living donor, any age	Global: 090	Issue: RAW	Screen: 090-Day Global Post-Operative Visits	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 52	Specialty Developing Recommendation: ACS, ASTS	First Identified: April 2014	2017 Est. Medicare Utilization:	2007 Work RVU: 70.39 2007 NF PE RVU: NA 2007 Fac PE RVU: 26.2 Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT October 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 26.2

47382	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	Global: 010	Issue: Interventional Radiology Procedures	Screen: CMS Request - Practice Expense Review	Complete? Yes
Most Recent RUC Meeting: October 2008	Tab 13	Specialty Developing Recommendation: ACR, SIR	First Identified: NA	2017 Est. Medicare Utilization: 2,941	2007 Work RVU: 15.19 2007 NF PE RVU: NA 2007 Fac PE RVU: 5.83 Result: PE Only
RUC Recommendation: New PE Inputs			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 14.97 2018 NF PE RVU: NA 2018 Fac PE RVU: 5.83

Status Report: CMS Requests and Relativity Assessment Issues

47490 Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation **Global:** 010 **Issue:** Cholecystostomy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent **Tab** 04 **Specialty Developing** ACR
RUC Meeting: October 2009 **Recommendation:**

First Identified: October 2008 **2017 Est. Medicare Utilization:** 11,639

2007 Work RVU: 8.05 **2018 Work RVU:** 4.76
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 5.32 **2018 Fac PE RVU:**5.32
Result: Decrease

RUC Recommendation: 4.76

Referred to CPT June 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

47500 Injection procedure for percutaneous transhepatic cholangiography **Global:** 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent **Tab** 06 **Specialty Developing** ACR, SIR
RUC Meeting: October 2015 **Recommendation:**

First Identified: October 2012 **2017 Est. Medicare Utilization:**

2007 Work RVU: 1.96 **2018 Work RVU:**
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 0.62 **2018 Fac PE RVU:**0.62
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

47505 Injection procedure for cholangiography through an existing catheter (eg, percutaneous transhepatic or T-tube) **Global:** 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent **Tab** 06 **Specialty Developing** ACR, SIR
RUC Meeting: October 2015 **Recommendation:**

First Identified: October 2012 **2017 Est. Medicare Utilization:**

2007 Work RVU: 0.76 **2018 Work RVU:**
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 0.24 **2018 Fac PE RVU:**0.24
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47510 Introduction of percutaneous transhepatic catheter for biliary drainage **Global:** 090 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent **Tab** 06 **Specialty Developing** ACR, SIR
RUC Meeting: October 2015 **Recommendation:**

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 7.94

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 4.76

2018 Fac PE RVU:4.76

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

47511 Introduction of percutaneous transhepatic stent for internal and external biliary drainage **Global:** 090 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent **Tab** 06 **Specialty Developing** ACR, SIR
RUC Meeting: October 2015 **Recommendation:**

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 10.74

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 4.87

2018 Fac PE RVU:4.87

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

47525 Change of percutaneous biliary drainage catheter **Global:** 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** High IWPUT **Complete?** Yes

Most Recent **Tab** 06 **Specialty Developing** ACR, SIR
RUC Meeting: October 2015 **Recommendation:**

First Identified: February 2008

2017 Est. Medicare Utilization:

2007 Work RVU: 5.55

2018 Work RVU:

2007 NF PE RVU: 14.8

2018 NF PE RVU: 14.8

2007 Fac PE RVU 2.67

2018 Fac PE RVU:2.67

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

47530 Revision and/or reinsertion of transhepatic tube

Global: 090

Issue: Percutaneous Biliary Procedures Bundling

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 06

Specialty Developing Recommendation: ACR, SIR

First Identified: February 2015

2017 Est. Medicare Utilization:

2007 Work RVU: 5.96

2018 Work RVU:

2007 NF PE RVU: 32.56

2018 NF PE RVU: 32.56

2007 Fac PE RVU 3.53

2018 Fac PE RVU: 3.53

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

47531 Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; existing access

Global: 000

Issue: Percutaneous Biliary Procedures Bundling

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 04

Specialty Developing Recommendation: ACR, SIR

First Identified: February 2015

2017 Est. Medicare Utilization: 8,528

2007 Work RVU:

2018 Work RVU: 1.30

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 1.30

Referred to CPT February 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

47532 Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access (eg, percutaneous transhepatic cholangiogram)

Global: 000

Issue: Percutaneous Biliary Procedures Bundling

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 04

Specialty Developing Recommendation: ACR, SIR

First Identified: February 2015

2017 Est. Medicare Utilization: 703

2007 Work RVU:

2018 Work RVU: 4.25

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 4.50

Referred to CPT February 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47533	Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; external	Global: 000	Issue: Percutaneous Biliary Procedures Bundling	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 04 Specialty Developing Recommendation: ACR, SIR	First Identified: February 2015	2017 Est. Medicare Utilization: 1,637	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase	2018 Work RVU: 5.38 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 5.63		Referred to CPT February 2015 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
47534	Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; internal-external	Global: 000	Issue: Percutaneous Biliary Procedures Bundling	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 04 Specialty Developing Recommendation: ACR, SIR	First Identified: February 2015	2017 Est. Medicare Utilization: 4,432	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase	2018 Work RVU: 7.60 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 7.85		Referred to CPT February 2015 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
47535	Conversion of external biliary drainage catheter to internal-external biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation	Global: 000	Issue: Percutaneous Biliary Procedures Bundling	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 04 Specialty Developing Recommendation: ACR, SIR	First Identified: February 2015	2017 Est. Medicare Utilization: 471	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase	2018 Work RVU: 3.95 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 4.20		Referred to CPT February 2015 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

47536 Exchange of biliary drainage catheter (eg, external, internal-external, or conversion of internal-external to external only), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation	Global: 000	Issue: Percutaneous Biliary Procedures Bundling	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 04 Specialty Developing Recommendation: ACR, SIR	First Identified: February 2015	2017 Est. Medicare Utilization: 13,399	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase 2018 Work RVU: 2.61 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 2.86	Referred to CPT February 2015 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
47537 Removal of biliary drainage catheter, percutaneous, requiring fluoroscopic guidance (eg, with concurrent indwelling biliary stents), including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation	Global: 000	Issue: Percutaneous Biliary Procedures Bundling	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 04 Specialty Developing Recommendation: ACR, SIR	First Identified: February 2015	2017 Est. Medicare Utilization: 1,518	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase 2018 Work RVU: 1.84 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.85	Referred to CPT February 2015 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
47538 Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; existing access	Global: 000	Issue: Percutaneous Biliary Procedures Bundling	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 04 Specialty Developing Recommendation: ACR, SIR	First Identified: February 2015	2017 Est. Medicare Utilization: 1,132	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase 2018 Work RVU: 4.75 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 5.00	Referred to CPT February 2015 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			

Status Report: CMS Requests and Relativity Assessment Issues

47539	Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, without placement of separate biliary drainage catheter	Global: 000	Issue: Percutaneous Biliary Procedures Bundling	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 04 Specialty Developing Recommendation: ACR, SIR	First Identified: February 2015	2017 Est. Medicare Utilization: 151	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase	2018 Work RVU: 8.75 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 9.00		Referred to CPT February 2015 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
47540	Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, with placement of separate biliary drainage catheter (eg, external or internal-external)	Global: 000	Issue: Percutaneous Biliary Procedures Bundling	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 04 Specialty Developing Recommendation: ACR, SIR	First Identified: February 2015	2017 Est. Medicare Utilization: 278	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase	2018 Work RVU: 9.03 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 9.28		Referred to CPT February 2015 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
47541	Placement of access through the biliary tree and into small bowel to assist with an endoscopic biliary procedure (eg, rendezvous procedure), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation, new access	Global: 000	Issue: Percutaneous Biliary Procedures Bundling	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 04 Specialty Developing Recommendation: ACR, SIR	First Identified: February 2015	2017 Est. Medicare Utilization: 127	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase	2018 Work RVU: 6.75 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 7.00		Referred to CPT February 2015 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			

Status Report: CMS Requests and Relativity Assessment Issues

47542 Balloon dilation of biliary duct(s) or of ampulla (sphincteroplasty), percutaneous, including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, each duct (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Percutaneous Biliary Procedures Bundling	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 04 Specialty Developing Recommendation: ACR, SIR	First Identified: February 2015	2017 Est. Medicare Utilization: 1,236	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase 2018 Work RVU: 2.85 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 2.85	Referred to CPT February 2015 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
47543 Endoluminal biopsy(ies) of biliary tree, percutaneous, any method(s) (eg, brush, forceps, and/or needle), including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, single or multiple (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Percutaneous Biliary Procedures Bundling	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 04 Specialty Developing Recommendation: ACR, SIR	First Identified: February 2015	2017 Est. Medicare Utilization: 838	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase 2018 Work RVU: 3.00 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 3.00	Referred to CPT February 2015 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
47544 Removal of calculi/debris from biliary duct(s) and/or gallbladder, percutaneous, including destruction of calculi by any method (eg, mechanical, electrohydraulic, lithotripsy) when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Percutaneous Biliary Procedures Bundling	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 04 Specialty Developing Recommendation: ACR, SIR	First Identified: February 2015	2017 Est. Medicare Utilization: 282	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase 2018 Work RVU: 3.28 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 3.28	Referred to CPT February 2015 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			

Status Report: CMS Requests and Relativity Assessment Issues

47560 Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy **Global:** 000 **Issue:** RAW **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent **Tab** 18 **Specialty Developing**
RUC Meeting: October 2013 **Recommendation:**

First Identified: July 2013 **2017 Est. Medicare Utilization:**

2007 Work RVU: 4.88 **2018 Work RVU:**
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 1.57 **2018 Fac PE RVU:**1.57
Result: Maintain

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

47562 Laparoscopy, surgical; cholecystectomy **Global:** 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 / Pre-Time Analysis **Complete?** Yes

Most Recent **Tab** 21 **Specialty Developing** ACS
RUC Meeting: September 2014 **Recommendation:**

First Identified: September 2011 **2017 Est. Medicare Utilization:** 107,597

2007 Work RVU: 11.63 **2018 Work RVU:** 10.47
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 5.06 **2018 Fac PE RVU:**5.06
Result: Maintain

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

47563 Laparoscopy, surgical; cholecystectomy with cholangiography **Global:** 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent **Tab** 18 **Specialty Developing**
RUC Meeting: October 2013 **Recommendation:**

First Identified: September 2011 **2017 Est. Medicare Utilization:** 42,832

2007 Work RVU: 12.03 **2018 Work RVU:** 11.47
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 5.24 **2018 Fac PE RVU:**5.24
Result: Maintain

RUC Recommendation: No further action. 12.11

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47600 Cholecystectomy;

Global: 090

Issue: Cholecystectomy

Screen: CMS Request - Final Rule for 2012

Complete? Yes

Most Recent RUC Meeting: April 2012

Tab 36

Specialty Developing Recommendation: ACS, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 9,716

2007 Work RVU: 17.35

2018 Work RVU: 17.48

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 6.4

2018 Fac PE RVU:6.4

Result: Increase

RUC Recommendation: 20.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

47605 Cholecystectomy; with cholangiography

Global: 090

Issue: Cholecystectomy

Screen: CMS Request - Final Rule for 2012

Complete? Yes

Most Recent RUC Meeting: April 2012

Tab 36

Specialty Developing Recommendation: ACS, SAGES

First Identified: September 2011

2017 Est. Medicare Utilization: 1,738

2007 Work RVU: 15.90

2018 Work RVU: 18.48

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 6.47

2018 Fac PE RVU:6.47

Result: Increase

RUC Recommendation: 21.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

48102 Biopsy of pancreas, percutaneous needle

Global: 010

Issue: Percutaneous Needle Biopsy

Screen: Site of Service Anomaly (99238-Only)

Complete? Yes

Most Recent RUC Meeting: September 2007

Tab 16

Specialty Developing Recommendation: SIR

First Identified: September 2007

2017 Est. Medicare Utilization: 1,159

2007 Work RVU: 4.68

2018 Work RVU: 4.70

2007 NF PE RVU: 8.21

2018 NF PE RVU: 8.21

2007 Fac PE RVU 1.85

2018 Fac PE RVU:1.85

Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

48511 External drainage, pseudocyst of pancreas; percutaneous

Global: 000

Issue: Drainage of Abscess

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: January 2013

Tab 04

Specialty Developing Recommendation:

First Identified: January 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 3.99

2018 Work RVU:

2007 NF PE RVU: 20.43

2018 NF PE RVU: 20.43

2007 Fac PE RVU 1.27

2018 Fac PE RVU:1.27

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

49021 Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous

Global: 000

Issue: Drainage of Abscess

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: January 2013

Tab 04

Specialty Developing Recommendation: ACR, SIR

First Identified: January 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 3.37

2018 Work RVU:

2007 NF PE RVU: 20.43

2018 NF PE RVU: 20.43

2007 Fac PE RVU 1.07

2018 Fac PE RVU:1.07

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

49041 Drainage of subdiaphragmatic or subphrenic abscess; percutaneous

Global: 000

Issue: Drainage of Abscess

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: January 2013

Tab 04

Specialty Developing Recommendation: ACR, SIR

First Identified: January 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 3.99

2018 Work RVU:

2007 NF PE RVU: 19.33

2018 NF PE RVU: 19.33

2007 Fac PE RVU 1.27

2018 Fac PE RVU:1.27

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49061 Drainage of retroperitoneal abscess; percutaneous

Global: 000

Issue: Drainage of Abscess

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: January 2013

Tab 04

Specialty Developing Recommendation: ACR, SIR

First Identified: January 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 3.69

2018 Work RVU:

2007 NF PE RVU: 19.38

2018 NF PE RVU: 19.38

2007 Fac PE RVU 1.17

2018 Fac PE RVU:1.17

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

49080 Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial

Global: 000

Issue: Peritoneocentesis

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: October 2010

Tab 5

Specialty Developing Recommendation: ACR, AGA, ASGE, AUR, SIR

First Identified: October 2009

2017 Est. Medicare Utilization:

2007 Work RVU: 1.35

2018 Work RVU:

2007 NF PE RVU: 3.63

2018 NF PE RVU: 3.63

2007 Fac PE RVU 0.45

2018 Fac PE RVU:0.45

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT June 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

49081 Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); subsequent

Global: 000

Issue: Peritoneocentesis

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: October 2010

Tab 5

Specialty Developing Recommendation: ACR, AGA, ASGE, AUR, SIR

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 1.26

2018 Work RVU:

2007 NF PE RVU: 2.65

2018 NF PE RVU: 2.65

2007 Fac PE RVU 0.43

2018 Fac PE RVU:0.43

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT June 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49082 Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance **Global:** 000 **Issue:** Abdominal Paracentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 05

Specialty Developing Recommendation:

ACR, ACS, AGA, ASGE, SIR

First Identified: February 2010

2017 Est. Medicare Utilization: 12,016

2007 Work RVU:

2018 Work RVU: 1.24

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 1.35

Referred to CPT June 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

49083 Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance **Global:** 000 **Issue:** Abdominal Paracentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 05

Specialty Developing Recommendation:

ACR, ACS, AGA, ASGE, SIR

First Identified: February 2010

2017 Est. Medicare Utilization: 245,214

2007 Work RVU:

2018 Work RVU: 2.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 2.00

Referred to CPT June 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

49084 Peritoneal lavage, including imaging guidance, when performed **Global:** 000 **Issue:** Abdominal Paracentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 05

Specialty Developing Recommendation:

ACR, ACS, AGA, ASGE, SIR

First Identified: February 2010

2017 Est. Medicare Utilization: 2,276

2007 Work RVU:

2018 Work RVU: 2.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 2.50

Referred to CPT June 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49405 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous **Global:** 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013

Tab 04 Specialty Developing Recommendation: ACR, SIR

First Identified: January 2012

2017 Est. Medicare Utilization: 6,050

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 4.00
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.25

Referred to CPT October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

49406 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous **Global:** 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013

Tab 04 Specialty Developing Recommendation: ACR, SIR

First Identified: January 2012

2017 Est. Medicare Utilization: 32,203

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 4.00
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.25

Referred to CPT October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

49407 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal **Global:** 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013

Tab 04 Specialty Developing Recommendation: ACR, SIR

First Identified: January 2012

2017 Est. Medicare Utilization: 254

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 4.25
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.50

Referred to CPT October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49418 Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous

Global: 000

Issue: Intraperitoneal Catheter Codes

Screen: Site of Service Anomaly

Complete? Yes

Most Recent RUC Meeting: April 2010

Tab 11

Specialty Developing Recommendation: ACS, ACR, SIR

First Identified:

2017 Est. Medicare Utilization: 5,789

2007 Work RVU:

2018 Work RVU: 3.96

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 4.21

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

49420 Deleted from CPT

Global: 000

Issue: Insertion of Intraperitoneal Cannula or Catheter

Screen: Site of Service Anomaly

Complete? Yes

Most Recent RUC Meeting: October 2009

Tab 40

Specialty Developing Recommendation: ACS

First Identified: April 2008

2017 Est. Medicare Utilization:

2007 Work RVU: 2.22

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 1.11

2018 Fac PE RVU: 1.11

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

49421 Insertion of tunneled intraperitoneal catheter for dialysis, open

Global: 000

Issue: Intraperitoneal Catheter Codes

Screen: Site of Service Anomaly

Complete? Yes

Most Recent RUC Meeting: April 2010

Tab 11

Specialty Developing Recommendation: ACS, ACR, SIR

First Identified: September 2007

2017 Est. Medicare Utilization: 2,201

2007 Work RVU: 5.87

2018 Work RVU: 4.21

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.15

2018 Fac PE RVU: 3.15

Result: Decrease

RUC Recommendation: 4.21

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49422 Removal of tunneled intraperitoneal catheter

Global: 010

Issue: Removal of Intraperitoneal Catheter

Screen: Site of Service Anomaly - 2016

Complete? Yes

Most Recent
RUC Meeting: April 2017

Tab 14

Specialty Developing ACS, SVS
Recommendation:

First
Identified: October 2016

2017 Est.
Medicare
Utilization: 11,581

2007 Work RVU: 6.26
2007 NF PE RVU: NA
2007 Fac PE RVU 2.82
Result: Decrease

2018 Work RVU: 6.29
2018 NF PE RVU: NA
2018 Fac PE RVU:2.82

RUC Recommendation: 4.00

Referred to CPT
Referred to CPT Asst ☐ Published in CPT Asst:

49505 Repair initial inguinal hernia, age 5 years or older; reducible

Global: 090

Issue: RAW review

Screen: CMS High Expenditure Procedural Codes1

Complete? Yes

Most Recent
RUC Meeting: January 2012

Tab 30

Specialty Developing ACS
Recommendation:

First
Identified: September 2011

2017 Est.
Medicare
Utilization: 60,568

2007 Work RVU: 7.88
2007 NF PE RVU: NA
2007 Fac PE RVU 3.78
Result: Maintain

2018 Work RVU: 7.96
2018 NF PE RVU: NA
2018 Fac PE RVU:3.78

RUC Recommendation: Reaffirmed

Referred to CPT
Referred to CPT Asst ☐ Published in CPT Asst:

49507 Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated

Global: 090

Issue: Hernia Repair

Screen: Site of Service Anomaly

Complete? Yes

Most Recent
RUC Meeting: February 2011

Tab 29

Specialty Developing ACS
Recommendation:

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 11,150

2007 Work RVU: 9.97
2007 NF PE RVU: NA
2007 Fac PE RVU 4.46
Result: Maintain

2018 Work RVU: 9.09
2018 NF PE RVU: NA
2018 Fac PE RVU:4.46

RUC Recommendation: 10.05

Referred to CPT
Referred to CPT Asst ☐ Published in CPT Asst:

49521 Repair recurrent inguinal hernia, any age; incarcerated or strangulated

Global: 090

Issue: Hernia Repair

Screen: Site of Service Anomaly

Complete? Yes

Most Recent
RUC Meeting: February 2011

Tab 29

Specialty Developing ACS
Recommendation:

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 2,094

2007 Work RVU: 12.36
2007 NF PE RVU: NA
2007 Fac PE RVU 5.18
Result: Maintain

2018 Work RVU: 11.48
2018 NF PE RVU: NA
2018 Fac PE RVU:5.18

RUC Recommendation: 12.44

Referred to CPT
Referred to CPT Asst ☐ Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

49587 Repair umbilical hernia, age 5 years or older; incarcerated or strangulated **Global:** 090 **Issue:** Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 29 **Specialty Developing** ACS **First** **2017 Est.** **2007 Work RVU:** 7.96 **2018 Work RVU:** 7.08
RUC Meeting: February 2011 **Recommendation:** **Identified:** September 2007 **Medicare** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA
Utilization: 8,923 **2007 Fac PE RVU** 3.77 **2018 Fac PE RVU:** 3.77
RUC Recommendation: 8.04 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

49652 Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible **Global:** 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 30 **Specialty Developing** ACS **First** **2017 Est.** **2007 Work RVU:** **2018 Work RVU:** 11.92
RUC Meeting: February 2011 **Recommendation:** **Identified:** June 2010 **Medicare** **2007 NF PE RVU:** **2018 NF PE RVU:**
Utilization: 8,739 **2007 Fac PE RVU** **2018 Fac PE RVU:**
RUC Recommendation: 12.88 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

49653 Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated **Global:** 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 30 **Specialty Developing** ACS **First** **2017 Est.** **2007 Work RVU:** **2018 Work RVU:** 14.94
RUC Meeting: February 2011 **Recommendation:** **Identified:** June 2010 **Medicare** **2007 NF PE RVU:** **2018 NF PE RVU:**
Utilization: 5,131 **2007 Fac PE RVU** **2018 Fac PE RVU:**
RUC Recommendation: 16.21 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

49654 Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible **Global:** 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 30 **Specialty Developing** ACS **First** **2017 Est.** **2007 Work RVU:** **2018 Work RVU:** 13.76
RUC Meeting: February 2011 **Recommendation:** **Identified:** June 2010 **Medicare** **2007 NF PE RVU:** **2018 NF PE RVU:**
Utilization: 7,029 **2007 Fac PE RVU** **2018 Fac PE RVU:**
RUC Recommendation: 15.03 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49655 Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated **Global:** 090 **Issue:** Laparoscopic Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 30 **Specialty Developing** ACS
RUC Meeting: February 2011 **Recommendation:**

First
Identified: June 2010

2017 Est.
Medicare
Utilization: 4,314

2007 Work RVU:

2018 Work RVU: 16.84

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: 18.11

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

50021 Drainage of perirenal or renal abscess; percutaneous

Global: 000

Issue: Drainage of Abscess

Screen: Codes Reported
Together 75% or More-
Part2

Complete? Yes

Most Recent **Tab** 04 **Specialty Developing**
RUC Meeting: January 2013 **Recommendation:**

First
Identified: January 2012

2017 Est.
Medicare
Utilization:

2007 Work RVU: 3.37

2018 Work RVU:

2007 NF PE RVU: 21.23

2018 NF PE RVU: 21.23

2007 Fac PE RVU 1.07

2018 Fac PE RVU: 1.07

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012

Referred to CPT Asst ☐

Published in CPT Asst:

50200 Renal biopsy; percutaneous, by trocar or needle

Global: 000

Issue: Interventional Radiology
Procedures

Screen: CMS Request - Practice
Expense Review

Complete? Yes

Most Recent **Tab** 13 **Specialty Developing** ACR, SIR
RUC Meeting: October 2008 **Recommendation:**

First
Identified: NA

2017 Est.
Medicare
Utilization: 36,305

2007 Work RVU: 2.63

2018 Work RVU: 2.38

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 1.24

2018 Fac PE RVU: 1.24

Result: PE Only

RUC Recommendation: New PE Inputs

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

50360	Renal allotransplantation, implantation of graft; without recipient nephrectomy	Global: 090	Issue: Renal Allotransplantation	Screen: Harvard-Valued Annual Allowed Charges Greater than \$10 million	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 21	Specialty Developing Recommendation: ACR, SIR	First Identified:	2017 Est. Medicare Utilization: 10,825	2007 Work RVU: 40.45 2007 NF PE RVU: NA 2007 Fac PE RVU: 16.32 Result: Maintain 2018 Work RVU: 39.88 2018 NF PE RVU: NA 2018 Fac PE RVU: 16.32
RUC Recommendation: 40.90			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
50387	Removal and replacement of externally accessible nephroureteral catheter (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation	Global: 000	Issue: Genitourinary Catheter Procedures	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: January 2015	Tab 09	Specialty Developing Recommendation: ACR, SIR	First Identified: October 2012	2017 Est. Medicare Utilization: 6,537	2007 Work RVU: 2.00 2007 NF PE RVU: 16.66 2007 Fac PE RVU: 0.65 Result: Maintain 2018 Work RVU: 1.75 2018 NF PE RVU: 16.66 2018 Fac PE RVU: 0.65
RUC Recommendation: 2.00			Referred to CPT October 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
50392	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous	Global: 000	Issue: Genitourinary Catheter Procedures	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: January 2015	Tab 09	Specialty Developing Recommendation: ACR, SIR	First Identified: October 2012	2017 Est. Medicare Utilization:	2007 Work RVU: 3.37 2007 NF PE RVU: NA 2007 Fac PE RVU: 1.46 Result: Deleted from CPT 2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 1.46
RUC Recommendation: Deleted from CPT			Referred to CPT October 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

50393 Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous **Global:** 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR
RUC Meeting: January 2015

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 4.15

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 1.71

2018 Fac PE RVU:1.71

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

50394 Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter

Global: 000

Issue: Genitourinary Catheter Procedures

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR
RUC Meeting: January 2015

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 0.76

2018 Work RVU:

2007 NF PE RVU: 2.45

2018 NF PE RVU: 2.45

2007 Fac PE RVU 0.63

2018 Fac PE RVU:0.63

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

50395 Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous

Global: 000

Issue: Dilation of Urinary Tract

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent **Tab** 12 **Specialty Developing Recommendation:** ACR, SIR
RUC Meeting: January 2018

First Identified: October 2014

2017 Est. Medicare Utilization: 3,279

2007 Work RVU: 3.37

2018 Work RVU: 3.37

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 1.47

2018 Fac PE RVU:1.47

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT September 2017

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50398	Change of nephrostomy or pyelostomy tube	Global: 000	Issue: Genitourinary Catheter Procedures	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: January 2015	Tab 09 Specialty Developing Recommendation: ACR, SIR	First Identified: October 2012	2017 Est. Medicare Utilization:	2007 Work RVU: 1.46 2007 NF PE RVU: 15.06 2007 Fac PE RVU: 0.51 Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 15.06 2018 Fac PE RVU: 0.51
RUC Recommendation: Deleted from CPT		Referred to CPT October 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
50430	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access	Global: 000	Issue: Genitourinary Catheter Procedures	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: January 2015	Tab 09 Specialty Developing Recommendation: ACR, SIR	First Identified: October 2014	2017 Est. Medicare Utilization: 1,177	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Increase	2018 Work RVU: 2.90 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 3.15		Referred to CPT October 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
50431	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access	Global: 000	Issue: Genitourinary Catheter Procedures	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: January 2015	Tab 09 Specialty Developing Recommendation: ACR, SIR	First Identified: October 2014	2017 Est. Medicare Utilization: 9,546	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Increase	2018 Work RVU: 1.10 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.42		Referred to CPT October 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

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50432 Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation **Global:** 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018

Tab 12 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2014

2017 Est. Medicare Utilization: 26,619

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Maintain

2018 Work RVU: 4.00
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.00

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

50433 Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access **Global:** 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018

Tab 12 **Specialty Developing Recommendation:**

First Identified: September 2017

2017 Est. Medicare Utilization: 4,974

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Maintain

2018 Work RVU: 5.05
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 5.05

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

50434 Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract **Global:** 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015

Tab 09 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2014

2017 Est. Medicare Utilization: 2,104

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Increase

2018 Work RVU: 3.75
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.20

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50435 Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation **Global:** 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2017 Est. Medicare Utilization:** 41,306 **2007 Work RVU:** **2018 Work RVU:** 1.82 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Increase **2018 Fac PE RVU:**

RUC Recommendation: 2.00 **Referred to CPT** October 2014 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

50542 Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed **Global:** 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AUA **First Identified:** October 2008 **2017 Est. Medicare Utilization:** 291 **2007 Work RVU:** 21.18 **2018 Work RVU:** 21.36 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU** 8.93 **2018 Fac PE RVU:** 8.93 **Result:** Remove from Screen

RUC Recommendation: Remove from screen **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

50548 Laparoscopy, surgical; nephrectomy with total ureterectomy **Global:** 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 26 **Specialty Developing Recommendation:** AUA **First Identified:** October 2008 **2017 Est. Medicare Utilization:** 2,309 **2007 Work RVU:** 25.26 **2018 Work RVU:** 25.36 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU** 9.99 **2018 Fac PE RVU:** 9.99 **Result:** Remove from Screen

RUC Recommendation: Remove from screen **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50590	Lithotripsy, extracorporeal shock wave	Global: 090	Issue: Lithotripsy	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 42 Specialty Developing Recommendation: AUA	First Identified: September 2011	2017 Est. Medicare Utilization: 58,177	2007 Work RVU: 9.64 2007 NF PE RVU: 13.6 2007 Fac PE RVU: 4.65 Result: Maintain	2018 Work RVU: 9.77 2018 NF PE RVU: 13.6 2018 Fac PE RVU: 4.65
RUC Recommendation: 9.77		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
50605	Ureterotomy for insertion of indwelling stent, all types	Global: 090	Issue: Ureterotomy	Screen: CMS Fastest Growing / CPT Assistant Analysis	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 21 Specialty Developing Recommendation: AUA, SIR	First Identified: October 2008	2017 Est. Medicare Utilization: 3,197	2007 Work RVU: 16.66 2007 NF PE RVU: NA 2007 Fac PE RVU: 7.06 Result: Maintain	2018 Work RVU: 16.79 2018 NF PE RVU: NA 2018 Fac PE RVU: 7.06
RUC Recommendation: Review action plan at the RAW Oct 2015. CPT Assistant article published.		Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Dec 2009		
<hr/>					
50606	Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Genitourinary Catheter Procedures	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2015	Tab 08 Specialty Developing Recommendation: ACR, SIR	First Identified: October 2014	2017 Est. Medicare Utilization: 115	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Increase	2018 Work RVU: 3.16 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 3.16		Referred to CPT October 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

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50693	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; pre-existing nephrostomy tract	Global: 000	Issue: Genitourinary Catheter Procedures	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: January 2015	Tab 09 Specialty Developing Recommendation: ACR, SIR	First Identified: October 2014	2017 Est. Medicare Utilization: 4,514	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase	2018 Work RVU: 3.96 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 4.60		Referred to CPT October 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
50694	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, without separate nephrostomy catheter	Global: 000	Issue: Genitourinary Catheter Procedures	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: January 2015	Tab 09 Specialty Developing Recommendation: ACR, SIR	First Identified: October 2014	2017 Est. Medicare Utilization: 971	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase	2018 Work RVU: 5.25 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 6.00		Referred to CPT October 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
50695	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, with separate nephrostomy catheter	Global: 000	Issue: Genitourinary Catheter Procedures	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: January 2015	Tab 09 Specialty Developing Recommendation: ACR, SIR	First Identified: October 2014	2017 Est. Medicare Utilization: 1,687	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase	2018 Work RVU: 6.80 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 7.55		Referred to CPT October 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

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50705 Ureteral embolization or occlusion, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015

Tab 08 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2014

2017 Est. Medicare Utilization: 72

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Increase

2018 Work RVU: 4.03
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.03

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

50706 Balloon dilation, ureteral stricture, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015

Tab 08 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2014

2017 Est. Medicare Utilization: 1,420

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Increase

2018 Work RVU: 3.80
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 3.80

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

50X39 **Global:** **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018

Tab 12 **Specialty Developing Recommendation:**

First Identified: September 2017

2017 Est. Medicare Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 3.37

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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50X40

Global: **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent **Tab** 12 **Specialty Developing**
RUC Meeting: January 2018 **Recommendation:**

First **2017 Est.**
Identified: September 2017 **Medicare**
Utilization:

2007 Work RVU: **2018 Work RVU:**
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU **2018 Fac PE RVU:**
Result: Decrease

RUC Recommendation: 5.44

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

51040 Cystostomy, cystotomy with drainage

Global: 090 **Issue:** Cystostomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent **Tab** 16 **Specialty Developing** AUA
RUC Meeting: September 2007 **Recommendation:**

First **2017 Est.**
Identified: September 2007 **Medicare**
Utilization: 5,633

2007 Work RVU: 4.43 **2018 Work RVU:** 4.49
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 3.01 **2018 Fac PE RVU:** 3.01
Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

51102 Aspiration of bladder; with insertion of suprapubic catheter

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 45 **Specialty Developing** AUA
RUC Meeting: April 2008 **Recommendation:**

First **2017 Est.**
Identified: September 2007 **Medicare**
Utilization: 14,111

2007 Work RVU: **2018 Work RVU:** 2.70
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU **2018 Fac PE RVU:**
Result: Decrease

RUC Recommendation: 2.70

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

51700 Bladder irrigation, simple, lavage and/or instillation

Global: 000 **Issue:** Bladder Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent **Tab** 32 **Specialty Developing** AUA
RUC Meeting: January 2016 **Recommendation:**

First **2017 Est.**
Identified: July 2015 **Medicare**
Utilization: 192,354

2007 Work RVU: 0.88 **2018 Work RVU:** 0.60
2007 NF PE RVU: 1.58 **2018 NF PE RVU:** 1.58
2007 Fac PE RVU 0.3 **2018 Fac PE RVU:** 0.3
Result: Decrease

RUC Recommendation: 0.60

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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51701 Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine) **Global:** 000 **Issue:** Bladder Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 32 Specialty Developing Recommendation: AUA

First Identified: July 2015

2017 Est. Medicare Utilization: 174,901

2007 Work RVU: 0.50

2018 Work RVU: 0.50

2007 NF PE RVU: 1.45

2018 NF PE RVU: 1.45

2007 Fac PE RVU 0.21

2018 Fac PE RVU:0.21

Result: Maintain

RUC Recommendation: 0.50

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

51702 Insertion of temporary indwelling bladder catheter; simple (eg, Foley)

Global: 000

Issue: Bladder Catheter

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab 32 Specialty Developing Recommendation: AUA

First Identified: July 2015

2017 Est. Medicare Utilization: 237,769

2007 Work RVU: 0.50

2018 Work RVU: 0.50

2007 NF PE RVU: 1.94

2018 NF PE RVU: 1.94

2007 Fac PE RVU 0.27

2018 Fac PE RVU:0.27

Result: Maintain

RUC Recommendation: 0.50

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

51703 Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)

Global: 000

Issue: Bladder Catheter

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab 32 Specialty Developing Recommendation: AUA

First Identified: July 2015

2017 Est. Medicare Utilization: 57,100

2007 Work RVU: 1.47

2018 Work RVU: 1.47

2007 NF PE RVU: 2.62

2018 NF PE RVU: 2.62

2007 Fac PE RVU 0.63

2018 Fac PE RVU:0.63

Result: Maintain

RUC Recommendation: 1.47

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

51720 Bladder instillation of anticarcinogenic agent (including retention time)

Global: 000

Issue: Treatment of Bladder Lesion

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab 33 Specialty Developing Recommendation: AUA

First Identified: July 2015

2017 Est. Medicare Utilization: 192,279

2007 Work RVU: 1.50

2018 Work RVU: 0.87

2007 NF PE RVU: 1.72

2018 NF PE RVU: 1.72

2007 Fac PE RVU 0.71

2018 Fac PE RVU:0.71

Result: Decrease

RUC Recommendation: 0.87

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

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51726	Complex cystometrogram (ie, calibrated electronic equipment);	Global: 000	Issue: Urodynamic Studies	Screen: Codes Reported Together 95% or More	Complete? Yes
Most Recent RUC Meeting: April 2009	Tab 16	Specialty Developing Recommendation: AUA, ACOG	First Identified: February 2008	2017 Est. Medicare Utilization: 5,881	2007 Work RVU: 1.71 2007 NF PE RVU: 7.41 2007 Fac PE RVU: 7.41 2018 Work RVU: 1.71 2018 NF PE RVU: 7.41 2018 Fac PE RVU: 7.41
RUC Recommendation: 1.71			Referred to CPT February 2009 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain

51727	Complex cystometrogram (ie, calibrated electronic equipment); with urethral pressure profile studies (ie, urethral closure pressure profile), any technique	Global: 000	Issue: Urodynamic Studies	Screen: Codes Reported Together 95% or More	Complete? Yes
Most Recent RUC Meeting: April 2009	Tab 16	Specialty Developing Recommendation: AUA, ACOG	First Identified:	2017 Est. Medicare Utilization: 2,134	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: 2018 Work RVU: 2.11 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 2.11			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease

51728	Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), any technique	Global: 000	Issue: Urodynamic Studies	Screen: Codes Reported Together 95% or More	Complete? Yes
Most Recent RUC Meeting: April 2009	Tab 16	Specialty Developing Recommendation: AUA, ACOG	First Identified: February 2009	2017 Est. Medicare Utilization: 74,180	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: 2018 Work RVU: 2.11 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 2.11			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease

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51729 Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique **Global:** 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009

Tab 16 **Specialty Developing Recommendation:** AUA, ACOG

First Identified:

2017 Est. Medicare Utilization: 69,787

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 2.51
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 2.51

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

51736 Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter) **Global:** XXX **Issue:** Uroflowmetry **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 11 **Specialty Developing Recommendation:** AUA

First Identified: February 2010

2017 Est. Medicare Utilization: 10,343

2007 Work RVU: 0.61
2007 NF PE RVU: 0.67
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 0.17
2018 NF PE RVU: 0.67
2018 Fac PE RVU: 0.67

RUC Recommendation: 0.17

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

51741 Complex uroflowmetry (eg, calibrated electronic equipment) **Global:** XXX **Issue:** Uroflowmetry **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 11 **Specialty Developing Recommendation:** AUA

First Identified: October 2009

2017 Est. Medicare Utilization: 472,555

2007 Work RVU: 1.14
2007 NF PE RVU: 0.91
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 0.17
2018 NF PE RVU: 0.91
2018 Fac PE RVU: 0.91

RUC Recommendation: 0.17

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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51772 Deleted from CPT **Global:** 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 16 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 1.61 **2018 Work RVU:** **2007 NF PE RVU:** 5.44 **2018 NF PE RVU:** 5.44 **2007 Fac PE RVU:** 5.44 **2018 Fac PE RVU:** 5.44 **RUC Recommendation:** Deleted from CPT **Referred to CPT** February 2009 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

51784 Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique **Global:** XXX **Issue:** Electromyography Studies (EMG) **Screen:** Codes Reported Together 75% or More- Part2 / CMS High Expenditure Procedural Codes2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 34 **Specialty Developing Recommendation:** AUA **First Identified:** October 2012 **2017 Est. Medicare Utilization:** 149,050 **2007 Work RVU:** 1.53 **2018 Work RVU:** 0.75 **2007 NF PE RVU:** 3.95 **2018 NF PE RVU:** 3.95 **2007 Fac PE RVU:** 3.95 **2018 Fac PE RVU:** 3.95 **RUC Recommendation:** 0.75 **Referred to CPT** February 2014 **Referred to CPT Asst** ☒ **Published in CPT Asst:** Feb 2014 **Result:** Decrease

51792 Stimulus evoked response (eg, measurement of bulbocavernosus reflex latency time) **Global:** 000 **Issue:** Urinary Reflex Studies with EMG **Screen:** Codes Reported Together 75% or More- Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** **Specialty Developing Recommendation:** AUA **First Identified:** October 2012 **2017 Est. Medicare Utilization:** 8,925 **2007 Work RVU:** 1.10 **2018 Work RVU:** 1.10 **2007 NF PE RVU:** 5.74 **2018 NF PE RVU:** 5.74 **2007 Fac PE RVU:** 5.74 **2018 Fac PE RVU:** 5.74 **RUC Recommendation:** CPT edits and CPT Assistant article complete. **Referred to CPT** February 2014 **Referred to CPT Asst** ☒ **Published in CPT Asst:** Feb 2014 **Result:** Maintain

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51795 Deleted from CPT

Global: 000

Issue: Urology Studies

Screen: Codes Reported
Together 95% or More

Complete? Yes

**Most Recent
RUC Meeting:** February 2008

Tab S

**Specialty Developing
Recommendation:**

**First
Identified:** February 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 1.53

2018 Work RVU:

2007 NF PE RVU: 7.15

2018 NF PE RVU: 7.15

2007 Fac PE RVU: 7.15

2018 Fac PE RVU: 7.15

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

**51797 Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal)
(List separately in addition to code for primary procedure)**

Global: ZZZ

Issue: Urology Studies

Screen: Codes Reported
Together 95% or More

Complete? Yes

**Most Recent
RUC Meeting:** February 2008

Tab S

**Specialty Developing
Recommendation:**

**First
Identified:** February 2008

**2017 Est.
Medicare
Utilization:** 124,360

2007 Work RVU: 1.60

2018 Work RVU: 0.80

2007 NF PE RVU: 5.55

2018 NF PE RVU: 5.55

2007 Fac PE RVU: 5.55

2018 Fac PE RVU: 5.55

Result: Maintain

RUC Recommendation: 0.80

Referred to CPT February 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

**51798 Measurement of post-voiding residual urine and/or bladder capacity by
ultrasound, non-imaging**

Global: XXX

Issue: Voiding Pressure Studies

Screen: CMS High Expenditure
Procedural Codes2

Complete? Yes

**Most Recent
RUC Meeting:** April 2016

Tab 25

**Specialty Developing
Recommendation:** AUA

**First
Identified:** July 2015

**2017 Est.
Medicare
Utilization:** 2,178,624

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: 0.4

2018 NF PE RVU: 0.4

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: PE Only

RUC Recommendation: PE Only

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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52000	Cystourethroscopy (separate procedure)	Global: 000	Issue: Cystourethroscopy	Screen: MPC List / CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 35	Specialty Developing Recommendation: AUA, ACOG	First Identified: October 2010	2017 Est. Medicare Utilization: 917,623	2007 Work RVU: 2.23 2007 NF PE RVU: 3.4 2007 Fac PE RVU: 0.91 Result: Decrease
RUC Recommendation: 1.75			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.53 2018 NF PE RVU: 3.4 2018 Fac PE RVU: 0.91
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	Global: 000	Issue: Cystourethroscopy	Screen: High Volume Growth1 / CPT Assistant Analysis	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 19	Specialty Developing Recommendation: AUA	First Identified: June 2008	2017 Est. Medicare Utilization: 19,306	2007 Work RVU: 3.70 2007 NF PE RVU: 33.55 2007 Fac PE RVU: 1.47 Result: Decrease
RUC Recommendation: 3.50			Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Aug 2009 and May 2016	2018 Work RVU: 3.50 2018 NF PE RVU: 33.55 2018 Fac PE RVU: 1.47
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	Global: 000	Issue: Cystourethroscopy	Screen: High Volume Growth1 / CPT Assistant Analysis	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 19	Specialty Developing Recommendation: AUA	First Identified: February 2008	2017 Est. Medicare Utilization: 40,787	2007 Work RVU: 3.14 2007 NF PE RVU: 32.11 2007 Fac PE RVU: 1.28 Result: Increase
RUC Recommendation: 4.05			Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Aug 2009 and May 2016	2018 Work RVU: 4.05 2018 NF PE RVU: 32.11 2018 Fac PE RVU: 1.28

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52234	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)	Global: 000	Issue: Cystourethroscopy and Ureteroscopy	Screen: Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis 2018	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 19	Specialty Developing Recommendation: AUA	First Identified: September 2011	2017 Est. Medicare Utilization: 28,081	2007 Work RVU: 4.62 2007 NF PE RVU: NA 2007 Fac PE RVU: 1.83 2018 Work RVU: 4.62 2018 NF PE RVU: NA 2018 Fac PE RVU: 1.83
RUC Recommendation: 4.62			Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: May 2016	Result: Maintain
<hr/>					
52235	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)	Global: 000	Issue: Cystourethroscopy and Ureteroscopy	Screen: Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 19	Specialty Developing Recommendation: AUA	First Identified: April 2011	2017 Est. Medicare Utilization: 32,857	2007 Work RVU: 5.44 2007 NF PE RVU: NA 2007 Fac PE RVU: 2.13 2018 Work RVU: 5.44 2018 NF PE RVU: NA 2018 Fac PE RVU: 2.13
RUC Recommendation: 5.44			Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: May 2016	Result: Maintain
<hr/>					
52240	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; LARGE bladder tumor(s)	Global: 000	Issue: Cystourethroscopy and Ureteroscopy	Screen: Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis 2018	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 19	Specialty Developing Recommendation: AUA	First Identified: September 2011	2017 Est. Medicare Utilization: 22,342	2007 Work RVU: 9.71 2007 NF PE RVU: NA 2007 Fac PE RVU: 3.6 2018 Work RVU: 7.50 2018 NF PE RVU: NA 2018 Fac PE RVU: 3.6
RUC Recommendation: 8.75			Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: May 2016	Result: Decrease

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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 **Global:** 000 **Issue:** Cystourethroscopy **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent
RUC Meeting: April 2010 **Tab** 38 **Specialty Developing** AUA
Recommendation:

First
Identified: October 2009

2017 Est.
Medicare
Utilization: 72,625

2007 Work RVU: 2.80 **2018 Work RVU:** 2.75
2007 NF PE RVU: 6.65 **2018 NF PE RVU:** 6.65
2007 Fac PE RVU 1.21 **2018 Fac PE RVU:**1.21
Result: Maintain

RUC Recommendation: 2.80

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

52332 Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type) **Global:** 000 **Issue:** Cystourethroscopy **Screen:** Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent
RUC Meeting: April 2013 **Tab** 13 **Specialty Developing** AUA
Recommendation:

First
Identified: October 2009

2017 Est.
Medicare
Utilization: 146,811

2007 Work RVU: 2.83 **2018 Work RVU:** 2.82
2007 NF PE RVU: 7.42 **2018 NF PE RVU:** 7.42
2007 Fac PE RVU 1.19 **2018 Fac PE RVU:**1.19
Result: Maintain

RUC Recommendation: 2.82

Referred to CPT February 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

52334 Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde **Global:** 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent
RUC Meeting: January 2018 **Tab** 12 **Specialty Developing**
Recommendation:

First
Identified: September 2017

2017 Est.
Medicare
Utilization: 309

2007 Work RVU: 4.82 **2018 Work RVU:** 4.82
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 1.89 **2018 Fac PE RVU:**1.89
Result: Decrease

RUC Recommendation: 3.37

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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52341 Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision) **Global:** 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 65 **Specialty Developing** AUA
RUC Meeting: October 2010 **Recommendation:**

First
Identified: April 2008

2017 Est.
Medicare
Utilization: 2,582

2007 Work RVU: 6.11

2018 Work RVU: 5.35

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 2.44

2018 Fac PE RVU:2.44

Result: Decrease

RUC Recommendation: 5.35

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

52342 Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision) **Global:** 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 65 **Specialty Developing** AUA
RUC Meeting: October 2010 **Recommendation:**

First
Identified: April 2008

2017 Est.
Medicare
Utilization: 225

2007 Work RVU: 6.61

2018 Work RVU: 5.85

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 2.59

2018 Fac PE RVU:2.59

Result: Decrease

RUC Recommendation: 5.85

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

52343 Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision) **Global:** 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 65 **Specialty Developing** AUA
RUC Meeting: October 2010 **Recommendation:**

First
Identified: April 2008

2017 Est.
Medicare
Utilization: 31

2007 Work RVU: 7.31

2018 Work RVU: 6.55

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 2.84

2018 Fac PE RVU:2.84

Result: Decrease

RUC Recommendation: 6.55

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

52344 Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision) **Global:** 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 65 **Specialty Developing** AUA
RUC Meeting: October 2010 **Recommendation:**

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 3,294

2007 Work RVU: 7.81

2018 Work RVU: 7.05

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.09

2018 Fac PE RVU:3.09

Result: Decrease

RUC Recommendation: 7.05

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

52345	Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)	Global: 000	Issue: Urological Procedures	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 65 Specialty Developing Recommendation: AUA	First Identified: April 2008	2017 Est. Medicare Utilization: 451	2007 Work RVU: 8.31 2007 NF PE RVU: NA 2007 Fac PE RVU: 3.27 Result: Decrease	2018 Work RVU: 7.55 2018 NF PE RVU: NA 2018 Fac PE RVU: 3.27
RUC Recommendation: 7.55		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
52346	Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	Global: 000	Issue: Urological Procedures	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 65 Specialty Developing Recommendation: AUA	First Identified: April 2008	2017 Est. Medicare Utilization: 260	2007 Work RVU: 9.34 2007 NF PE RVU: NA 2007 Fac PE RVU: 3.62 Result: Decrease	2018 Work RVU: 8.58 2018 NF PE RVU: NA 2018 Fac PE RVU: 3.62
RUC Recommendation: 8.58		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
52351	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic	Global: 000	Issue: Cystourethroscopy and Ureteroscopy	Screen: Harvard Valued - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: September 2011	Tab 23 Specialty Developing Recommendation: AUA	First Identified: September 2011	2017 Est. Medicare Utilization: 22,573	2007 Work RVU: 5.85 2007 NF PE RVU: NA 2007 Fac PE RVU: 2.36 Result: Decrease	2018 Work RVU: 5.75 2018 NF PE RVU: NA 2018 Fac PE RVU: 2.36
RUC Recommendation: 5.75		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)	Global: 000	Issue: Cystourethroscopy and Ureteroscopy	Screen: Harvard Valued - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: September 2011	Tab 23 Specialty Developing Recommendation: AUA	First Identified: September 2011	2017 Est. Medicare Utilization: 24,504	2007 Work RVU: 6.87 2007 NF PE RVU: NA 2007 Fac PE RVU: 2.77 Result: Decrease	2018 Work RVU: 6.75 2018 NF PE RVU: NA 2018 Fac PE RVU: 2.77
RUC Recommendation: 6.75		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

52353 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included) **Global:** 000 **Issue:** Cystourethroscopy **Screen:** Harvard Valued - Utilization over 30,000 / Harvard-Valued Annual Allowed Charges Greater than \$10 million / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 13 **Specialty Developing Recommendation:** AUA

First Identified: April 2011

2017 Est. Medicare Utilization: 11,592

2007 Work RVU: 7.96

2018 Work RVU: 7.50

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 3.14

2018 Fac PE RVU: 3.14

Result: Decrease

RUC Recommendation: 7.50

Referred to CPT February 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

52354 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion

Global: 000

Issue: Cystourethroscopy and Ureteroscopy

Screen: Harvard Valued - Utilization over 30,000

Complete? Yes

Most Recent RUC Meeting: September 2011

Tab 23 **Specialty Developing Recommendation:** AUA

First Identified: September 2011

2017 Est. Medicare Utilization: 8,777

2007 Work RVU: 7.33

2018 Work RVU: 8.00

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 2.94

2018 Fac PE RVU: 2.94

Result: Increase

RUC Recommendation: 8.58

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

52355 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor

Global: 000

Issue: Cystourethroscopy and Ureteroscopy

Screen: Harvard Valued - Utilization over 30,000

Complete? Yes

Most Recent RUC Meeting: September 2011

Tab 23 **Specialty Developing Recommendation:** AUA

First Identified: September 2011

2017 Est. Medicare Utilization: 972

2007 Work RVU: 8.81

2018 Work RVU: 9.00

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 3.44

2018 Fac PE RVU: 3.44

Result: Increase

RUC Recommendation: 10.00

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52356 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)

Global: 000

Issue: Cystourethroscopy

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: April 2013

Tab 13

Specialty Developing Recommendation: AUA

First Identified: January 2013

2017 Est. Medicare Utilization: 65,831

2007 Work RVU:

2018 Work RVU: 8.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 8.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

52400 Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds

Global: 090

Issue: Urological Procedures

Screen: Site of Service Anomaly

Complete? Yes

Most Recent RUC Meeting: October 2010

Tab 65

Specialty Developing Recommendation: AUA

First Identified: September 2007

2017 Est. Medicare Utilization: 220

2007 Work RVU: 10.06

2018 Work RVU: 8.69

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 4.18

2018 Fac PE RVU: 4.18

Result: Decrease

RUC Recommendation: 8.69

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

52500 Transurethral resection of bladder neck (separate procedure)

Global: 090

Issue: Urological Procedures

Screen: Site of Service Anomaly

Complete? Yes

Most Recent RUC Meeting: October 2010

Tab 65

Specialty Developing Recommendation: AUA

First Identified: September 2007

2017 Est. Medicare Utilization: 3,644

2007 Work RVU: 9.39

2018 Work RVU: 8.14

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 4.52

2018 Fac PE RVU: 4.52

Result: Decrease

RUC Recommendation: 8.14

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

52601	Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	Global: 090	Issue: Transurethral Electrosurgical Resection of Prostate (TURP)	Screen: Site of Service Anomaly - 2015	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 26 Specialty Developing Recommendation: AUA	First Identified: October 2015	2017 Est. Medicare Utilization: 46,069	2007 Work RVU: 15.13 2007 NF PE RVU: NA 2007 Fac PE RVU: 5.99 Result: Decrease	2018 Work RVU: 13.16 2018 NF PE RVU: NA 2018 Fac PE RVU: 5.99
RUC Recommendation: 13.16	Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:		

52640	Transurethral resection; of postoperative bladder neck contracture	Global: 090	Issue: Urological Procedures	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting: April 2008	Tab 45 Specialty Developing Recommendation: AUA	First Identified: September 2007	2017 Est. Medicare Utilization: 1,532	2007 Work RVU: 6.89 2007 NF PE RVU: NA 2007 Fac PE RVU: 3.35 Result: Decrease	2018 Work RVU: 4.79 2018 NF PE RVU: NA 2018 Fac PE RVU: 3.35
RUC Recommendation: 4.79	Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:		

52648	Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)	Global: 090	Issue: Laser Surgery of Prostate	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: April 2008	Tab 57 Specialty Developing Recommendation: AUA	First Identified: February 2008	2017 Est. Medicare Utilization: 20,787	2007 Work RVU: 12.00 2007 NF PE RVU: 66.1 2007 Fac PE RVU: 5.44 Result: Remove from Screen	2018 Work RVU: 12.15 2018 NF PE RVU: 66.1 2018 Fac PE RVU: 5.44
RUC Recommendation: Remove from screen	Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

53445 Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 31 **Specialty Developing** AUA
RUC Meeting: February 2011 **Recommendation:**

First Identified: September 2007 **2017 Est. Medicare Utilization:** 2,108

2007 Work RVU: 15.21 **2018 Work RVU:** 13.00
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 7.55 **2018 Fac PE RVU:** 7.55
Result: Decrease

RUC Recommendation: 13.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

53850 Transurethral destruction of prostate tissue; by microwave thermotherapy **Global:** 090 **Issue:** Transurethral Destruction of Prostate Tissue **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent **Tab** 43 **Specialty Developing** AUA
RUC Meeting: April 2012 **Recommendation:**

First Identified: September 2011 **2017 Est. Medicare Utilization:** 4,253

2007 Work RVU: 9.98 **2018 Work RVU:** 10.08
2007 NF PE RVU: 82.87 **2018 NF PE RVU:** 82.87
2007 Fac PE RVU: 4.46 **2018 Fac PE RVU:** 4.46
Result: Maintain

RUC Recommendation: 10.08

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

54405 Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 45 **Specialty Developing** AUA
RUC Meeting: April 2008 **Recommendation:**

First Identified: September 2007 **2017 Est. Medicare Utilization:** 5,382

2007 Work RVU: 14.39 **2018 Work RVU:** 14.52
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 6.51 **2018 Fac PE RVU:** 6.51
Result: Maintain

RUC Recommendation: 14.39

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

54410 Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 31 **Specialty Developing** AUA
RUC Meeting: February 2011 **Recommendation:**

First Identified: September 2007 **2017 Est. Medicare Utilization:** 1,277

2007 Work RVU: 16.48 **2018 Work RVU:** 15.18
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 7.35 **2018 Fac PE RVU:** 7.35
Result: Decrease

RUC Recommendation: 15.18

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

54520 Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach **Global:** 090 **Issue:** Removal of Testical **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent **Tab** 16 **Specialty Developing** AUA
RUC Meeting: September 2007 **Recommendation:**

First Identified: September 2007 **2017 Est. Medicare Utilization:** 2,942

2007 Work RVU: 5.25 **2018 Work RVU:** 5.30
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 3.03 **2018 Fac PE RVU:**3.03
Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

54530 Orchiectomy, radical, for tumor; inguinal approach

Global: 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** 65 **Specialty Developing** AUA
RUC Meeting: October 2010 **Recommendation:**

First Identified: September 2007 **2017 Est. Medicare Utilization:** 1,231

2007 Work RVU: 9.31 **2018 Work RVU:** 8.46
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 4.72 **2018 Fac PE RVU:**4.72
Result: Decrease

RUC Recommendation: 8.46

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

55700 Biopsy, prostate; needle or punch, single or multiple, any approach

Global: 000 **Issue:** Biopsy of Prostate **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent **Tab** 36 **Specialty Developing** AUA
RUC Meeting: January 2016 **Recommendation:**

First Identified: July 2015 **2017 Est. Medicare Utilization:** 148,323

2007 Work RVU: 2.58 **2018 Work RVU:** 2.50
2007 NF PE RVU: 4.08 **2018 NF PE RVU:** 4.08
2007 Fac PE RVU 0.82 **2018 Fac PE RVU:**0.82
Result: Decrease

RUC Recommendation: 2.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

55706 Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance

Global: 010 **Issue:** RAW **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent **Tab** 52 **Specialty Developing**
RUC Meeting: April 2014 **Recommendation:**

First Identified: January 2014 **2017 Est. Medicare Utilization:** 1,438

2007 Work RVU: **2018 Work RVU:** 6.28
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU **2018 Fac PE RVU:**
Result: Maintain

RUC Recommendation: Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

55840 Prostatectomy, retropubic radical, with or without nerve sparing;

Global: 090

Issue:

Screen: CMS Request - Final Rule for 2014

Complete? Yes

Most Recent RUC Meeting: April 2014

Tab 31

Specialty Developing Recommendation: AUA

First Identified: October 2013

2017 Est. Medicare Utilization: 1,744

2007 Work RVU: 24.45

2018 Work RVU: 21.36

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 10.19

2018 Fac PE RVU:10.19

Result: Decrease

RUC Recommendation: 21.36

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

55842 Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)

Global: 090

Issue:

Screen: CMS Request - Final Rule for 2014

Complete? Yes

Most Recent RUC Meeting: April 2014

Tab 31

Specialty Developing Recommendation: AUA

First Identified: October 2013

2017 Est. Medicare Utilization: 229

2007 Work RVU: 26.31

2018 Work RVU: 21.36

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 10.83

2018 Fac PE RVU:10.83

Result: Decrease

RUC Recommendation: 24.16

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

55845 Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes

Global: 090

Issue: RAW

Screen: CMS Request - Final Rule for 2014

Complete? Yes

Most Recent RUC Meeting: April 2014

Tab 31

Specialty Developing Recommendation: AUA

First Identified: July 2013

2017 Est. Medicare Utilization: 1,377

2007 Work RVU: 30.52

2018 Work RVU: 25.18

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 12.01

2018 Fac PE RVU:12.01

Result: Decrease

RUC Recommendation: 29.07

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

55866 Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed **Global:** 090 **Issue:** Laparoscopic Radical Prostatectomy **Screen:** New Technology / CMS Fastest Growing / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent **Tab** 27 **Specialty Developing** AUA
RUC Meeting: April 2015 **Recommendation:**

First Identified: September 2007 **2017 Est. Medicare Utilization:** 18,369

2007 Work RVU: 32.25 **2018 Work RVU:** 26.80
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 12.87 **2018 Fac PE RVU:**12.87
Result: Decrease

RUC Recommendation: 26.80

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

55873 Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring) **Global:** 090 **Issue:** Cryoablation of Prostate **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent **Tab** 25 **Specialty Developing** AUA
RUC Meeting: February 2009 **Recommendation:**

First Identified: September 2007 **2017 Est. Medicare Utilization:** 1,753

2007 Work RVU: 20.25 **2018 Work RVU:** 13.60
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 9.59 **2018 Fac PE RVU:**9.59
Result: Decrease

RUC Recommendation: 13.45

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

55875 Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy **Global:** 090 **Issue:** RAW **Screen:** RUC request **Complete?** Yes

Most Recent **Tab** 21 **Specialty Developing**
RUC Meeting: October 2015 **Recommendation:**

First Identified: April 2015 **2017 Est. Medicare Utilization:** 5,848

2007 Work RVU: 13.31 **2018 Work RVU:** 13.46
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 6.38 **2018 Fac PE RVU:**6.38
Result: Not Part of RAW

RUC Recommendation: Review data at RAW

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

56515 Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) **Global:** 010 **Issue:** Destruction of Lesions **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent **Tab** 16 **Specialty Developing** ACOG
RUC Meeting: September 2007 **Recommendation:**

First Identified: September 2007 **2017 Est. Medicare Utilization:** 2,449

2007 Work RVU: 3.03 **2018 Work RVU:** 3.08
2007 NF PE RVU: 2.5 **2018 NF PE RVU:** 2.5
2007 Fac PE RVU: 1.79 **2018 Fac PE RVU:** 1.79
Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

56620 Vulvectomy simple; partial

Global: 090 **Issue:** Partial Removal of Vulva **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent **Tab** D **Specialty Developing** ACOG
RUC Meeting: February 2008 **Recommendation:**

First Identified: September 2007 **2017 Est. Medicare Utilization:** 3,043

2007 Work RVU: 8.44 **2018 Work RVU:** 7.53
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 4.7 **2018 Fac PE RVU:** 4.7
Result: Decrease

RUC Recommendation: 7.35

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

57150 Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease **Global:** 000 **Issue:** Vaginal Treatments

Screen: CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent **Tab** 15 **Specialty Developing** ACOG
RUC Meeting: April 2017 **Recommendation:**

First Identified: July 2016 **2017 Est. Medicare Utilization:** 27,932

2007 Work RVU: 0.55 **2018 Work RVU:** 0.55
2007 NF PE RVU: 0.97 **2018 NF PE RVU:** 0.97
2007 Fac PE RVU: 0.2 **2018 Fac PE RVU:** 0.2
Result: Decrease

RUC Recommendation: 0.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

57155 Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy **Global:** 000 **Issue:** RAW **Screen:** Site of Service Anomaly / Different Performing Specialty from Survey **Complete?** Yes

Most Recent
RUC Meeting: January 2017

Tab 30

Specialty Developing ACOG,
Recommendation: ASTRO

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 3,235

2007 Work RVU: 6.79

2018 Work RVU: 5.15

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 4.3

2018 Fac PE RVU:4.3

Result: Decrease

RUC Recommendation: 5.40

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

57156 Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy **Global:** 000 **Issue:** RAW

Screen: Site of Service Anomaly **Complete?** Yes

Most Recent
RUC Meeting: January 2017

Tab 30

Specialty Developing ACOG,
Recommendation: ASTRO

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 14,376

2007 Work RVU:

2018 Work RVU: 2.69

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 2.69

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

57160 Fitting and insertion of pessary or other intravaginal support device

Global: 000

Issue: Vaginal Treatments

Screen: CMS 000-Day Global
Typically Reported with
an E/M

Complete? Yes

Most Recent
RUC Meeting: April 2017

Tab 15

Specialty Developing ACOG
Recommendation:

First
Identified: July 2016

2017 Est.
Medicare
Utilization: 90,878

2007 Work RVU: 0.89

2018 Work RVU: 0.89

2007 NF PE RVU: 1.02

2018 NF PE RVU: 1.02

2007 Fac PE RVU 0.32

2018 Fac PE RVU:0.32

Result: Maintain

RUC Recommendation: 0.89

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

57240 Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed **Global:** 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 14 **Specialty Developing Recommendation:** ACOG

First Identified: October 2015 **2017 Est. Medicare Utilization:** 9,932

2007 Work RVU: 11.42 **2018 Work RVU:** 10.08
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 4.22 **2018 Fac PE RVU:** 4.22
Result: Decrease

RUC Recommendation: 10.08

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

57250 Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy **Global:** 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 14 **Specialty Developing Recommendation:** ACOG

First Identified: April 2016 **2017 Est. Medicare Utilization:** 8,308

2007 Work RVU: 11.42 **2018 Work RVU:** 10.08
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 3.93 **2018 Fac PE RVU:** 3.93
Result: Decrease

RUC Recommendation: 10.08

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

57260 Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed; **Global:** 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 14 **Specialty Developing Recommendation:** ACOG

First Identified: April 2016 **2017 Est. Medicare Utilization:** 9,505

2007 Work RVU: 14.36 **2018 Work RVU:** 13.25
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 5.08 **2018 Fac PE RVU:** 5.08
Result: Decrease

RUC Recommendation: 13.25

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

57265 Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed; with enterocele repair **Global:** 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 14 **Specialty Developing Recommendation:** ACOG

First Identified: April 2016 **2017 Est. Medicare Utilization:** 4,474

2007 Work RVU: 15.86 **2018 Work RVU:** 15.00
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 6.1 **2018 Fac PE RVU:** 6.1
Result: Decrease

RUC Recommendation: 15.00

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

57287	Removal or revision of sling for stress incontinence (eg, fascia or synthetic)	Global: 090	Issue: Urological Procedures	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting: February 2008	Tab C	Specialty Developing Recommendation: AUA	First Identified: September 2007	2017 Est. Medicare Utilization: 2,014	2007 Work RVU: 11.49 2007 NF PE RVU: NA 2007 Fac PE RVU: 5.73 Result: Decrease
RUC Recommendation: 10.97			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 11.15 2018 NF PE RVU: NA 2018 Fac PE RVU: 5.73

57288	Sling operation for stress incontinence (eg, fascia or synthetic)	Global: 090	Issue: Sling Operation for Stress Incontinence	Screen: New Technology	Complete? Yes
Most Recent RUC Meeting: February 2008	Tab O	Specialty Developing Recommendation: ACOG, AUA	First Identified: September 2007	2017 Est. Medicare Utilization: 25,968	2007 Work RVU: 14.01 2007 NF PE RVU: NA 2007 Fac PE RVU: 6.21 Result: Decrease
RUC Recommendation: 12.00			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 12.13 2018 NF PE RVU: NA 2018 Fac PE RVU: 6.21

58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)	Global: 000	Issue: Biopsy of Uterus Lining	Screen: CMS 000-Day Global Typically Reported with an E/M	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 16	Specialty Developing Recommendation: ACOG	First Identified: July 2016	2017 Est. Medicare Utilization: 73,605	2007 Work RVU: 1.53 2007 NF PE RVU: 1.27 2007 Fac PE RVU: 0.69 Result: Decrease
RUC Recommendation: 1.21			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.53 2018 NF PE RVU: 1.27 2018 Fac PE RVU: 0.69

Status Report: CMS Requests and Relativity Assessment Issues

58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Biopsy of Uterus Lining	Screen: CMS 000-Day Global Typically Reported with an E/M	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 16 Specialty Developing Recommendation: ACOG	First Identified: April 2017	2017 Est. Medicare Utilization: 715	2007 Work RVU: 0.77 2007 NF PE RVU: 0.51 2007 Fac PE RVU: 0.29 Result: Maintain	2018 Work RVU: 0.77 2018 NF PE RVU: 0.51 2018 Fac PE RVU: 0.29
RUC Recommendation: 0.77		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
58555	Hysteroscopy, diagnostic (separate procedure)	Global: 000	Issue: Hysteroscopy	Screen: CMS Request - Practice Expense Review	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 37 Specialty Developing Recommendation: ACOG	First Identified: NA	2017 Est. Medicare Utilization: 1,783	2007 Work RVU: 3.33 2007 NF PE RVU: 2.32 2007 Fac PE RVU: 1.47 Result: Decrease	2018 Work RVU: 2.65 2018 NF PE RVU: 2.32 2018 Fac PE RVU: 1.47
RUC Recommendation: 3.07		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C	Global: 000	Issue: Hysteroscopy	Screen: CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 37 Specialty Developing Recommendation: ACOG	First Identified: NA	2017 Est. Medicare Utilization: 45,516	2007 Work RVU: 4.74 2007 NF PE RVU: 2.52 2007 Fac PE RVU: 2.05 Result: Decrease	2018 Work RVU: 4.17 2018 NF PE RVU: 2.52 2018 Fac PE RVU: 2.05
RUC Recommendation: 4.37		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

58559 Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)			Global: 000	Issue: Hysteroscopy	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 37	Specialty Developing Recommendation: ACOG	First Identified: July 2015	2017 Est. Medicare Utilization: 207	2007 Work RVU: 6.16 2007 NF PE RVU: NA 2007 Fac PE RVU 2.56 Result: Decrease	2018 Work RVU: 5.20 2018 NF PE RVU: NA 2018 Fac PE RVU:2.56
RUC Recommendation: 5.54			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
58560 Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)			Global: 000	Issue: Hysteroscopy	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 37	Specialty Developing Recommendation: ACOG	First Identified: July 2015	2017 Est. Medicare Utilization: 55	2007 Work RVU: 6.99 2007 NF PE RVU: NA 2007 Fac PE RVU 2.88 Result: Decrease	2018 Work RVU: 5.75 2018 NF PE RVU: NA 2018 Fac PE RVU:2.88
RUC Recommendation: 6.15			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
58561 Hysteroscopy, surgical; with removal of leiomyomata			Global: 000	Issue: Hysteroscopy	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 37	Specialty Developing Recommendation: ACOG	First Identified: July 2015	2017 Est. Medicare Utilization: 2,623	2007 Work RVU: 9.99 2007 NF PE RVU: NA 2007 Fac PE RVU 4 Result: Decrease	2018 Work RVU: 6.60 2018 NF PE RVU: NA 2018 Fac PE RVU:4
RUC Recommendation: 7.00			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

58562	Hysteroscopy, surgical; with removal of impacted foreign body		Global: 000	Issue: Hysteroscopy		Screen: CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 37	Specialty Developing Recommendation:	ACOG	First Identified: NA	2017 Est. Medicare Utilization: 258	2007 Work RVU: 5.20 2007 NF PE RVU: 2.63 2007 Fac PE RVU: 2.21 Result: Decrease	2018 Work RVU: 4.00 2018 NF PE RVU: 2.63 2018 Fac PE RVU: 2.21
RUC Recommendation: 4.17				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>							
58563	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)		Global: 000	Issue: Hysteroscopy		Screen: CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 37	Specialty Developing Recommendation:	ACOG	First Identified: NA	2017 Est. Medicare Utilization: 3,629	2007 Work RVU: 6.16 2007 NF PE RVU: 51.38 2007 Fac PE RVU: 2.58 Result: Decrease	2018 Work RVU: 4.47 2018 NF PE RVU: 51.38 2018 Fac PE RVU: 2.58
RUC Recommendation: 4.62				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>							
58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)		Global: 090	Issue: Laproscopic Procedures		Screen: Site of Service Anomaly (99238-Only)	Complete? Yes
Most Recent RUC Meeting: September 2007	Tab 16	Specialty Developing Recommendation:	AUA, ACOG	First Identified: September 2007	2017 Est. Medicare Utilization: 966	2007 Work RVU: 11.54 2007 NF PE RVU: NA 2007 Fac PE RVU: 5.07 Result: PE Only	2018 Work RVU: 11.59 2018 NF PE RVU: NA 2018 Fac PE RVU: 5.07
RUC Recommendation: Reduce 99238 to 0.5				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

58661 Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy) **Global:** 010 **Issue:** Laproscopic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent **Tab** 16 **Specialty Developing** ACOG
RUC Meeting: September 2007 **Recommendation:**

First Identified: September 2007 **2017 Est. Medicare Utilization:** 12,115

2007 Work RVU: 11.30 **2018 Work RVU:** 11.35
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 4.84 **2018 Fac PE RVU:**4.84
Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

58823 Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic) **Global:** 000 **Issue:** Drainage of Abscess

Screen: Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent **Tab** 04 **Specialty Developing**
RUC Meeting: January 2013 **Recommendation:**

First Identified: January 2012 **2017 Est. Medicare Utilization:**

2007 Work RVU: 3.37 **2018 Work RVU:**
2007 NF PE RVU: 20.75 **2018 NF PE RVU:** 20.75
2007 Fac PE RVU 1.08 **2018 Fac PE RVU:**1.08
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012
Referred to CPT Asst ☐ **Published in CPT Asst:**

59400 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care **Global:** MMM **Issue:** Obstetrical Care

Screen: High IWPUT **Complete?** Yes

Most Recent **Tab** 15 **Specialty Developing** ACOG, AAFP
RUC Meeting: October 2009 **Recommendation:**

First Identified: February 2008 **2017 Est. Medicare Utilization:** 3,371

2007 Work RVU: 26.80 **2018 Work RVU:** 32.16
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 15.06 **2018 Fac PE RVU:**15.06
Result: Increase

RUC Recommendation: 32.69

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

59409 Vaginal delivery only (with or without episiotomy and/or forceps); **Global:** MMM **Issue:** Obstetrical Care

Screen: High IWPUT **Complete?** Yes

Most Recent **Tab** 15 **Specialty Developing** ACOG, AAFP
RUC Meeting: October 2009 **Recommendation:**

First Identified: February 2008 **2017 Est. Medicare Utilization:** 1,742

2007 Work RVU: 13.48 **2018 Work RVU:** 14.37
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 4.91 **2018 Fac PE RVU:**4.91
Result: Increase

RUC Recommendation: 14.37

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59410 Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2017 Est. Medicare Utilization:** 964 **2007 Work RVU:** 15.29 **2018 Work RVU:** 18.01
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 5.96 **2018 Fac PE RVU:** 5.96
Result: Increase

RUC Recommendation: 18.54 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

59412 External cephalic version, with or without tocolysis **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2017 Est. Medicare Utilization:** 50 **2007 Work RVU:** 1.71 **2018 Work RVU:** 1.71
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 0.77 **2018 Fac PE RVU:** 0.77
Result: Maintain

RUC Recommendation: 1.71 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

59414 Delivery of placenta (separate procedure) **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2017 Est. Medicare Utilization:** 56 **2007 Work RVU:** 1.61 **2018 Work RVU:** 1.61
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 0.59 **2018 Fac PE RVU:** 0.59
Result: Maintain

RUC Recommendation: 1.61 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

59425 Antepartum care only; 4-6 visits **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2017 Est. Medicare Utilization:** 743 **2007 Work RVU:** 6.22 **2018 Work RVU:** 6.31
2007 NF PE RVU: 4.21 **2018 NF PE RVU:** 4.21
2007 Fac PE RVU: 1.81 **2018 Fac PE RVU:** 1.81
Result: Decrease

RUC Recommendation: 6.31 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59426 Antepartum care only; 7 or more visits

Global: MMM

Issue: Obstetrical Care

Screen: High IWPUT

Complete? Yes

Most Recent
RUC Meeting: October 2009

Tab 15

Specialty Developing
Recommendation: ACOG, AAFP

First
Identified: April 2008

2017 Est.
Medicare
Utilization: 827

2007 Work RVU: 11.04

2018 Work RVU: 11.16

2007 NF PE RVU: 7.6

2018 NF PE RVU: 7.6

2007 Fac PE RVU 3.17

2018 Fac PE RVU:3.17

Result: Decrease

RUC Recommendation: 11.16

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

59430 Postpartum care only (separate procedure)

Global: MMM

Issue: Obstetrical Care

Screen: High IWPUT

Complete? Yes

Most Recent
RUC Meeting: October 2009

Tab 15

Specialty Developing
Recommendation: ACOG, AAFP

First
Identified: April 2008

2017 Est.
Medicare
Utilization: 1,251

2007 Work RVU: 2.13

2018 Work RVU: 2.47

2007 NF PE RVU: 1.19

2018 NF PE RVU: 1.19

2007 Fac PE RVU 0.88

2018 Fac PE RVU:0.88

Result: Increase

RUC Recommendation: 2.47

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

59510 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care

Global: MMM

Issue: Obstetrical Care

Screen: High IWPUT

Complete? Yes

Most Recent
RUC Meeting: October 2009

Tab 15

Specialty Developing
Recommendation: ACOG, AAFP

First
Identified: February 2008

2017 Est.
Medicare
Utilization: 2,885

2007 Work RVU: 30.34

2018 Work RVU: 35.64

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 16.92

2018 Fac PE RVU:16.92

Result: Increase

RUC Recommendation: 36.17

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

59514 Cesarean delivery only;

Global: MMM

Issue: Obstetrical Care

Screen: High IWPUT

Complete? Yes

Most Recent
RUC Meeting: October 2009

Tab 15

Specialty Developing
Recommendation: ACOG, AAFP

First
Identified:

2017 Est.
Medicare
Utilization: 1,451

2007 Work RVU: 15.95

2018 Work RVU: 16.13

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 5.78

2018 Fac PE RVU:5.78

Result: Increase

RUC Recommendation: 16.13

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

59515 Cesarean delivery only; including postpartum care

Global: MMM

Issue: Obstetrical Care

Screen: High IWPUT

Complete? Yes

Most Recent
RUC Meeting: October 2009

Tab 15

Specialty Developing
Recommendation: ACOG, AAFP

First
Identified: April 2008

2017 Est.
Medicare
Utilization: 930

2007 Work RVU: 18.26
2007 NF PE RVU: NA
2007 Fac PE RVU 7.43
Result: Increase

2018 Work RVU: 21.47
2018 NF PE RVU: NA
2018 Fac PE RVU:7.43

RUC Recommendation: 22.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery

Global: MMM

Issue: Obstetrical Care

Screen: High IWPUT

Complete? Yes

Most Recent
RUC Meeting: October 2009

Tab 15

Specialty Developing
Recommendation: ACOG, AAFP

First
Identified: April 2008

2017 Est.
Medicare
Utilization: 110

2007 Work RVU: 28.21
2007 NF PE RVU: NA
2007 Fac PE RVU 15.52
Result: Increase

2018 Work RVU: 33.87
2018 NF PE RVU: NA
2018 Fac PE RVU:15.52

RUC Recommendation: 34.40

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);

Global: MMM

Issue: Obstetrical Care

Screen: High IWPUT

Complete? Yes

Most Recent
RUC Meeting: October 2009

Tab 15

Specialty Developing
Recommendation: ACOG, AAFP

First
Identified: April 2008

2017 Est.
Medicare
Utilization: 68

2007 Work RVU: 15.04
2007 NF PE RVU: NA
2007 Fac PE RVU 5.6
Result: Increase

2018 Work RVU: 16.09
2018 NF PE RVU: NA
2018 Fac PE RVU:5.6

RUC Recommendation: 16.09

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

59614 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care

Global: MMM

Issue: Obstetrical Care

Screen: High IWPUT

Complete? Yes

Most Recent
RUC Meeting: October 2009

Tab 15

Specialty Developing
Recommendation: ACOG, AAFP

First
Identified: April 2008

2017 Est.
Medicare
Utilization: 45

2007 Work RVU: 16.59
2007 NF PE RVU: NA
2007 Fac PE RVU 6.49
Result: Increase

2018 Work RVU: 19.73
2018 NF PE RVU: NA
2018 Fac PE RVU:6.49

RUC Recommendation: 20.26

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

59618 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009

Tab 15 Specialty Developing Recommendation: ACOG, AAFP

First Identified: April 2008

2017 Est. Medicare Utilization: 22

2007 Work RVU: 31.78
2007 NF PE RVU: NA
2007 Fac PE RVU 17.74
Result: Increase

2018 Work RVU: 36.16
2018 NF PE RVU: NA
2018 Fac PE RVU:17.74

RUC Recommendation: 36.69

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009

Tab 15 Specialty Developing Recommendation: ACOG, AAFP

First Identified: April 2008

2017 Est. Medicare Utilization: 16

2007 Work RVU: 17.50
2007 NF PE RVU: NA
2007 Fac PE RVU 6.27
Result: Decrease

2018 Work RVU: 16.66
2018 NF PE RVU: NA
2018 Fac PE RVU:6.27

RUC Recommendation: 16.66

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

59622 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009

Tab 15 Specialty Developing Recommendation: ACOG, AAFP

First Identified: April 2008

2017 Est. Medicare Utilization: 6

2007 Work RVU: 19.70
2007 NF PE RVU: NA
2007 Fac PE RVU 8.14
Result: Increase

2018 Work RVU: 22.00
2018 NF PE RVU: NA
2018 Fac PE RVU:8.14

RUC Recommendation: 22.53

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

60220 Total thyroid lobectomy, unilateral; with or without isthmusectomy **Global:** 090 **Issue:** Total Thyroid Lobectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008

Tab 46 Specialty Developing Recommendation: ACS, AAO-HNS

First Identified: September 2007

2017 Est. Medicare Utilization: 8,164

2007 Work RVU: 12.29
2007 NF PE RVU: NA
2007 Fac PE RVU 5.96
Result: Maintain

2018 Work RVU: 11.19
2018 NF PE RVU: NA
2018 Fac PE RVU:5.96

RUC Recommendation: 12.29

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

60225 Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy **Global:** 090 **Issue:** Total Thyroid Lobectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008

Tab 46 **Specialty Developing Recommendation:** ACS, AAO-HNS

First Identified: September 2007

2017 Est. Medicare Utilization: 359

2007 Work RVU: 14.67

2018 Work RVU: 14.79

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 7.22

2018 Fac PE RVU: 7.22

Result: Maintain

RUC Recommendation: 14.67

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

60520 Thymectomy, partial or total; transcervical approach (separate procedure)

Global: 090

Issue: RAW Review

Screen: CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013

Complete? Yes

Most Recent RUC Meeting: January 2013

Tab 34 **Specialty Developing Recommendation:**

First Identified: November 2011

2017 Est. Medicare Utilization: 365

2007 Work RVU: 17.07

2018 Work RVU: 17.16

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 7.95

2018 Fac PE RVU: 7.95

Result: Remove from Screen

RUC Recommendation: No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures.

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

60521 Thymectomy, partial or total; sternal split or transthoracic approach, without radical mediastinal dissection (separate procedure)

Global: 090

Issue: RAW Review

Screen: CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013

Complete? Yes

Most Recent RUC Meeting: January 2013

Tab 34 **Specialty Developing Recommendation:**

First Identified: November 2011

2017 Est. Medicare Utilization: 331

2007 Work RVU: 19.11

2018 Work RVU: 19.18

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 9.22

2018 Fac PE RVU: 9.22

Result: Remove from Screen

RUC Recommendation: No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures.

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

60522	Thymectomy, partial or total; sternal split or transthoracic approach, with radical mediastinal dissection (separate procedure)	Global: 090	Issue: RAW Review	Screen: CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013	Complete? Yes
Most Recent RUC Meeting: January 2013	Tab 34 Specialty Developing Recommendation:	First Identified: November 2011	2017 Est. Medicare Utilization: 116	2007 Work RVU: 23.37 2007 NF PE RVU: NA 2007 Fac PE RVU: 10.89 Result: Remove from Screen	2018 Work RVU: 23.48 2018 NF PE RVU: NA 2018 Fac PE RVU: 10.89
RUC Recommendation: No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures.		Referred to CPT			
		Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	
61055	Cisternal or lateral cervical (C1-C2) puncture; with injection of medication or other substance for diagnosis or treatment	Global: 000	Issue: Myelography	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 17 Specialty Developing Recommendation:	First Identified: January 2014	2017 Est. Medicare Utilization: 437	2007 Work RVU: 2.10 2007 NF PE RVU: NA 2007 Fac PE RVU: 1.37 Result: Remove from screen	2018 Work RVU: 2.10 2018 NF PE RVU: NA 2018 Fac PE RVU: 1.37
RUC Recommendation: Editorial change		Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	
61781	Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Stereotactic Computer-Assisted Volumetric Navigational Procedures	Screen: CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: February 2010	Tab 13 Specialty Developing Recommendation: NASS, AANS/CNS	First Identified: October 2009	2017 Est. Medicare Utilization: 14,634	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Decrease	2018 Work RVU: 3.75 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 3.75		Referred to CPT October 2009 Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

61782	Stereotactic computer-assisted (navigational) procedure; cranial, extradural (List separately in addition to code for primary procedure)		Global: ZZZ	Issue: Stereotactic Computer-Assisted Volumetric Navigational Procedures	Screen: CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: February 2010	Tab 13	Specialty Developing Recommendation: NASS, AANS/CNS, AAO-HNS	First Identified: October 2009	2017 Est. Medicare Utilization: 14,610	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 3.18 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 3.18			Referred to CPT October 2009 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
61783	Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)		Global: ZZZ	Issue: Stereotactic Computer-Assisted Volumetric Navigational Procedures	Screen: CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: February 2010	Tab 13	Specialty Developing Recommendation: NASS, AANS/CNS	First Identified: October 2009	2017 Est. Medicare Utilization: 11,189	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 3.75 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 3.75			Referred to CPT October 2009 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
61793	Deleted from CPT		Global: 090	Issue: Stereotactic Radiosurgery	Screen: CMS Fastest Growing, Site of Service Anomaly (99238-Only)	Complete? Yes
Most Recent RUC Meeting: October 2008	Tab 26	Specialty Developing Recommendation: AANS	First Identified: September 2007	2017 Est. Medicare Utilization:	2007 Work RVU: 17.75 2007 NF PE RVU: NA 2007 Fac PE RVU 10.08 Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU:10.08
RUC Recommendation: Deleted from CPT			Referred to CPT February 2008 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

61795 Deleted from CPT **Global:** ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** NASS, AAO-HNS, AANS **First Identified:** October 2008 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 4.03 **2018 Work RVU:** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 1.87 **2018 Fac PE RVU:** 1.87 **Result:** Deleted from CPT
RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

61796 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion **Global:** 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2017 Est. Medicare Utilization:** 6,487 **2007 Work RVU:** **2018 Work RVU:** 13.93 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Decrease
RUC Recommendation: 15.50 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

61797 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2017 Est. Medicare Utilization:** 7,200 **2007 Work RVU:** **2018 Work RVU:** 3.48 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Decrease
RUC Recommendation: 3.48 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

61798 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion **Global:** 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2017 Est. Medicare Utilization:** 3,523 **2007 Work RVU:** **2018 Work RVU:** 19.85 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Decrease
RUC Recommendation: 19.75 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

61799 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2017 Est. Medicare Utilization:** 701 **2007 Work RVU:** **2007 NF PE RVU:** **2007 Fac PE RVU Result:** Decrease **2018 Work RVU:** 4.81 **2018 NF PE RVU:** **2018 Fac PE RVU:**

RUC Recommendation: 4.81 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

61800 Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 16 **Specialty Developing Recommendation:** **First Identified:** **2017 Est. Medicare Utilization:** 5,921 **2007 Work RVU:** **2007 NF PE RVU:** **2007 Fac PE RVU Result:** Decrease **2018 Work RVU:** 2.25 **2018 NF PE RVU:** **2018 Fac PE RVU:**

RUC Recommendation: 2.25 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

61885 Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array **Global:** 090 **Issue:** Vagal Nerve Stimulator **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 14 **Specialty Developing Recommendation:** AANS/CNS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 5,781 **2007 Work RVU:** 7.37 **2007 NF PE RVU:** NA **2007 Fac PE RVU** 5.85 **2018 Work RVU:** 6.05 **2018 NF PE RVU:** NA **2018 Fac PE RVU:** 5.85

RUC Recommendation: 6.44 **Referred to CPT** October 2009 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

Status Report: CMS Requests and Relativity Assessment Issues

62263 Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days **Global:** 010 **Issue:** Epidural Lysis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 66

Specialty Developing Recommendation:

AAPM, AANS/CNS, ASA, NASS

First Identified: September 2007

2017 Est. Medicare Utilization: 467

2007 Work RVU: 6.41

2018 Work RVU: 5.00

2007 NF PE RVU: 11.78

2018 NF PE RVU: 11.78

2007 Fac PE RVU 3.11

2018 Fac PE RVU:3.11

Result: Maintain

RUC Recommendation: 6.54

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

62270 Spinal puncture, lumbar, diagnostic

Global: 000

Issue: Lumbar Puncture

Screen: Different Performing Specialty from Survey

Complete? No

Most Recent RUC Meeting: January 2018

Tab 31

Specialty Developing Recommendation:

ACR, ASNR, SIR

First Identified: October 2017

2017 Est. Medicare Utilization: 81,867

2007 Work RVU: 1.37

2018 Work RVU: 1.37

2007 NF PE RVU: 2.82

2018 NF PE RVU: 2.82

2007 Fac PE RVU 0.55

2018 Fac PE RVU:0.55

Result:

RUC Recommendation: Refer to CPT

Referred to CPT September 2018

Referred to CPT Asst ☐

Published in CPT Asst:

62272 Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter)

Global: 000

Issue: Lumbar Puncture

Screen: Different Performing Specialty from Survey

Complete? No

Most Recent RUC Meeting:

Tab

Specialty Developing Recommendation:

First Identified: September 2018

2017 Est. Medicare Utilization: 6,526

2007 Work RVU: 1.35

2018 Work RVU: 1.35

2007 NF PE RVU: 3.47

2018 NF PE RVU: 3.47

2007 Fac PE RVU 0.68

2018 Fac PE RVU:0.68

Result:

RUC Recommendation:

Referred to CPT September 2018

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

62281 Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic **Global:** 010 **Issue:** Injection of Neurolytic Agent **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 415 **2007 Work RVU:** 2.66 **2018 Work RVU:** 2.66 **2007 NF PE RVU:** 5.16 **2018 NF PE RVU:** 5.16 **2007 Fac PE RVU:** 0.89 **2018 Fac PE RVU:** 0.89 **RUC Recommendation:** Remove 99238 **Referred to CPT** **Referred to CPT Asst** ☒ **Published in CPT Asst:** Q&A May 2010 **Result:** PE Only

62284 Injection procedure for myelography and/or computed tomography, lumbar **Global:** 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2017 Est. Medicare Utilization:** 14,665 **2007 Work RVU:** 1.54 **2018 Work RVU:** 1.54 **2007 NF PE RVU:** 4.62 **2018 NF PE RVU:** 4.62 **2007 Fac PE RVU:** 0.67 **2018 Fac PE RVU:** 0.67 **RUC Recommendation:** 1.54 **Referred to CPT** October 2013 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

62287 Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar **Global:** 090 **Issue:** Percutaneous Discectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab** 16 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 205 **2007 Work RVU:** 8.88 **2018 Work RVU:** 9.03 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 5.18 **2018 Fac PE RVU:** 5.18 **RUC Recommendation:** Reduce 99238 to 0.5 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** PE Only

Status Report: CMS Requests and Relativity Assessment Issues

62290 Injection procedure for discography, each level; lumbar

Global: 000

Issue: Injection for discography

Screen: Different Performing
Specialty from Survey

Complete? Yes

**Most Recent
RUC Meeting:** April 2010

Tab 45

**Specialty Developing
Recommendation:**

ASA, AAPM,
AAMPR,
AUR, NASS,
ACR, ASNR,
ISIS, AANS

**First
Identified:** October 2009

**2017 Est.
Medicare
Utilization:** 9,063

2007 Work RVU: 3.00

2018 Work RVU: 3.00

2007 NF PE RVU: 6.43

2018 NF PE RVU: 6.43

2007 Fac PE RVU 1.31

2018 Fac PE RVU:1.31

RUC Recommendation: 3.00, CPT Assistant article published.

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Mar 2011

Result: Maintain

622X0

Global:

Issue: Lumbar Puncture

Screen: Different Performing
Specialty from Survey

Complete? No

**Most Recent
RUC Meeting:**

Tab

**Specialty Developing
Recommendation:**

**First
Identified:** September 2018

**2017 Est.
Medicare
Utilization:**

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation:

Referred to CPT September 2018

Referred to CPT Asst ☐

Published in CPT Asst:

Result:

622X1

Global:

Issue: Lumbar Puncture

Screen: Different Performing
Specialty from Survey

Complete? No

**Most Recent
RUC Meeting:**

Tab

**Specialty Developing
Recommendation:**

**First
Identified:** September 2018

**2017 Est.
Medicare
Utilization:**

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation:

Referred to CPT September 2018

Referred to CPT Asst ☐

Published in CPT Asst:

Result:

Status Report: CMS Requests and Relativity Assessment Issues

62302 Myelography via lumbar injection, including radiological supervision and interpretation; cervical **Global:** 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 17 **Specialty Developing Recommendation:** ACR, ASNR

First Identified: October 2012

2017 Est. Medicare Utilization: 5,249

2007 Work RVU:

2018 Work RVU: 2.29

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 2.29

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

62303 Myelography via lumbar injection, including radiological supervision and interpretation; thoracic

Global: 000 **Issue:** Myelography

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: April 2014

Tab 17 **Specialty Developing Recommendation:** ACR, ASNR

First Identified: October 2012

2017 Est. Medicare Utilization: 459

2007 Work RVU:

2018 Work RVU: 2.29

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 2.29

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

62304 Myelography via lumbar injection, including radiological supervision and interpretation; lumbosacral

Global: 000 **Issue:** Myelography

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: April 2014

Tab 17 **Specialty Developing Recommendation:** ACR, ASNR

First Identified: October 2012

2017 Est. Medicare Utilization: 23,115

2007 Work RVU:

2018 Work RVU: 2.25

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 2.25

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62305 Myelography via lumbar injection, including radiological supervision and interpretation; 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical) **Global:** 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 17 Specialty Developing Recommendation: ACR, ASNR

First Identified: October 2012

2017 Est. Medicare Utilization: 7,295

2007 Work RVU:

2018 Work RVU: 2.35

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 2.35

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

62310 Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic

Global: 000

Issue: Epidural Injections

Screen: CMS High Expenditure Procedural Codes1 / Final Rule for 2015

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 10 Specialty Developing Recommendation: AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP

First Identified: January 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 1.91

2018 Work RVU:

2007 NF PE RVU: 4.35

2018 NF PE RVU: 4.35

2007 Fac PE RVU 0.63

2018 Fac PE RVU: 0.63

RUC Recommendation: Deleted from CPT

Referred to CPT May 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

62311 Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)

Global: 000

Issue: Epidural Injections

Screen: CMS High Expenditure Procedural Codes1 / Final Rule for 2015

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 10 Specialty Developing Recommendation: AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP

First Identified: September 2011

2017 Est. Medicare Utilization:

2007 Work RVU: 1.54

2018 Work RVU:

2007 NF PE RVU: 4.35

2018 NF PE RVU: 4.35

2007 Fac PE RVU 0.58

2018 Fac PE RVU: 0.58

RUC Recommendation: Deleted from CPT

Referred to CPT May 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

62318	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic	Global: 000	Issue: Epidural Injections	Screen: CMS High Expenditure Procedural Codes1 / Final Rule for 2015	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 10	Specialty Developing Recommendation: AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP	First Identified: January 2012	2017 Est. Medicare Utilization:	2007 Work RVU: 2.04 2007 NF PE RVU: 5.09 2007 Fac PE RVU 0.61 2018 Work RVU: 2018 NF PE RVU: 5.09 2018 Fac PE RVU:0.61
RUC Recommendation: Deleted from CPT			Referred to CPT May 2015 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Deleted from CPT

62319	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)	Global: 000	Issue: Epidural Injections	Screen: CMS High Expenditure Procedural Codes1 / Final Rule for 2015	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 10	Specialty Developing Recommendation: AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP	First Identified: January 2012	2017 Est. Medicare Utilization:	2007 Work RVU: 1.87 2007 NF PE RVU: 4.45 2007 Fac PE RVU 0.58 2018 Work RVU: 2018 NF PE RVU: 4.45 2018 Fac PE RVU:0.58
RUC Recommendation: Deleted from CPT			Referred to CPT May 2015 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

62320 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, cervical or thoracic; without imaging guidance **Global:** 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015

Tab 10

Specialty Developing Recommendation:

AANS,
AANEM,
AAPM,
AAPM&R,
ACR, ASIPP,
ASA, ASNR,
CNS, ISIS,
NASS

First Identified: May 2015

2017 Est. Medicare Utilization: 10,537

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 1.80
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.80

Referred to CPT May 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

62321 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, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT) **Global:** 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015

Tab 10

Specialty Developing Recommendation:

AANS,
AANEM,
AAPM,
AAPM&R,
ACR, ASIPP,
ASA, ASNR,
CNS, ISIS,
NASS

First Identified: May 2015

2017 Est. Medicare Utilization: 215,908

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 1.95
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.95

Referred to CPT May 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

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 **Global:** 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015

Tab 10

Specialty Developing Recommendation:

AANS,
AANEM,
AAPM,
AAPM&R,
ACR, ASIPP,
ASA, ASNR,
CNS, ISIS,
NASS

First Identified: May 2015

2017 Est. Medicare Utilization: 60,800

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU:

2018 Work RVU: 1.55
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.55

Referred to CPT May 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

62323 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); with imaging guidance (ie, fluoroscopy or CT) **Global:** 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015

Tab 10

Specialty Developing Recommendation:

AANS,
AANEM,
AAPM,
AAPM&R,
ACR, ASIPP,
ASA, ASNR,
CNS, ISIS,
NASS

First Identified: May 2015

2017 Est. Medicare Utilization: 738,694

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU:

2018 Work RVU: 1.80
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.80

Referred to CPT May 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

62324 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent
RUC Meeting: October 2015

Tab 10

Specialty Developing
Recommendation:

AANS,
AANEM,
AAPM,
AAPM&R,
ACR, ASIPP,
ASA, ASNR,
CNS, ISIS,
NASS

First
Identified: May 2015

2017 Est.
Medicare
Utilization: 25,856

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 1.89
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.89

Referred to CPT May 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

62325 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent
RUC Meeting: October 2015

Tab 10

Specialty Developing
Recommendation:

AANS,
AANEM,
AAPM,
AAPM&R,
ACR, ASIPP,
ASA, ASNR,
CNS, ISIS,
NASS

First
Identified: May 2015

2017 Est.
Medicare
Utilization: 1,756

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 2.20
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 2.20

Referred to CPT May 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

62326 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance **Global:** 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent
RUC Meeting: October 2015

Tab 10

Specialty Developing Recommendation: AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS

First Identified: May 2015

2017 Est. Medicare Utilization: 7,763

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 1.78
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.78

Referred to CPT May 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

62327 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT) **Global:** 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent
RUC Meeting: October 2015

Tab 10

Specialty Developing Recommendation: AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS

First Identified: May 2015

2017 Est. Medicare Utilization: 2,316

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 1.90
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.90

Referred to CPT May 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

62350	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy	Global: 010	Issue: Intrathecal Epidural Catheters & Pumps	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 67	Specialty Developing Recommendation: AAPM, AANS/CNS, ASA, ISIS, NASS	First Identified: September 2007	2017 Est. Medicare Utilization: 5,299	2007 Work RVU: 8.04 2007 NF PE RVU: NA 2007 Fac PE RVU 4 2018 Work RVU: 6.05 2018 NF PE RVU: NA 2018 Fac PE RVU: 4
RUC Recommendation: 6.05			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease
<hr/>					
62355	Removal of previously implanted intrathecal or epidural catheter	Global: 010	Issue: Intrathecal Epidural Catheters & Pumps	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 67	Specialty Developing Recommendation: AAPM, AANS/CNS, ASA, ISIS, NASS	First Identified: September 2007	2017 Est. Medicare Utilization: 1,135	2007 Work RVU: 6.60 2007 NF PE RVU: NA 2007 Fac PE RVU 3.27 2018 Work RVU: 3.55 2018 NF PE RVU: NA 2018 Fac PE RVU: 3.27
RUC Recommendation: 4.35			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease
<hr/>					
62360	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir	Global: 010	Issue: Intrathecal Epidural Catheters & Pumps	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 67	Specialty Developing Recommendation: AAPMR, ASA, NASS, AAPM, AANS/CNS	First Identified: April 2008	2017 Est. Medicare Utilization: 299	2007 Work RVU: 3.68 2007 NF PE RVU: NA 2007 Fac PE RVU 2.87 2018 Work RVU: 4.33 2018 NF PE RVU: NA 2018 Fac PE RVU: 2.87
RUC Recommendation: 4.33			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

62361 Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump **Global:** 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 67

Specialty Developing Recommendation: AAPM, AANS/CNS, ASA, ISIS, NASS

First Identified: April 2008

2017 Est. Medicare Utilization: 42

2007 Work RVU: 6.59

2018 Work RVU: 5.00

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.94

2018 Fac PE RVU:3.94

RUC Recommendation: 5.65

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

62362 Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming **Global:** 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 67

Specialty Developing Recommendation: AAPM, AANS/CNS, ASA, ISIS, NASS

First Identified: September 2007

2017 Est. Medicare Utilization: 7,500

2007 Work RVU: 8.58

2018 Work RVU: 5.60

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 4.46

2018 Fac PE RVU:4.46

RUC Recommendation: 6.10

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

62365 Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion **Global:** 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010

Tab 67

Specialty Developing Recommendation: AAPMR, ASA, NASS, AAPM, AANS/CNS

First Identified: September 2007

2017 Est. Medicare Utilization: 1,241

2007 Work RVU: 6.57

2018 Work RVU: 3.93

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.65

2018 Fac PE RVU:3.65

RUC Recommendation: 4.65

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

62367	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill	Global: XXX	Issue: Electronic Analysis Implanted Pump (PE Only)	Screen: Different Performing Specialty from Survey	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 14 Specialty Developing Recommendation: AAPM, AAPMR, ASA, SIS	First Identified: October 2009	2017 Est. Medicare Utilization: 9,842	2007 Work RVU: 0.48 2007 NF PE RVU: 0.56 2007 Fac PE RVU: 0.1 Result: Maintain	2018 Work RVU: 0.48 2018 NF PE RVU: 0.56 2018 Fac PE RVU: 0.1
RUC Recommendation: New PE inputs. 0.48		Referred to CPT October 2010 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
62368	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming	Global: XXX	Issue: Electronic Analysis Implanted Pump (PE Only)	Screen: Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 14 Specialty Developing Recommendation: AAPM, AAPMR, ASA, SIS	First Identified: October 2009	2017 Est. Medicare Utilization: 42,780	2007 Work RVU: 0.75 2007 NF PE RVU: 0.67 2007 Fac PE RVU: 0.17 Result: Decrease	2018 Work RVU: 0.67 2018 NF PE RVU: 0.67 2018 Fac PE RVU: 0.17
RUC Recommendation: New PE inputs. 0.67		Referred to CPT October 2010 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
62369	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill	Global: XXX	Issue: Electronic Analysis Implanted Pump (PE Only)	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 14 Specialty Developing Recommendation: AAPM, AAPMR, ASA, SIS	First Identified:	2017 Est. Medicare Utilization: 35,471	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Decrease	2018 Work RVU: 0.67 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: New PE inputs. 0.67		Referred to CPT October 2010 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

62370	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)	Global: XXX	Issue: Electronic Analysis Implanted Pump (PE Only)	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes	
Most Recent RUC Meeting: April 2018	Tab 14	Specialty Developing Recommendation: AAPM, AAPMR, ASA, SIS	First Identified:	2017 Est. Medicare Utilization: 96,344	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 0.90 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: New PE inputs. 1.10			Referred to CPT October 2010 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	Global: 090	Issue: RAW	Screen: Pre-Time Analysis / Site of Service Anomaly - 2018	Complete? No	
Most Recent RUC Meeting: September 2014	Tab 21	Specialty Developing Recommendation: AANS, AAOS, NASS	First Identified: January 2014	2017 Est. Medicare Utilization: 32,823	2007 Work RVU: 13.03 2007 NF PE RVU: NA 2007 Fac PE RVU 8.5 Result: Maintain	2018 Work RVU: 13.18 2018 NF PE RVU: NA 2018 Fac PE RVU: 8.5
RUC Recommendation: Review action plan. Maintain work RVU and adjust the times from pre-time package 4.			Referred to CPT Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar	Global: 090	Issue: RAW	Screen: Pre-Time Analysis	Complete? Yes	
Most Recent RUC Meeting: September 2014	Tab 21	Specialty Developing Recommendation: AANS, AAOS, NASS	First Identified: January 2014	2017 Est. Medicare Utilization: 13,453	2007 Work RVU: 18.61 2007 NF PE RVU: NA 2007 Fac PE RVU 11.2 Result: Maintain	2018 Work RVU: 18.76 2018 NF PE RVU: NA 2018 Fac PE RVU: 11.2
RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.			Referred to CPT Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			

Status Report: CMS Requests and Relativity Assessment Issues

63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical	Global: 090	Issue: Laminectomy	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: September 2014	Tab 16 Specialty Developing Recommendation:	First Identified: November 2013	2017 Est. Medicare Utilization: 10,213	2007 Work RVU: 17.82 2007 NF PE RVU: NA 2007 Fac PE RVU: 10.4 Result: Maintain	2018 Work RVU: 17.95 2018 NF PE RVU: NA 2018 Fac PE RVU: 10.4
RUC Recommendation: 17.95		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
63046	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; thoracic	Global: 090	Issue: Laminectomy	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: September 2014	Tab 16 Specialty Developing Recommendation:	First Identified: November 2013	2017 Est. Medicare Utilization: 3,547	2007 Work RVU: 17.12 2007 NF PE RVU: NA 2007 Fac PE RVU: 10.13 Result: Maintain	2018 Work RVU: 17.25 2018 NF PE RVU: NA 2018 Fac PE RVU: 10.13
RUC Recommendation: 17.25		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar	Global: 090	Issue: Laminectomy	Screen: CMS High Expenditure Procedural Codes ¹	Complete? Yes
Most Recent RUC Meeting: January 2013	Tab 24 Specialty Developing Recommendation: NASS, AANS	First Identified: September 2011	2017 Est. Medicare Utilization: 104,390	2007 Work RVU: 15.22 2007 NF PE RVU: NA 2007 Fac PE RVU: 9.79 Result: Maintain	2018 Work RVU: 15.37 2018 NF PE RVU: NA 2018 Fac PE RVU: 9.79
RUC Recommendation: 15.37		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Laminectomy	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: January 2013	Tab 24	Specialty Developing Recommendation: NASS, AANS	First Identified: January 2012	2017 Est. Medicare Utilization: 134,483	2007 Work RVU: 3.47 2007 NF PE RVU: NA 2007 Fac PE RVU: 1.58 Result: Maintain 2018 Work RVU: 3.47 2018 NF PE RVU: NA 2018 Fac PE RVU: 1.58
RUC Recommendation: 3.47			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
<hr/>					
63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)	Global: 090	Issue: RAW	Screen: CMS Fastest Growing / CPT Assistant Analysis	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 21	Specialty Developing Recommendation: NASS, AANS	First Identified: October 2008	2017 Est. Medicare Utilization: 6,495	2007 Work RVU: 21.73 2007 NF PE RVU: NA 2007 Fac PE RVU: 12.31 Result: Maintain 2018 Work RVU: 21.86 2018 NF PE RVU: NA 2018 Fac PE RVU: 12.31
RUC Recommendation: Review action plan at RAW Oct 2015. Maintain			Referred to CPT February 2010 Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Oct 2009	
<hr/>					
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace	Global: 090	Issue: Arthrodesis Including Discectomy	Screen: Codes Reported Together 95% or More	Complete? Yes
Most Recent RUC Meeting: February 2010	Tab 5	Specialty Developing Recommendation: NASS, AANS/CNS	First Identified: February 2008	2017 Est. Medicare Utilization: 614	2007 Work RVU: 19.47 2007 NF PE RVU: NA 2007 Fac PE RVU: 11.87 Result: Maintain 2018 Work RVU: 19.60 2018 NF PE RVU: NA 2018 Fac PE RVU: 11.87
RUC Recommendation: 19.60			Referred to CPT October 2009 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

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63076	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Arthrodesis Including Discectomy	Screen: Codes Reported Together 95% or More	Complete? Yes
Most Recent RUC Meeting: February 2010	Tab 5	Specialty Developing Recommendation: NASS, AANS/CNS	First Identified:	2017 Est. Medicare Utilization: 425	2007 Work RVU: 4.04 2007 NF PE RVU: NA 2007 Fac PE RVU: 1.93 Result: Maintain 2018 Work RVU: 4.04 2018 NF PE RVU: NA 2018 Fac PE RVU: 1.93
RUC Recommendation: 4.04			Referred to CPT October 2009 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
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63090	Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment	Global: 090	Issue: Vertebral Corpectomy with Arthrodesis	Screen: Codes Reported Together 75% or More-Part3	Complete? No
Most Recent RUC Meeting: January 2017	Tab 30	Specialty Developing Recommendation: AAOS, AANS	First Identified: January 2015	2017 Est. Medicare Utilization: 886	2007 Work RVU: 30.78 2007 NF PE RVU: NA 2007 Fac PE RVU: 15.58 Result: 2018 Work RVU: 30.93 2018 NF PE RVU: NA 2018 Fac PE RVU: 15.58
RUC Recommendation: Review action plan and additional data			Referred to CPT September 2016 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
<hr/>					
63620	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion	Global: 090	Issue: Stereotactic Radiosurgery	Screen: CMS Request - 2009 Final Rule	Complete? Yes
Most Recent RUC Meeting: February 2009	Tab 38	Specialty Developing Recommendation:	First Identified: NA	2017 Est. Medicare Utilization: 443	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Decrease 2018 Work RVU: 15.60 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 15.50			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

63621	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)		Global: ZZZ	Issue: Stereotactic Radiosurgery	Screen: CMS Request - 2009 Final Rule	Complete? Yes	
Most Recent RUC Meeting:	February 2009	Tab 38	Specialty Developing Recommendation:	First Identified: NA	2017 Est. Medicare Utilization: 98	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 4.00 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 4.00				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
63650	Percutaneous implantation of neurostimulator electrode array, epidural		Global: 010	Issue: Percutaneous implantation of neurostimulator	Screen: Site of Service Anomaly / CMS Fastest Growing / CMS Request - Final Rule for 2013	Complete? Yes	
Most Recent RUC Meeting:	April 2013	Tab 22	Specialty Developing Recommendation: AAPM, AANS/CNS, ASA, ISIS, NASS	First Identified: September 2007	2017 Est. Medicare Utilization: 79,224	2007 Work RVU: 7.57 2007 NF PE RVU: NA 2007 Fac PE RVU 3.11	2018 Work RVU: 7.15 2018 NF PE RVU: NA 2018 Fac PE RVU:3.11
RUC Recommendation: 7.20. New PE Inputs				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease	
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural		Global: 090	Issue: Neurostimulator (Spinal)	Screen: CMS Fastest Growing	Complete? Yes	
Most Recent RUC Meeting:	April 2009	Tab 17	Specialty Developing Recommendation: NASS, AANS	First Identified: October 2008	2017 Est. Medicare Utilization: 8,225	2007 Work RVU: 11.43 2007 NF PE RVU: NA 2007 Fac PE RVU 7.15	2018 Work RVU: 10.92 2018 NF PE RVU: NA 2018 Fac PE RVU:7.15
RUC Recommendation: 11.43				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain	

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63660 Deleted from CPT

Global: 090

Issue: Neurostimulator (Spinal)

Screen: Site of Service Anomaly
/ CMS Fastest Growing

Complete? Yes

**Most Recent
RUC Meeting:** April 2009

Tab 17

**Specialty Developing
Recommendation:**

AAPM,
AANS/CNS,
ASA, ISIS,
NASS

**First
Identified:** September 2007

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 6.87

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 3.54

2018 Fac PE RVU:3.54

RUC Recommendation: Deleted from CPT

Referred to CPT October 2008

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

63661 Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed

Global: 010

Issue: Neurostimulator (Spinal)

Screen: Site of Service Anomaly
/ CMS Fastest Growing

Complete? Yes

**Most Recent
RUC Meeting:** April 2009

Tab 17

**Specialty Developing
Recommendation:**

ISIS, NASS,
AANS/CNS,
ASA, AAPM

**First
Identified:**

**2017 Est.
Medicare
Utilization:** 3,505

2007 Work RVU:

2018 Work RVU: 5.08

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: 5.03

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

63662 Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed

Global: 090

Issue: Neurostimulator (Spinal)

Screen: Site of Service Anomaly
/ CMS Fastest Growing

Complete? Yes

**Most Recent
RUC Meeting:** April 2009

Tab 17

**Specialty Developing
Recommendation:**

ISIS, NASS,
AANS/CNS,
ASA, AAPM

**First
Identified:**

**2017 Est.
Medicare
Utilization:** 2,046

2007 Work RVU:

2018 Work RVU: 11.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: 10.87

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

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63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	Global: 010	Issue: Neurostimulator (Spinal)	Screen: Site of Service Anomaly / CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: April 2009	Tab 17	Specialty Developing Recommendation: ISIS, NASS, AANS/CNS, ASA, AAPM	First Identified:	2017 Est. Medicare Utilization: 1,311	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease
RUC Recommendation: 70			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 7.75 2018 NF PE RVU: 2018 Fac PE RVU:
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	Global: 090	Issue: Neurostimulator (Spinal)	Screen: Site of Service Anomaly / CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: April 2009	Tab 17	Specialty Developing Recommendation: ISIS, NASS, AANS/CNS, ASA, AAPM	First Identified:	2017 Est. Medicare Utilization: 715	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease
RUC Recommendation: 11.39			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 11.52 2018 NF PE RVU: 2018 Fac PE RVU:
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	Global: 010	Issue: Neurostimulators	Screen: Site of Service Anomaly / CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 68	Specialty Developing Recommendation: AAPM, AANS/CNS, ASA, ISIS, NASS	First Identified: September 2007	2017 Est. Medicare Utilization: 25,603	2007 Work RVU: 7.87 2007 NF PE RVU: NA 2007 Fac PE RVU 4.03 Result: Decrease
RUC Recommendation: 6.05			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 5.19 2018 NF PE RVU: NA 2018 Fac PE RVU: 4.03

Status Report: CMS Requests and Relativity Assessment Issues

63688 Revision or removal of implanted spinal neurostimulator pulse generator or receiver **Global:** 010 **Issue:** Neurostimulators **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** 1 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 7,445 **2007 Work RVU:** 6.10 **2018 Work RVU:** 5.30 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 3.56 **2018 Fac PE RVU:** 3.56 **RUC Recommendation:** 5.25 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

64405 Injection, anesthetic agent; greater occipital nerve **Global:** 000 **Issue:** Injection - Greater Occipital Nerve **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 17 **Specialty Developing Recommendation:** AAN, AAPM, AAPMR, ASA **First Identified:** July 2016 **2017 Est. Medicare Utilization:** 123,405 **2007 Work RVU:** 1.32 **2018 Work RVU:** 0.94 **2007 NF PE RVU:** 1.39 **2018 NF PE RVU:** 1.39 **2007 Fac PE RVU:** 0.47 **2018 Fac PE RVU:** 0.47 **RUC Recommendation:** 0.94 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

64412 Injection, anesthetic agent; spinal accessory nerve **Global:** 000 **Issue:** Anesthetic Injection – Spinal Nerve **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 36 **Specialty Developing Recommendation:** AAN, ASA, AAPMR, ISIS **First Identified:** April 2013 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 1.18 **2018 Work RVU:** **2007 NF PE RVU:** 2.5 **2018 NF PE RVU:** 2.5 **2007 Fac PE RVU:** 0.46 **2018 Fac PE RVU:** 0.46 **RUC Recommendation:** Deleted from CPT **Referred to CPT** October 2014 **Referred to CPT Asst** ☒ **Published in CPT Asst:** FAQ Sept 2015 **Result:** Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

64415	Injection, anesthetic agent; brachial plexus, single	Global: 000	Issue:	Screen: CMS Fastest Growing	Complete? No
Most Recent	Tab 09	Specialty Developing	AAPM, ASA	First Identified: October 2008	2017 Est. Medicare Utilization: 175,767
RUC Meeting: October 2018		Recommendation:			
RUC Recommendation: Refer to CPT for bundling. 1.48			Referred to CPT May 2019	2007 Work RVU: 1.48	2018 Work RVU: 1.48
			Referred to CPT Asst <input checked="" type="checkbox"/>	2007 NF PE RVU: 2.47	2018 NF PE RVU: 2.47
			Published in CPT Asst: Dec 2011 & Apr 2012	2007 Fac PE RVU 0.43	2018 Fac PE RVU: 0.43
				Result: Maintain	

64416	Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)	Global: 000	Issue: Anesthetic Agent Nerve Injection	Screen: Site of Service Anomaly / High Volume Growth2	Complete? No
Most Recent	Tab 09	Specialty Developing	ASA	First Identified: September 2007	2017 Est. Medicare Utilization: 20,870
RUC Meeting: October 2018		Recommendation:			
RUC Recommendation: Refer to CPT for bundling. Remove from screen. 1.81			Referred to CPT May 2019	2007 Work RVU: 3.85	2018 Work RVU: 1.81
			Referred to CPT Asst <input type="checkbox"/>	2007 NF PE RVU: NA	2018 NF PE RVU: NA
			Published in CPT Asst:	2007 Fac PE RVU 0.74	2018 Fac PE RVU: 0.74
				Result: Decrease	

64417	Injection, anesthetic agent; axillary nerve	Global: 000	Issue: Somatic Nerve Injection	Screen: part of New/Revised Review	Complete? No
Most Recent	Tab 09	Specialty Developing		First Identified:	2017 Est. Medicare Utilization: 13,923
RUC Meeting: October 2018		Recommendation:			
RUC Recommendation: Refer to CPT			Referred to CPT May 2019	2007 Work RVU: 1.44	2018 Work RVU: 1.44
			Referred to CPT Asst <input type="checkbox"/>	2007 NF PE RVU: 2.65	2018 NF PE RVU: 2.65
			Published in CPT Asst:	2007 Fac PE RVU 0.46	2018 Fac PE RVU: 0.46
				Result:	

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64418	Injection, anesthetic agent; suprascapular nerve			Global: 000	Issue: Injection, Anesthetic Agent	Screen: Harvard Valued - Utilization over 30,000-Part2	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 28	Specialty Developing Recommendation: AAPM, AAPMR, ASA	First Identified: October 2015	2017 Est. Medicare Utilization: 30,576	2007 Work RVU: 1.32	2018 Work RVU: 1.10	
					2007 NF PE RVU: 2.43	2018 NF PE RVU: 2.43	
					2007 Fac PE RVU 0.46	2018 Fac PE RVU:0.46	
RUC Recommendation: 1.10			Referred to CPT		Result: Decrease		
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:			
64445	Injection, anesthetic agent; sciatic nerve, single			Global: 000	Issue: RAW	Screen: CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 19	Specialty Developing Recommendation: AAPM, ASA	First Identified: October 2008	2017 Est. Medicare Utilization: 119,520	2007 Work RVU: 1.48	2018 Work RVU: 1.48	
					2007 NF PE RVU: 2.42	2018 NF PE RVU: 2.42	
					2007 Fac PE RVU 0.51	2018 Fac PE RVU:0.51	
RUC Recommendation: 1.48			Referred to CPT		Result: Maintain		
			Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Dec 2011 & Apr 2012			
64446	Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement)			Global: 000	Issue: Anesthetic Agent Nerve Injection	Screen: Site of Service Anomaly / High Volume Growth1	Complete? No
Most Recent RUC Meeting: October 2018	Tab 09	Specialty Developing Recommendation: ASA	First Identified: February 2008	2017 Est. Medicare Utilization: 5,877	2007 Work RVU: 3.61	2018 Work RVU: 1.81	
					2007 NF PE RVU: NA	2018 NF PE RVU: NA	
					2007 Fac PE RVU 0.9	2018 Fac PE RVU:0.9	
RUC Recommendation: Refer to CPT for bundling. 1.81			Referred to CPT May 2019		Result: Decrease		
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:			
64447	Injection, anesthetic agent; femoral nerve, single			Global: 000	Issue:	Screen: CMS Fastest Growing	Complete? No
Most Recent RUC Meeting: October 2018	Tab 09	Specialty Developing Recommendation: AAPM, ASA	First Identified: October 2008	2017 Est. Medicare Utilization: 225,366	2007 Work RVU: 1.50	2018 Work RVU: 1.50	
					2007 NF PE RVU: NA	2018 NF PE RVU: NA	
					2007 Fac PE RVU 0.38	2018 Fac PE RVU:0.38	
RUC Recommendation: Refer to CPT for bundling. 1.50			Referred to CPT May 2019		Result: Maintain		
			Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Dec 2011 & Apr 2012			

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64448	Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)	Global: 000	Issue: Anesthetic Agent Nerve Injection	Screen: Site of Service Anomaly / High Volume Growth1 / CMS Fastest Growing / High Volume Growth2	Complete? No
Most Recent RUC Meeting: October 2018	Tab 09 Specialty Developing Recommendation: ASA	First Identified: February 2008	2017 Est. Medicare Utilization: 42,755	2007 Work RVU: 3.36 2007 NF PE RVU: NA 2007 Fac PE RVU: 0.73 Result: Decrease	2018 Work RVU: 1.63 2018 NF PE RVU: NA 2018 Fac PE RVU: 0.73
RUC Recommendation: Refer to CPT for Bundling. Remove from screen. 1.63		Referred to CPT May 2019	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
<hr/>					
64449	Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)	Global: 000	Issue: Anesthetic Agent Nerve Injection	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting: April 2008	Tab 19 Specialty Developing Recommendation: ASA	First Identified: September 2007	2017 Est. Medicare Utilization: 2,328	2007 Work RVU: 3.24 2007 NF PE RVU: NA 2007 Fac PE RVU: 0.84 Result: Decrease	2018 Work RVU: 1.81 2018 NF PE RVU: NA 2018 Fac PE RVU: 0.84
RUC Recommendation: 1.81		Referred to CPT February 2008	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
<hr/>					
64450	Injection, anesthetic agent; other peripheral nerve or branch	Global: 000	Issue: Injection - Anesthetic Agent	Screen: Harvard Valued - Utilization over 100,000 / Harvard-Valued Annual Allowed Charges Greater than \$10 million / High Volume Growth4	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 38 Specialty Developing Recommendation: ASA, AAPM, APMA, ASIPP	First Identified: October 2009	2017 Est. Medicare Utilization: 413,282	2007 Work RVU: 1.27 2007 NF PE RVU: 1.25 2007 Fac PE RVU: 0.49 Result: Decrease	2018 Work RVU: 0.75 2018 NF PE RVU: 1.25 2018 Fac PE RVU: 0.49
RUC Recommendation: 0.75 and review additional utilization data (October 2019).		Referred to CPT	Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Jan 2013	

Status Report: CMS Requests and Relativity Assessment Issues

64455 Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma) **Global:** 000 **Issue:** Injection – Digital Nerves **Screen:** High Volume Growth4 / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017

Tab 18

Specialty Developing Recommendation: AAOS, AOFAS, APMA

First Identified: October 2016

2017 Est. Medicare Utilization: 71,016

2007 Work RVU:

2018 Work RVU: 0.75

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: 0.75

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

64461 Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed)

Global: 000

Issue: Paravertebral Block Injection

Screen: New code for CPT 2016.

Complete? Yes

Most Recent RUC Meeting: April 2015

Tab 10

Specialty Developing Recommendation: ASA

First Identified: April 2015

2017 Est. Medicare Utilization: 3,135

2007 Work RVU:

2018 Work RVU: 1.75

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Not Part of RAW

RUC Recommendation: CPT Assistant article published Jan 2016

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2016

64462 Paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure)

Global: ZZZ

Issue: Paravertebral Block Injection

Screen: New code for CPT 2016.

Complete? Yes

Most Recent RUC Meeting: April 2015

Tab 10

Specialty Developing Recommendation: ASA

First Identified: April 2015

2017 Est. Medicare Utilization: 1,296

2007 Work RVU:

2018 Work RVU: 1.10

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Not Part of RAW

RUC Recommendation: CPT Assistant article published Jan 2016

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2016

Status Report: CMS Requests and Relativity Assessment Issues

64463	Paravertebral block (PVB) (paraspinous block), thoracic; continuous infusion by catheter (includes imaging guidance, when performed)	Global: 000	Issue: Paravertebral Block Injection	Screen: New code for CPT 2016.	Complete? Yes
Most Recent RUC Meeting: April 2015	Tab 10 Specialty Developing Recommendation: ASA	First Identified: April 2015	2017 Est. Medicare Utilization: 1,066	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU	2018 Work RVU: 1.90 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: CPT Assistant article published Jan 2016		Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Jan 2016	Result: Not Part of RAW	
<hr/>					
64470	Deleted from CPT	Global: 000	Issue: Injection Anesthetic Agent	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: April 2008	Tab 57 Specialty Developing Recommendation: ASA, NASS, AAPM	First Identified: April 2008	2017 Est. Medicare Utilization:	2007 Work RVU: 1.85 2007 NF PE RVU: 6.37 2007 Fac PE RVU 0.71	2018 Work RVU: 2018 NF PE RVU: 6.37 2018 Fac PE RVU: 0.71
RUC Recommendation: Deleted from CPT		Referred to CPT February 2009 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Deleted from CPT	
<hr/>					
64472	Deleted from CPT	Global: ZZZ	Issue: Injection Anesthetic Agent	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: April 2008	Tab 57 Specialty Developing Recommendation: ASA, NASS, AAPM	First Identified: February 2008	2017 Est. Medicare Utilization:	2007 Work RVU: 1.29 2007 NF PE RVU: 2.05 2007 Fac PE RVU 0.34	2018 Work RVU: 2018 NF PE RVU: 2.05 2018 Fac PE RVU: 0.34
RUC Recommendation: Deleted from CPT		Referred to CPT February 2009 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Deleted from CPT	
<hr/>					
64475	Deleted from CPT	Global: 000	Issue: Injection Anesthetic Agent	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: April 2008	Tab 57 Specialty Developing Recommendation: ASA, NASS, AAPM	First Identified: April 2008	2017 Est. Medicare Utilization:	2007 Work RVU: 1.41 2007 NF PE RVU: 6.07 2007 Fac PE RVU 0.62	2018 Work RVU: 2018 NF PE RVU: 6.07 2018 Fac PE RVU: 0.62
RUC Recommendation: Deleted from CPT		Referred to CPT February 2009 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Deleted from CPT	

Status Report: CMS Requests and Relativity Assessment Issues

64476 Deleted from CPT

Global: ZZZ

Issue: Injection Anesthetic Agent

Screen: High Volume Growth1

Complete? Yes

Most Recent RUC Meeting: April 2008

Tab 57

Specialty Developing Recommendation:

ASA, NASS, AAPM

First Identified: April 2008

2017 Est. Medicare Utilization:

2007 Work RVU: 0.98

2007 NF PE RVU: 1.86

2007 Fac PE RVU 0.24

Result: Deleted from CPT

2018 Work RVU:

2018 NF PE RVU: 1.86

2018 Fac PE RVU:0.24

RUC Recommendation: Deleted from CPT

Referred to CPT February 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

64479 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level

Global: 000

Issue: Injection Anesthetic Agent

Screen: CMS Fastest Growing

Complete? Yes

Most Recent RUC Meeting: October 2009

Tab 05

Specialty Developing Recommendation:

AAPM, ISIS, ASA, NASS, AAPMR

First Identified: October 2008

2017 Est. Medicare Utilization: 45,820

2007 Work RVU: 2.20

2007 NF PE RVU: 6.55

2007 Fac PE RVU 0.87

Result: Increase

2018 Work RVU: 2.29

2018 NF PE RVU: 6.55

2018 Fac PE RVU:0.87

RUC Recommendation: 2.29

Referred to CPT June 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

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)

Global: ZZZ

Issue: Injection Anesthetic Agent

Screen: CMS Fastest Growing

Complete? Yes

Most Recent RUC Meeting: October 2009

Tab 05

Specialty Developing Recommendation:

AAPM, ISIS, ASA, NASS, AAPMR

First Identified: October 2008

2017 Est. Medicare Utilization: 22,183

2007 Work RVU: 1.54

2007 NF PE RVU: 2.5

2007 Fac PE RVU 0.45

Result: Decrease

2018 Work RVU: 1.20

2018 NF PE RVU: 2.5

2018 Fac PE RVU:0.45

RUC Recommendation: 1.20

Referred to CPT June 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

64483 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

Global: 000

Issue: Injection of Anesthetic Agent

Screen: CMS Fastest Growing

Complete? Yes

Most Recent RUC Meeting: October 2009

Tab 05

Specialty Developing Recommendation:

AAPM, ISIS, ASA, NASS, AAPMR

First Identified: October 2008

2017 Est. Medicare Utilization: 1,043,217

2007 Work RVU: 1.90

2007 NF PE RVU: 6.86

2007 Fac PE RVU 0.81

Result: Decrease

2018 Work RVU: 1.90

2018 NF PE RVU: 6.86

2018 Fac PE RVU:0.81

RUC Recommendation: 1.90

Referred to CPT June 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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) **Global:** ZZZ **Issue:** Injection of Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009

Tab 05

Specialty Developing Recommendation:

AAPM, ISIS, ASA, NASS, AAPMR

First Identified: October 2008

2017 Est. Medicare Utilization: 450,460

2007 Work RVU: 1.33

2018 Work RVU: 1.00

2007 NF PE RVU: 2.86

2018 NF PE RVU: 2.86

2007 Fac PE RVU 0.36

2018 Fac PE RVU:0.36

Result: Decrease

RUC Recommendation: 1.00

Referred to CPT June 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

64490 Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level

Global: 000

Issue: Facet Joint Injections

Screen: High Volume Growth1

Complete? Yes

Most Recent RUC Meeting: April 2009

Tab 18

Specialty Developing Recommendation:

ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS

First Identified:

2017 Est. Medicare Utilization: 247,465

2007 Work RVU:

2018 Work RVU: 1.82

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 1.82

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64491 Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)

Global: ZZZ

Issue: Facet Joint Injections

Screen: High Volume Growth1

Complete? Yes

Most Recent RUC Meeting: April 2009

Tab 18

Specialty Developing Recommendation:

ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS

First Identified:

2017 Est. Medicare Utilization: 223,218

2007 Work RVU:

2018 Work RVU: 1.16

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 1.16

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Facet Joint Injections	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: April 2009	Tab 18 Specialty Developing Recommendation: ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS	First Identified:	2017 Est. Medicare Utilization: 152,467	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU	2018 Work RVU: 1.16 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.16	Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease		
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level	Global: 000	Issue: Facet Joint Injections	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: April 2009	Tab 18 Specialty Developing Recommendation: ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS	First Identified:	2017 Est. Medicare Utilization: 862,364	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU	2018 Work RVU: 1.52 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.52	Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease		
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Facet Joint Injections	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: April 2009	Tab 18 Specialty Developing Recommendation: ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS	First Identified:	2017 Est. Medicare Utilization: 770,105	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU	2018 Work RVU: 1.00 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.00	Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease		

Status Report: CMS Requests and Relativity Assessment Issues

64495 Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab 18** **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2017 Est. Medicare Utilization:** 451,042 **2007 Work RVU:** **2007 NF PE RVU:** **2007 Fac PE RVU:** **2018 Work RVU:** 1.00 **2018 NF PE RVU:** **2018 Fac PE RVU:**

RUC Recommendation: 1.00 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

64510 Injection, anesthetic agent; stellate ganglion (cervical sympathetic) **Global:** 000 **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab 27** **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2009 **2017 Est. Medicare Utilization:** 6,890 **2007 Work RVU:** 1.22 **2007 NF PE RVU:** 3.06 **2007 Fac PE RVU:** 0.49 **2018 Work RVU:** 1.22 **2018 NF PE RVU:** 3.06 **2018 Fac PE RVU:** 0.49

RUC Recommendation: New PE inputs **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** PE Only

64520 Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic) **Global:** 000 **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab 27** **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2009 **2017 Est. Medicare Utilization:** 23,540 **2007 Work RVU:** 1.35 **2007 NF PE RVU:** 4.5 **2007 Fac PE RVU:** 0.54 **2018 Work RVU:** 1.35 **2018 NF PE RVU:** 4.5 **2018 Fac PE RVU:** 0.54

RUC Recommendation: PE Review - no change **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** PE Only

Status Report: CMS Requests and Relativity Assessment Issues

64550 Application of surface (transcutaneous) neurostimulator (eg, TENS unit) **Global:** 000 **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** AANS, CNS, AOTA **First Identified:** January 2017 **2017 Est. Medicare Utilization:** 6,594 **2007 Work RVU:** 0.18 **2018 Work RVU:** 0.18 **2007 NF PE RVU:** 0.26 **2018 NF PE RVU:** 0.26 **2007 Fac PE RVU:** 0.05 **2018 Fac PE RVU:** 0.05

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

64553 Percutaneous implantation of neurostimulator electrode array; cranial nerve **Global:** 010 **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 15 **Specialty Developing Recommendation:** AANS, CNS, ASA **First Identified:** July 2014 **2017 Est. Medicare Utilization:** 1,509 **2007 Work RVU:** 2.33 **2018 Work RVU:** 6.13 **2007 NF PE RVU:** 2.75 **2018 NF PE RVU:** 2.75 **2007 Fac PE RVU:** 1.73 **2018 Fac PE RVU:** 1.73

RUC Recommendation: 6.13 **Referred to CPT** September 2016 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

64555 Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve) **Global:** 010 **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** High Volume Growth1 / CMS Fastest Growing / Final Rule for 2015 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 15 **Specialty Developing Recommendation:** AANS, CNS, ASA **First Identified:** February 2008 **2017 Est. Medicare Utilization:** 4,247 **2007 Work RVU:** 2.29 **2018 Work RVU:** 5.76 **2007 NF PE RVU:** 2.96 **2018 NF PE RVU:** 2.96 **2007 Fac PE RVU:** 1.23 **2018 Fac PE RVU:** 1.23

RUC Recommendation: 5.76. Develop CPT Assistant article.Review September 2017. **Referred to CPT** September 2016 **Referred to CPT Asst** ☒ **Published in CPT Asst:** Jan 2016

Status Report: CMS Requests and Relativity Assessment Issues

64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed	Global: 010	Issue: Percutaneous NeurostimulatorPlacement	Screen: CMS Fastest Growing / High Volume Growth2 / High Level E/M in Global Period	Complete? Yes		
Most Recent RUC Meeting:	January 2017	Tab 15	Specialty Developing Recommendation: AANS, CNS	First Identified: October 2008	2017 Est. Medicare Utilization: 15,344	2007 Work RVU: 7.07	2018 Work RVU: 5.44
						2007 NF PE RVU: 27.51	2018 NF PE RVU: 27.51
						2007 Fac PE RVU 3.05	2018 Fac PE RVU:3.05
RUC Recommendation:	5.44. 99214 visit appropriate. Remove from screen.			Referred to CPT September 2016		Result: Decrease	
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
64565	Percutaneous implantation of neurostimulator electrode array; neuromuscular	Global: 010	Issue: Percutaneous NeurostimulatorPlacement	Screen: Final Rule for 2015	Complete? Yes		
Most Recent RUC Meeting:	January 2017	Tab 15	Specialty Developing Recommendation: AANS, CNS	First Identified: January 2017	2017 Est. Medicare Utilization: 1,182	2007 Work RVU: 1.78	2018 Work RVU:
						2007 NF PE RVU: 3.08	2018 NF PE RVU: 3.08
						2007 Fac PE RVU 1.27	2018 Fac PE RVU:1.27
RUC Recommendation:	Deleted from CPT			Referred to CPT September 2016		Result: Deleted from CPT	
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	Global: 000	Issue: Posterior Tibial Neurostimulation	Screen: CMS Request - Final Rule for 2014 / High Volume Growth5	Complete? Yes		
Most Recent RUC Meeting:	April 2015	Tab 29	Specialty Developing Recommendation: ACOG, AUA	First Identified: July 2013	2017 Est. Medicare Utilization: 188,828	2007 Work RVU:	2018 Work RVU: 0.60
						2007 NF PE RVU:	2018 NF PE RVU:
						2007 Fac PE RVU	2018 Fac PE RVU:
RUC Recommendation:	Review action plan. 0.60			Referred to CPT		Result: Maintain	
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

64568 Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator **Global:** 090 **Issue:** Vagus Nerve Stimulator **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010	Tab 14	Specialty Developing Recommendation: AANS/CNS	First Identified:	2017 Est. Medicare Utilization: 586	2007 Work RVU:	2018 Work RVU: 9.00
RUC Recommendation: 11.19			Referred to CPT October 2009		2007 NF PE RVU:	2018 NF PE RVU:
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU	2018 Fac PE RVU:
					Result: Decrease	

64573 Deleted from CPT **Global:** 090 **Issue:** Neurosurgical Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009	Tab 28	Specialty Developing Recommendation: AANS/CNS	First Identified: September 2007	2017 Est. Medicare Utilization:	2007 Work RVU: 8.15	2018 Work RVU:
RUC Recommendation: Deleted from CPT			Referred to CPT October 2009		2007 NF PE RVU: NA	2018 NF PE RVU: NA
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU 5.31	2018 Fac PE RVU: 5.31
					Result: Deleted from CPT	

64581 Incision for implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly / High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2016	Tab 54	Specialty Developing Recommendation: AUA	First Identified: September 2007	2017 Est. Medicare Utilization: 10,637	2007 Work RVU: 14.15	2018 Work RVU: 12.20
RUC Recommendation: 12.20. 99214 visit appropriate. Remove from screen.			Referred to CPT		2007 NF PE RVU: NA	2018 NF PE RVU: NA
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU 5.73	2018 Fac PE RVU: 5.73
					Result: Decrease	

Status Report: CMS Requests and Relativity Assessment Issues

64590 Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling **Global:** 010 **Issue:** RAW **Screen:** Harvard-Valued Annual Allowed Charges Greater than \$10 million / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab** 31 **Specialty Developing Recommendation:** ACOG, AUA **First Identified:** October 2012 **2017 Est. Medicare Utilization:** 11,834 **2007 Work RVU:** 2.42 **2018 Work RVU:** 2.45 **2007 NF PE RVU:** 6.95 **2018 NF PE RVU:** 6.95 **2007 Fac PE RVU:** 2.33 **2018 Fac PE RVU:** 2.33 **Result:** Remove from screen

RUC Recommendation: **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

64622 Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level **Global:** 010 **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review, High Volume Growth1 / CMS Fastest Growing, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2008 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 3.02 **2018 Work RVU:** **2007 NF PE RVU:** 6.82 **2018 NF PE RVU:** 6.82 **2007 Fac PE RVU:** 1.34 **2018 Fac PE RVU:** 1.34 **Result:** Deleted from CPT

RUC Recommendation: PE Review - no change **Referred to CPT** June 2008 and Feb 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

64623 Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Destruction by Neurolytic Agent **Screen:** High Volume Growth1, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** February 2008 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 0.99 **2018 Work RVU:** **2007 NF PE RVU:** 2.62 **2018 NF PE RVU:** 2.62 **2007 Fac PE RVU:** 0.22 **2018 Fac PE RVU:** 0.22 **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2008 and Feb 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64626	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level	Global: 010	Issue: Fluoroscopy	Screen: CMS Request - Practice Expense Review, High Volume Growth1 / CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: April 2009	Tab 27	Specialty Developing Recommendation: ASA, ISIS, AAPM, APM&R	First Identified: April 2008	2017 Est. Medicare Utilization:	2007 Work RVU: 3.82 2007 NF PE RVU: 6.99 2007 Fac PE RVU: 1.93 2018 Work RVU: 2018 NF PE RVU: 6.99 2018 Fac PE RVU: 1.93
RUC Recommendation: PE Review - no change			Referred to CPT June 2008 and Feb 2011 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:	Result: Deleted from CPT	
<hr/>					
64627	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Destruction by Neurolytic Agent	Screen: High Volume Growth1/ CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: April 2008	Tab 57	Specialty Developing Recommendation: ASA, NASS, AAPM	First Identified: April 2008	2017 Est. Medicare Utilization:	2007 Work RVU: 1.16 2007 NF PE RVU: 3.98 2007 Fac PE RVU: 0.26 2018 Work RVU: 2018 NF PE RVU: 3.98 2018 Fac PE RVU: 0.26
RUC Recommendation: Deleted from CPT			Referred to CPT June 2008 and Feb 2011 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:	Result: Deleted from CPT	
<hr/>					
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	Global: 010	Issue: Destruction by Neurolytic Agent	Screen: Work Neutrality Review	Complete? No
Most Recent RUC Meeting: April 2017	Tab 38	Specialty Developing Recommendation: ASA, AAPM, AAPMR, ISIS, NASS	First Identified: September 2014	2017 Est. Medicare Utilization: 73,704	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: 2018 Work RVU: 3.84 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: RAW review additional data			Referred to CPT May 2015 Referred to CPT Asst <input checked="" type="checkbox"/> Published in CPT Asst: February 2015	Result:	

Status Report: CMS Requests and Relativity Assessment Issues

64634 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Destruction by Neurolytic Agent **Screen:** Work Neutrality Review **Complete?** No

Most Recent RUC Meeting: April 2017

Tab 38

Specialty Developing Recommendation:

ASA, AAPM, AAPMR, ISIS, NASS

First Identified: September 2014

2017 Est. Medicare Utilization: 118,863

2007 Work RVU:

2007 NF PE RVU:

2007 Fac PE RVU

Result:

2018 Work RVU: 1.32

2018 NF PE RVU:

2018 Fac PE RVU:

RUC Recommendation: RAW review additional data

Referred to CPT May 2015

Referred to CPT Asst ☒

Published in CPT Asst: February 2015

64635 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint **Global:** 010 **Issue:** Destruction by Neurolytic Agent **Screen:** Work Neutrality Review **Complete?** No

Most Recent RUC Meeting: April 2017

Tab 38

Specialty Developing Recommendation:

ASA, AAPM, AAPMR, ISIS, NASS

First Identified: September 2014

2017 Est. Medicare Utilization: 314,114

2007 Work RVU:

2007 NF PE RVU:

2007 Fac PE RVU

Result:

2018 Work RVU: 3.78

2018 NF PE RVU:

2018 Fac PE RVU:

RUC Recommendation: RAW review additional data

Referred to CPT May 2015

Referred to CPT Asst ☒

Published in CPT Asst: February 2015

64636 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Destruction by Neurolytic Agent **Screen:** Work Neutrality Review **Complete?** No

Most Recent RUC Meeting: April 2017

Tab 38

Specialty Developing Recommendation:

ASA, AAPM, AAPMR, ISIS, NASS

First Identified: September 2014

2017 Est. Medicare Utilization: 486,964

2007 Work RVU:

2007 NF PE RVU:

2007 Fac PE RVU

Result:

2018 Work RVU: 1.16

2018 NF PE RVU:

2018 Fac PE RVU:

RUC Recommendation: RAW review additional data

Referred to CPT May 2015

Referred to CPT Asst ☒

Published in CPT Asst: Feb 2015

Status Report: CMS Requests and Relativity Assessment Issues

64640 Destruction by neurolytic agent; other peripheral nerve or branch **Global:** 010 **Issue:** Injection Treatment of Nerve **Screen:** Site of Service Anomaly (99238-Only) / Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 25 **Specialty Developing Recommendation:** ASAM, AAPM, APMA, ASIPP **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 130,645 **2007 Work RVU:** 2.78 **2018 Work RVU:** 1.23 **2007 NF PE RVU:** 3.75 **2018 NF PE RVU:** 3.75 **2007 Fac PE RVU:** 1.75 **2018 Fac PE RVU:** 1.75

RUC Recommendation: 1.23. Remove 99238.

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

64708 Neuroplasty, major peripheral nerve, arm or leg, open; other than specified **Global:** 090 **Issue:** Neuroplasty – Leg or Arm **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 69 **Specialty Developing Recommendation:** AOFAS, ASSH, AAOS, ASPS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 4,042 **2007 Work RVU:** 6.22 **2018 Work RVU:** 6.36 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 4.73 **2018 Fac PE RVU:** 4.73

RUC Recommendation: 6.36

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Maintain

64712 Neuroplasty, major peripheral nerve, arm or leg, open; sciatic nerve **Global:** 090 **Issue:** Neuroplasty – Leg or Arm **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** AOFAS, ASSH, AAOS, ASPS **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 765 **2007 Work RVU:** 7.98 **2018 Work RVU:** 8.07 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 4.86 **2018 Fac PE RVU:** 4.86

RUC Recommendation: Remove from screen

Referred to CPT February 2010

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Remove from Screen

64831 Suture of digital nerve, hand or foot; 1 nerve **Global:** 090 **Issue:** Neurorrhaphy – Finger **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 70 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 977 **2007 Work RVU:** 10.23 **2018 Work RVU:** 9.16 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 7 **2018 Fac PE RVU:** 7

RUC Recommendation: 9.16

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

65105 Enucleation of eye; with implant, muscles attached to implant

Global: 090

Issue: Ophthalmologic Procedures

Screen: Site of Service Anomaly (99238-Only)

Complete? Yes

Most Recent **Tab** 16 **Specialty Developing** AAO
RUC Meeting: September 2007 **Recommendation:**

First
Identified: September 2007

2017 Est.
Medicare
Utilization: 799

2007 Work RVU: 9.70

2018 Work RVU: 9.93

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 10.13

2018 Fac PE RVU:10.13

Result: PE Only

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

65205 Removal of foreign body, external eye; conjunctival superficial

Global: 000

Issue: Removal of Foreign Body - Eye

Screen: CMS 000-Day Global Typically Reported with an E/M

Complete? Yes

Most Recent **Tab** 19 **Specialty Developing** AAO, AOA
RUC Meeting: April 2017 **Recommendation:**

First
Identified: July 2016

2017 Est.
Medicare
Utilization: 28,041

2007 Work RVU: 0.71

2018 Work RVU: 0.71

2007 NF PE RVU: 0.63

2018 NF PE RVU: 0.63

2007 Fac PE RVU 0.3

2018 Fac PE RVU:0.3

Result: Decrease

RUC Recommendation: 0.49

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

65210 Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating

Global: 000

Issue: Removal of Foreign Body - Eye

Screen: CMS 000-Day Global Typically Reported with an E/M

Complete? Yes

Most Recent **Tab** 19 **Specialty Developing** AAO, AOA
RUC Meeting: April 2017 **Recommendation:**

First
Identified: July 2016

2017 Est.
Medicare
Utilization: 23,270

2007 Work RVU: 0.84

2018 Work RVU: 0.84

2007 NF PE RVU: 0.79

2018 NF PE RVU: 0.79

2007 Fac PE RVU 0.39

2018 Fac PE RVU:0.39

Result: Decrease

RUC Recommendation: 0.75

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

65222 Removal of foreign body, external eye; corneal, with slit lamp **Global:** 000 **Issue:** Removal of Foreign Body **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011

Tab 26

Specialty Developing Recommendation: AAO, AOA (optometric)

First Identified: April 2011

2017 Est. Medicare Utilization: 27,017

2007 Work RVU: 0.93

2018 Work RVU: 0.84

2007 NF PE RVU: 0.87

2018 NF PE RVU: 0.87

2007 Fac PE RVU 0.4

2018 Fac PE RVU:0.4

Result: Maintain

RUC Recommendation: 0.93

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

65285 Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue

Global: 090

Issue: Repair of Eye Wound

Screen: Site of Service Anomaly

Complete? Yes

Most Recent RUC Meeting: February 2011

Tab 8

Specialty Developing Recommendation: AAO

First Identified: September 2007

2017 Est. Medicare Utilization: 753

2007 Work RVU: 14.43

2018 Work RVU: 15.36

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 9.12

2018 Fac PE RVU:9.12

Result: Decrease

RUC Recommendation: 16.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

65780 Ocular surface reconstruction; amniotic membrane transplantation, multiple layers

Global: 090

Issue: Ocular Reconstruction Transplant

Screen: CMS Fastest Growing / 090-Day Global Post-Operative Visits

Complete? Yes

Most Recent RUC Meeting: April 2015

Tab 31

Specialty Developing Recommendation: AAO

First Identified: October 2008

2017 Est. Medicare Utilization: 2,096

2007 Work RVU: 10.43

2018 Work RVU: 7.81

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 10.04

2018 Fac PE RVU:10.04

Result: Decrease

RUC Recommendation: 8.80

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jun 2009

Status Report: CMS Requests and Relativity Assessment Issues

65800 Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous **Global:** 000 **Issue:** Paracentesis of the Eye **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent **Tab** 21 **Specialty Developing** AAO
RUC Meeting: April 2012 **Recommendation:**

First **2017 Est.**
Identified: September 2011 **Medicare**
Utilization: 22,624

2007 Work RVU: 1.91 **2018 Work RVU:** 1.53
2007 NF PE RVU: 1.71 **2018 NF PE RVU:** 1.71
2007 Fac PE RVU: 1.16 **2018 Fac PE RVU:** 1.16
Result: Decrease

RUC Recommendation: 1.53

Referred to CPT October 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

65805 Paracentesis of anterior chamber of eye (separate procedure); with therapeutic release of aqueous **Global:** 000 **Issue:** Paracentesis of the Eye **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent **Tab** 21 **Specialty Developing** AAO
RUC Meeting: April 2012 **Recommendation:**

First **2017 Est.**
Identified: April 2011 **Medicare**
Utilization:

2007 Work RVU: 1.91 **2018 Work RVU:**
2007 NF PE RVU: 2.07 **2018 NF PE RVU:** 2.07
2007 Fac PE RVU: 1.16 **2018 Fac PE RVU:** 1.16
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

65855 Trabeculoplasty by laser surgery **Global:** 010 **Issue:** Trabeculoplasty by Laser Surgery **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent **Tab** 11 **Specialty Developing** AAO
RUC Meeting: April 2015 **Recommendation:**

First **2017 Est.**
Identified: January 2014 **Medicare**
Utilization: 153,861

2007 Work RVU: 3.90 **2018 Work RVU:** 3.00
2007 NF PE RVU: 4.14 **2018 NF PE RVU:** 4.14
2007 Fac PE RVU: 3.01 **2018 Fac PE RVU:** 3.01
Result: Decrease

RUC Recommendation: 3.00

Referred to CPT February 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

66170 Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery **Global:** 090 **Issue:** Glaucoma Surgery **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent **Tab** 32 **Specialty Developing** AAO
RUC Meeting: April 2015 **Recommendation:**

First **2017 Est.**
Identified: January 2014 **Medicare**
Utilization: 9,919

2007 Work RVU: 14.57 **2018 Work RVU:** 13.94
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 12.17 **2018 Fac PE RVU:** 12.17
Result: Decrease

RUC Recommendation: 13.94

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66172	Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)	Global: 090	Issue: Glaucoma Surgery	Screen: 090-Day Global Post-Operative Visits	Complete? Yes
Most Recent RUC Meeting: April 2015	Tab 32 Specialty Developing Recommendation: AAO	First Identified: January 2014	2017 Est. Medicare Utilization: 4,190	2007 Work RVU: 18.26 2007 NF PE RVU: NA 2007 Fac PE RVU: 15.21 Result: Decrease	2018 Work RVU: 14.84 2018 NF PE RVU: NA 2018 Fac PE RVU: 15.21
RUC Recommendation: 14.81		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
66179	Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft	Global: 090	Issue: Aqueous Shunt	Screen: Harvard-Valued Annual Allowed Charges Greater than \$10 million	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 12 Specialty Developing Recommendation: AAO	First Identified: January 2014	2017 Est. Medicare Utilization: 994	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Decrease	2018 Work RVU: 14.00 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 14.00		Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
66180	Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft	Global: 090	Issue: Aqueous Shunt	Screen: Harvard-Valued Annual Allowed Charges Greater than \$10 million	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 12 Specialty Developing Recommendation: AAO	First Identified: October 2012	2017 Est. Medicare Utilization: 11,673	2007 Work RVU: 16.02 2007 NF PE RVU: NA 2007 Fac PE RVU: 10.62 Result: Decrease	2018 Work RVU: 15.00 2018 NF PE RVU: NA 2018 Fac PE RVU: 10.62
RUC Recommendation: 15.00		Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	Global: 090	Issue: Aqueous Shunt	Screen: Harvard-Valued Annual Allowed Charges Greater than \$10 million	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 12 Specialty Developing Recommendation: AAO	First Identified: January 2014	2017 Est. Medicare Utilization: 3,486	2007 Work RVU:	2018 Work RVU: 13.20
RUC Recommendation: 13.20		Referred to CPT		2007 NF PE RVU:	2018 NF PE RVU:
		Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU	2018 Fac PE RVU:
				Result: Maintain	
<hr/>					
66184	Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft	Global: 090	Issue: Aqueous Shunt	Screen: Harvard-Valued Annual Allowed Charges Greater than \$10 million	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 12 Specialty Developing Recommendation: AAO	First Identified: January 2014	2017 Est. Medicare Utilization: 522	2007 Work RVU:	2018 Work RVU: 9.58
RUC Recommendation: 9.58		Referred to CPT October 2013		2007 NF PE RVU:	2018 NF PE RVU:
		Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU	2018 Fac PE RVU:
				Result: Decrease	
<hr/>					
66185	Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft	Global: 090	Issue: Aqueous Shunt	Screen: Harvard-Valued Annual Allowed Charges Greater than \$10 million	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 12 Specialty Developing Recommendation: AAO	First Identified: October 2012	2017 Est. Medicare Utilization: 1,752	2007 Work RVU: 9.35	2018 Work RVU: 10.58
RUC Recommendation: 10.58		Referred to CPT October 2013		2007 NF PE RVU: NA	2018 NF PE RVU: NA
		Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU 7.37	2018 Fac PE RVU: 7.37
				Result: Increase	

Status Report: CMS Requests and Relativity Assessment Issues

66711 Ciliary body destruction; cyclophotocoagulation, endoscopic

Global: 090

Issue: Codes Reported Together

Screen: Codes Reported Together 75% or More-Part4

Complete? No

Most Recent RUC Meeting: January 2019

Tab

Specialty Developing Recommendation: AAO

First Identified: October 2017

2017 Est. Medicare Utilization: 9,799

2007 Work RVU: 7.70

2018 Work RVU: 7.93

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 6.49

2018 Fac PE RVU: 6.49

RUC Recommendation: Refer to CPT to bundle

Referred to CPT May 2018

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

66761 Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)

Global: 010

Issue: Iridotomy

Screen: High IWP/UT / 010-Day Global Post-Operative Visits

Complete? Yes

Most Recent RUC Meeting: April 2014

Tab 52

Specialty Developing Recommendation: AAO

First Identified: February 2008

2017 Est. Medicare Utilization: 76,844

2007 Work RVU: 4.87

2018 Work RVU: 3.00

2007 NF PE RVU: 5.49

2018 NF PE RVU: 5.49

2007 Fac PE RVU: 4.32

2018 Fac PE RVU: 4.32

RUC Recommendation: 3.00

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

66821 Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (1 or more stages)

Global: 090

Issue:

Screen: MPC List

Complete? Yes

Most Recent RUC Meeting: February 2011

Tab 41

Specialty Developing Recommendation: AAO

First Identified: October 2010

2017 Est. Medicare Utilization: 674,426

2007 Work RVU: 3.32

2018 Work RVU: 3.42

2007 NF PE RVU: 4.05

2018 NF PE RVU: 4.05

2007 Fac PE RVU: 3.6

2018 Fac PE RVU: 3.6

RUC Recommendation: Maintain

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

66982 Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage	Global: 090	Issue: Cataract Surgery	Screen: High IWPUT / CMS Fastest Growing, Site of Service Anomaly (99238-Only) / CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: January 2012	Tab 17 Specialty Developing Recommendation: AAO	First Identified: September 2007	2017 Est. Medicare Utilization: 163,451	2007 Work RVU: 14.83 2007 NF PE RVU: NA 2007 Fac PE RVU: 9.75 2018 Work RVU: 11.08 2018 NF PE RVU: NA 2018 Fac PE RVU: 9.75 Result: Decrease
RUC Recommendation: 11.08. CPT Assistant article published; Reduce to 2x99213 & 3x99212	Referred to CPT	Referred to CPT Asst <input checked="" type="checkbox"/> Published in CPT Asst: Sep 2009		
66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)	Global: 090	Issue: Cataract Surgery	Screen: High IWPUT / MPC List / Codes Reported Together 75%or More-Part4	Complete? No
Most Recent RUC Meeting: January 2018	Tab 31 Specialty Developing Recommendation: AAO	First Identified: February 2008	2017 Est. Medicare Utilization: 1,719,833	2007 Work RVU: 10.36 2007 NF PE RVU: NA 2007 Fac PE RVU: 7.24 2018 Work RVU: 8.52 2018 NF PE RVU: NA 2018 Fac PE RVU: 7.24 Result: Decrease
RUC Recommendation: Refer to CPT to bundle. 8.52	Referred to CPT May 2018	Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		
67028 Intravitreal injection of a pharmacologic agent (separate procedure)	Global: 000	Issue: Treatment of Retinal Lesion	Screen: High Volume Growth1 / CMS Fastest Growing, Harvard Valued - Utilization over 100,000 / CMS High Expenditure Procedural Codes1 / High Volume Growth3	Complete? No
Most Recent RUC Meeting: January 2016	Tab 54 Specialty Developing Recommendation: AAO	First Identified: February 2008	2017 Est. Medicare Utilization: 3,456,916	2007 Work RVU: 2.52 2007 NF PE RVU: 2.59 2007 Fac PE RVU: 1.42 2018 Work RVU: 1.44 2018 NF PE RVU: 2.59 2018 Fac PE RVU: 1.42 Result: Decrease
RUC Recommendation: Review utilization at RAW Oct 2018. 1.44	Referred to CPT	Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

67036	Vitrectomy, mechanical, pars plana approach;		Global: 090	Issue: Vitrectomy	Screen: Harvard-Valued Annual Allowed Charges Greater than \$10 million	Complete? Yes
Most Recent RUC Meeting: October 2013	Tab 11	Specialty Developing Recommendation: AAO	First Identified: October 2012	2017 Est. Medicare Utilization: 16,218	2007 Work RVU: 13.09 2007 NF PE RVU: NA 2007 Fac PE RVU: 8.96 Result: Decrease	2018 Work RVU: 12.13 2018 NF PE RVU: NA 2018 Fac PE RVU: 8.96
RUC Recommendation: 12.13			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
67038	Deleted from CPT		Global: 090	Issue: Ophthalmological Procedures	Screen: Site of Service Anomaly	Complete? Yes
Most Recent RUC Meeting: September 2007	Tab 16	Specialty Developing Recommendation: AAO	First Identified: September 2007	2017 Est. Medicare Utilization:	2007 Work RVU: 23.30 2007 NF PE RVU: NA 2007 Fac PE RVU: 15.16 Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 15.16
RUC Recommendation: Deleted from CPT			Referred to CPT February 2007 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
67039	Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation		Global: 090	Issue: Vitrectomy	Screen: Site of Service Anomaly (99238-Only) / Harvard-Valued Annual Allowed Charges Greater than \$10 million	Complete? Yes
Most Recent RUC Meeting: October 2013	Tab 11	Specialty Developing Recommendation: AAO	First Identified: September 2007	2017 Est. Medicare Utilization: 2,874	2007 Work RVU: 16.39 2007 NF PE RVU: NA 2007 Fac PE RVU: 11.94 Result: Decrease	2018 Work RVU: 13.20 2018 NF PE RVU: NA 2018 Fac PE RVU: 11.94
RUC Recommendation: 13.20			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

67040	Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation	Global: 090	Issue: Vitrectomy	Screen: Site of Service Anomaly (99238-Only) / Harvard-Valued Annual Allowed Charges Greater than \$10 million	Complete? Yes
Most Recent RUC Meeting: October 2013	Tab 11 Specialty Developing Recommendation: AAO	First Identified: September 2007	2017 Est. Medicare Utilization: 9,114	2007 Work RVU: 19.23 2007 NF PE RVU: NA 2007 Fac PE RVU: 13.41 Result: Decrease	2018 Work RVU: 14.50 2018 NF PE RVU: NA 2018 Fac PE RVU: 13.41
RUC Recommendation: 14.50		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
67041	Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (eg, macular pucker)	Global: 090	Issue: Vitrectomy	Screen: Harvard-Valued Annual Allowed Charges Greater than \$10 million	Complete? Yes
Most Recent RUC Meeting: October 2013	Tab 11 Specialty Developing Recommendation: AAO	First Identified: October 2012	2017 Est. Medicare Utilization: 13,929	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Decrease	2018 Work RVU: 16.33 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 16.33		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
67042	Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)	Global: 090	Issue: Vitrectomy	Screen: Harvard-Valued Annual Allowed Charges Greater than \$10 million	Complete? Yes
Most Recent RUC Meeting: October 2013	Tab 11 Specialty Developing Recommendation: AAO	First Identified: October 2012	2017 Est. Medicare Utilization: 26,955	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Decrease	2018 Work RVU: 16.33 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 16.33		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

67043 Vitrectomy, mechanical, pars plana approach; with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation **Global:** 090 **Issue:** Vitrectomy **Screen:** Harvard-Valued Annual Allowed Charges Greater than \$10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013

Tab 11 **Specialty Developing Recommendation:** AAO

First Identified: October 2012

2017 Est. Medicare Utilization: 491

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 17.40
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 17.40

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

67101 Repair of retinal detachment, including drainage of subretinal fluid when performed; cryotherapy **Global:** 010 **Issue:** Retinal Detachment Repair **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2015

Tab 11 **Specialty Developing Recommendation:** AAO, ASRS

First Identified: April 2015

2017 Est. Medicare Utilization: 412

2007 Work RVU: 8.60
2007 NF PE RVU: 9.04
2007 Fac PE RVU 6.51
Result: Decrease

2018 Work RVU: 3.50
2018 NF PE RVU: 9.04
2018 Fac PE RVU: 6.51

RUC Recommendation: 3.50

Referred to CPT May 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

67105 Repair of retinal detachment, including drainage of subretinal fluid when performed; photocoagulation **Global:** 010 **Issue:** Retinal Detachment Repair **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2015

Tab 11 **Specialty Developing Recommendation:** AAO, ASRS

First Identified: April 2015

2017 Est. Medicare Utilization: 4,570

2007 Work RVU: 8.35
2007 NF PE RVU: 7.99
2007 Fac PE RVU 6.13
Result: Decrease

2018 Work RVU: 3.39
2018 NF PE RVU: 7.99
2018 Fac PE RVU: 6.13

RUC Recommendation: 3.84

Referred to CPT May 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67107	Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, cryotherapy, photocoagulation, and drainage of subretinal fluid	Global: 090	Issue: Retinal Detachment Repair	Screen: Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits	Complete? Yes
Most Recent RUC Meeting: April 2015	Tab 12 Specialty Developing Recommendation: AAO	First Identified: September 2007	2017 Est. Medicare Utilization: 703	2007 Work RVU: 16.35 2007 NF PE RVU: NA 2007 Fac PE RVU: 11.19 Result: Decrease	2018 Work RVU: 16.00 2018 NF PE RVU: NA 2018 Fac PE RVU: 11.19
RUC Recommendation: 16.00. Reduce 99238 to 0.5		Referred to CPT October 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
67108	Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique	Global: 090	Issue: Retinal Detachment Repair	Screen: Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits	Complete? Yes
Most Recent RUC Meeting: April 2015	Tab 12 Specialty Developing Recommendation: AAO	First Identified: September 2007	2017 Est. Medicare Utilization: 16,164	2007 Work RVU: 22.49 2007 NF PE RVU: NA 2007 Fac PE RVU: 14.22 Result: Decrease	2018 Work RVU: 17.13 2018 NF PE RVU: NA 2018 Fac PE RVU: 14.22
RUC Recommendation: 17.13		Referred to CPT October 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
67110	Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)	Global: 090	Issue: Retinal Detachment Repair	Screen: Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits	Complete? Yes
Most Recent RUC Meeting: April 2015	Tab 12 Specialty Developing Recommendation: AAO	First Identified: September 2007	2017 Est. Medicare Utilization: 2,605	2007 Work RVU: 10.02 2007 NF PE RVU: 9.99 2007 Fac PE RVU: 7.37 Result: Maintain	2018 Work RVU: 10.25 2018 NF PE RVU: 9.99 2018 Fac PE RVU: 7.37
RUC Recommendation: 10.25. Remove 99238		Referred to CPT October 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

67112	Repair of retinal detachment; by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques			Global: 090	Issue: Retinal Detachment Repair	Screen: 090-Day Global Post-Operative Visits	Complete?	Yes								
Most Recent RUC Meeting:	April 2015	Tab 12	Specialty Developing Recommendation:	AAO	First Identified:	April 2014	2017 Est. Medicare Utilization:		2007 Work RVU: 18.45	2018 Work RVU:		2007 NF PE RVU: NA	2018 NF PE RVU: NA	2007 Fac PE RVU 11.71	2018 Fac PE RVU:11.71	
RUC Recommendation:					Deleted from CPT		Referred to CPT		October 2014		Referred to CPT Asst		<input type="checkbox"/>		Published in CPT Asst:	
67113	Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, including, when performed, air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens			Global: 090	Issue: Retinal Detachment Repair	Screen: 090-Day Global Post-Operative Visits	Complete?	Yes								
Most Recent RUC Meeting:	April 2015	Tab 12	Specialty Developing Recommendation:	AAO	First Identified:	January 2014	2017 Est. Medicare Utilization:	12,499	2007 Work RVU:		2018 Work RVU: 19.00	2007 NF PE RVU:	2018 NF PE RVU:	2007 Fac PE RVU	2018 Fac PE RVU:	
RUC Recommendation:					19.00		Referred to CPT		October 2014		Referred to CPT Asst		<input type="checkbox"/>		Published in CPT Asst:	
67210	Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation			Global: 090	Issue: Treatment of Retinal Lesion or Choroid	Screen: High IWPUT	Complete?	Yes								
Most Recent RUC Meeting:	October 2010	Tab 13	Specialty Developing Recommendation:	AAO	First Identified:	February 2008	2017 Est. Medicare Utilization:	65,087	2007 Work RVU: 9.35	2018 Work RVU: 6.36	2007 NF PE RVU: 6.48	2018 NF PE RVU: 6.48	2007 Fac PE RVU 5.84	2018 Fac PE RVU:5.84		
RUC Recommendation:					6.36		Referred to CPT				Referred to CPT Asst		<input type="checkbox"/>		Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

67220 Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions **Global:** 090 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 13 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2017 Est. Medicare Utilization:** 4,423 **2007 Work RVU:** 14.19 **2018 Work RVU:** 6.36
2007 NF PE RVU: 10.23 **2018 NF PE RVU:** 10.23
2007 Fac PE RVU: 8.9 **2018 Fac PE RVU:** 8.9
Result: Decrease

RUC Recommendation: 6.36 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

67225 Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy, second eye, at single session (List separately in addition to code for primary eye treatment) **Global:** ZZZ **Issue:** Photodynamic Therapy of the Eye **Screen:** New Technology **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** P **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2017 Est. Medicare Utilization:** 229 **2007 Work RVU:** 0.47 **2018 Work RVU:** 0.47
2007 NF PE RVU: 0.25 **2018 NF PE RVU:** 0.25
2007 Fac PE RVU: 0.2 **2018 Fac PE RVU:** 0.2
Result: Maintain

RUC Recommendation: 0.47 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

67228 Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), photocoagulation **Global:** 010 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 40 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2017 Est. Medicare Utilization:** 71,265 **2007 Work RVU:** 13.67 **2018 Work RVU:** 4.39
2007 NF PE RVU: 11.2 **2018 NF PE RVU:** 11.2
2007 Fac PE RVU: 8.43 **2018 Fac PE RVU:** 8.43
Result: Remove from Screen

RUC Recommendation: Remove from screen **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67255 Scleral reinforcement (separate procedure); with graft				Global: 090	Issue: Aqueous Shunt	Screen: Harvard-Valued Annual Allowed Charges Greater than \$10 million	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 12	Specialty Developing Recommendation:	AAO	First Identified: January 2014	2017 Est. Medicare Utilization: 1,178	2007 Work RVU: 9.97 2007 NF PE RVU: NA 2007 Fac PE RVU 9.61 Result: Maintain	2018 Work RVU: 8.38 2018 NF PE RVU: NA 2018 Fac PE RVU:9.61
RUC Recommendation: 10.17				Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
67500 Retrobulbar injection; medication (separate procedure, does not include supply of medication)				Global: 000	Issue: Injection – Eye	Screen: CMS 000-Day Global Typically Reported with an E/M	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 11	Specialty Developing Recommendation:	AAO, ASRS	First Identified: October 2017	2017 Est. Medicare Utilization: 8,944	2007 Work RVU: 1.44 2007 NF PE RVU: 0.66 2007 Fac PE RVU 0.34 Result: Decrease	2018 Work RVU: 1.44 2018 NF PE RVU: 0.66 2018 Fac PE RVU:0.34
RUC Recommendation: 1.18				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
67505 Retrobulbar injection; alcohol				Global: 000	Issue: Injection – Eye	Screen: CMS 000-Day Global Typically Reported with an E/M	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 11	Specialty Developing Recommendation:	AAO, ASRS	First Identified: October 2017	2017 Est. Medicare Utilization: 181	2007 Work RVU: 1.27 2007 NF PE RVU: 0.65 2007 Fac PE RVU 0.34 Result: Decrease	2018 Work RVU: 1.27 2018 NF PE RVU: 0.65 2018 Fac PE RVU:0.34
RUC Recommendation: 1.18				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

67515	Injection of medication or other substance into Tenon's capsule	Global: 000	Issue: Injection – Eye	Screen: CMS 000-Day Global Typically Reported with an E/M	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 11	Specialty Developing Recommendation: AAO, ASRS	First Identified: July 2016	2017 Est. Medicare Utilization: 26,441	2007 Work RVU: 1.40 2007 NF PE RVU: 0.65 2007 Fac PE RVU: 0.45 Result: Decrease 2018 Work RVU: 1.40 2018 NF PE RVU: 0.65 2018 Fac PE RVU: 0.45
RUC Recommendation: 0.84			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
<hr/>					
67820	Correction of trichiasis; epilation, by forceps only	Global: 000	Issue: Correction of Trichiasis	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 29	Specialty Developing Recommendation: AOA, AOA (optometry)	First Identified: July 2015	2017 Est. Medicare Utilization: 239,804	2007 Work RVU: 0.71 2007 NF PE RVU: 0.57 2007 Fac PE RVU: 0.54 Result: Decrease 2018 Work RVU: 0.32 2018 NF PE RVU: 0.57 2018 Fac PE RVU: 0.54
RUC Recommendation: 0.32			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
<hr/>					
67914	Repair of ectropion; suture	Global: 090	Issue: Repair of Eyelid	Screen: Harvard-Valued Annual Allowed Charges Greater than \$10 million	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 24	Specialty Developing Recommendation: AAO	First Identified: October 2012	2017 Est. Medicare Utilization: 1,694	2007 Work RVU: 3.70 2007 NF PE RVU: 5.98 2007 Fac PE RVU: 2.99 Result: Maintain 2018 Work RVU: 3.75 2018 NF PE RVU: 5.98 2018 Fac PE RVU: 2.99
RUC Recommendation: 3.75			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

67915 Repair of ectropion; thermocauterization

Global: 090

Issue: Repair of Eyelid

Screen: Harvard-Valued Annual
Allowed Charges
Greater than \$10 million

Complete? Yes

**Most Recent
RUC Meeting:** April 2013

Tab 24

**Specialty Developing
Recommendation:** AAO

**First
Identified:** October 2012

**2017 Est.
Medicare
Utilization:** 327

2007 Work RVU: 3.21

2018 Work RVU: 2.03

2007 NF PE RVU: 5.62

2018 NF PE RVU: 5.62

2007 Fac PE RVU 2.75

2018 Fac PE RVU:2.75

Result: Decrease

RUC Recommendation: 2.03

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

67916 Repair of ectropion; excision tarsal wedge

Global: 090

Issue: Repair of Eyelid

Screen: Harvard-Valued Annual
Allowed Charges
Greater than \$10 million

Complete? Yes

**Most Recent
RUC Meeting:** April 2013

Tab 24

**Specialty Developing
Recommendation:** AAO

**First
Identified:** October 2012

**2017 Est.
Medicare
Utilization:** 1,886

2007 Work RVU: 5.37

2018 Work RVU: 5.48

2007 NF PE RVU: 7.68

2018 NF PE RVU: 7.68

2007 Fac PE RVU 4.65

2018 Fac PE RVU:4.65

Result: Maintain

RUC Recommendation: 5.48

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

67917 Repair of ectropion; extensive (eg, tarsal strip operations)

Global: 090

Issue: Repair of Eyelid

Screen: Harvard-Valued Annual
Allowed Charges
Greater than \$10 million

Complete? Yes

**Most Recent
RUC Meeting:** April 2013

Tab 24

**Specialty Developing
Recommendation:** AAO

**First
Identified:** October 2012

**2017 Est.
Medicare
Utilization:** 25,326

2007 Work RVU: 6.08

2018 Work RVU: 5.93

2007 NF PE RVU: 8.08

2018 NF PE RVU: 8.08

2007 Fac PE RVU 4.95

2018 Fac PE RVU:4.95

Result: Decrease

RUC Recommendation: 5.93

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

67921 Repair of entropion; suture

Global: 090

Issue: Repair of Eyelid

Screen: Harvard-Valued Annual
Allowed Charges
Greater than \$10 million

Complete? Yes

**Most Recent
RUC Meeting:** April 2013

Tab 24

**Specialty Developing
Recommendation:** AAO

**First
Identified:** October 2012

**2017 Est.
Medicare
Utilization:** 3,721

2007 Work RVU: 3.42

2018 Work RVU: 3.47

2007 NF PE RVU: 5.83

2018 NF PE RVU: 5.83

2007 Fac PE RVU 2.84

2018 Fac PE RVU:2.84

Result: Maintain

RUC Recommendation: 3.47

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

67922 Repair of entropion; thermocauterization

Global: 090

Issue: Repair of Eyelid

Screen: Harvard-Valued Annual
Allowed Charges
Greater than \$10 million

Complete? Yes

**Most Recent
RUC Meeting:** April 2013

Tab 24

**Specialty Developing
Recommendation:** AAO

**First
Identified:** October 2012

**2017 Est.
Medicare
Utilization:** 130

2007 Work RVU: 3.09

2018 Work RVU: 2.03

2007 NF PE RVU: 5.55

2018 NF PE RVU: 5.55

2007 Fac PE RVU 2.7

2018 Fac PE RVU:2.7

Result: Decrease

RUC Recommendation: 2.03

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

67923 Repair of entropion; excision tarsal wedge

Global: 090

Issue: Repair of Eyelid

Screen: Harvard-Valued Annual
Allowed Charges
Greater than \$10 million

Complete? Yes

**Most Recent
RUC Meeting:** April 2013

Tab 24

**Specialty Developing
Recommendation:** AAO

**First
Identified:** October 2012

**2017 Est.
Medicare
Utilization:** 1,635

2007 Work RVU: 5.94

2018 Work RVU: 5.48

2007 NF PE RVU: 7.76

2018 NF PE RVU: 7.76

2007 Fac PE RVU 4.86

2018 Fac PE RVU:4.86

Result: Decrease

RUC Recommendation: 5.48

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

67924 Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation) **Global:** 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than \$10 million **Complete?** Yes

Most Recent **Tab** 24 **Specialty Developing** AAO
RUC Meeting: April 2013 **Recommendation:**

First Identified: October 2012 **2017 Est. Medicare Utilization:** 11,602

2007 Work RVU: 5.84 **2018 Work RVU:** 5.93
2007 NF PE RVU: 8.48 **2018 NF PE RVU:** 8.48
2007 Fac PE RVU: 4.57 **2018 Fac PE RVU:** 4.57
Result: Maintain

RUC Recommendation: 5.93

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

68040 Expression of conjunctival follicles (eg, for trachoma)

Global: 000 **Issue:** Treatment of Eyelid Lesions **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent **Tab** 51 **Specialty Developing** AAO
RUC Meeting: September 2011 **Recommendation:**

First Identified: February 2008 **2017 Est. Medicare Utilization:** 5,287

2007 Work RVU: 0.85 **2018 Work RVU:** 0.85
2007 NF PE RVU: 0.69 **2018 NF PE RVU:** 0.69
2007 Fac PE RVU: 0.42 **2018 Fac PE RVU:** 0.42
Result: Maintain

RUC Recommendation: Revised parenthetical

Referred to CPT February 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

68200 Subconjunctival injection

Global: 000 **Issue:** Subconjunctival Injection **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent **Tab** 18 **Specialty Developing** AAO
RUC Meeting: October 2013 **Recommendation:**

First Identified: April 2011 **2017 Est. Medicare Utilization:** 9,141

2007 Work RVU: 0.49 **2018 Work RVU:** 0.49
2007 NF PE RVU: 0.52 **2018 NF PE RVU:** 0.52
2007 Fac PE RVU: 0.32 **2018 Fac PE RVU:** 0.32
Result: Maintain

RUC Recommendation: 0.49

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

68801 Dilation of lacrimal punctum, with or without irrigation

Global: 010

Issue: Dilation and Probing of
Lacrimal and Nasolacrimal
Duct

Screen: 010-Day Global Post-
Operative Visits

Complete? Yes

**Most Recent
RUC Meeting:** January 2015

Tab 23

**Specialty Developing
Recommendation:** AAO, AOA
(optometry)

**First
Identified:** January 2014

**2017 Est.
Medicare
Utilization:** 36,456

2007 Work RVU: 0.96

2018 Work RVU: 0.82

2007 NF PE RVU: 1.91

2018 NF PE RVU: 1.91

2007 Fac PE RVU 1.48

2018 Fac PE RVU:1.48

Result: Maintain

RUC Recommendation: 1.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

68810 Probing of nasolacrimal duct, with or without irrigation;

Global: 010

Issue: Dilation and Probing of
Lacrimal and Nasolacrimal
Duct

Screen: Site of Service Anomaly
/ 010-Day Global Post-
Operative Visits

Complete? Yes

**Most Recent
RUC Meeting:** January 2015

Tab 23

**Specialty Developing
Recommendation:** AAO, AOA
(optometry)

**First
Identified:** September 2007

**2017 Est.
Medicare
Utilization:** 28,740

2007 Work RVU: 2.63

2018 Work RVU: 1.54

2007 NF PE RVU: 3.62

2018 NF PE RVU: 3.62

2007 Fac PE RVU 2.7

2018 Fac PE RVU:2.7

Result: Decrease

RUC Recommendation: 1.54

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

68811 Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia

Global: 010

Issue:

Screen: 010-Day Global Post-
Operative Visits

Complete? Yes

**Most Recent
RUC Meeting:** January 2015

Tab 23

**Specialty Developing
Recommendation:** AAO, AOA
(optometry)

**First
Identified:** September 2014

**2017 Est.
Medicare
Utilization:** 522

2007 Work RVU: 2.39

2018 Work RVU: 1.74

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 2.36

2018 Fac PE RVU:2.36

Result: Decrease

RUC Recommendation: 2.03

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

68815 Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent **Global:** 010 **Issue:** Dilation and Probing of Lacrimal and Nasolacrimal Duct **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** January 2014 **2017 Est. Medicare Utilization:** 8,040 **2007 Work RVU:** 3.24 **2018 Work RVU:** 2.70 **2007 NF PE RVU:** 7.82 **2018 NF PE RVU:** 7.82 **2007 Fac PE RVU:** 2.74 **2018 Fac PE RVU:** 2.74 **RUC Recommendation:** 3.00 **Result:** Decrease

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

68816 Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation **Global:** 010 **Issue:** **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** September 2014 **2017 Est. Medicare Utilization:** 243 **2007 Work RVU:** **2018 Work RVU:** 2.10 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** 2.35 **Result:** Decrease

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

69100 Biopsy external ear **Global:** 000 **Issue:** Biopsy of Ear **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 28 **Specialty Developing Recommendation:** AAD **First Identified:** October 2008 **2017 Est. Medicare Utilization:** 155,215 **2007 Work RVU:** 0.81 **2018 Work RVU:** 0.81 **2007 NF PE RVU:** 1.75 **2018 NF PE RVU:** 1.75 **2007 Fac PE RVU:** 0.4 **2018 Fac PE RVU:** 0.4 **RUC Recommendation:** 0.81 **Result:** Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

69200 Removal foreign body from external auditory canal; without general anesthesia **Global:** 000 **Issue:** Removal of Foreign Body **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 29 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2011 **2017 Est. Medicare Utilization:** 50,432 **2007 Work RVU:** 0.77 **2018 Work RVU:** 0.77 **2007 NF PE RVU:** 2.29 **2018 NF PE RVU:** 2.29 **2007 Fac PE RVU:** 0.56 **2018 Fac PE RVU:** 0.56 **RUC Recommendation:** 0.77 **Result:** Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

69210 Removal impacted cerumen requiring instrumentation, unilateral **Global:** 000 **Issue:** Removal of Cerumen **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2015

Tab 29

Specialty Developing Recommendation: AAFP, AAO-HNS

First Identified: September 2011

2017 Est. Medicare Utilization: 1,597,810

2007 Work RVU: 0.61

2018 Work RVU: 0.61

2007 NF PE RVU: 0.61

2018 NF PE RVU: 0.61

2007 Fac PE RVU 0.21

2018 Fac PE RVU:0.21

Result: Decrease

RUC Recommendation: 0.58.

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

69400 Eustachian tube inflation, transnasal; with catheterization

Global: 000

Issue: Eustachian Tube Procedures

Screen: High Volume Growth2

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab 18

Specialty Developing Recommendation: AAO-HNS

First Identified: October 2013

2017 Est. Medicare Utilization:

2007 Work RVU: 0.83

2018 Work RVU:

2007 NF PE RVU: 2.27

2018 NF PE RVU: 2.27

2007 Fac PE RVU 0.66

2018 Fac PE RVU:0.66

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

69401 Eustachian tube inflation, transnasal; without catheterization

Global: 000

Issue: Eustachian Tube Procedures

Screen: High Volume Growth2

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab 18

Specialty Developing Recommendation: AAO-HNS

First Identified: April 2013

2017 Est. Medicare Utilization:

2007 Work RVU: 0.63

2018 Work RVU:

2007 NF PE RVU: 1.3

2018 NF PE RVU: 1.3

2007 Fac PE RVU 0.63

2018 Fac PE RVU:0.63

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

69405 Eustachian tube catheterization, transtympanic

Global: 010

Issue: Eustachian Tube Procedures

Screen: High Volume Growth2

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab 18

Specialty Developing Recommendation: AAO-HNS

First Identified: October 2013

2017 Est. Medicare Utilization:

2007 Work RVU: 2.65

2018 Work RVU:

2007 NF PE RVU: 3.48

2018 NF PE RVU: 3.48

2007 Fac PE RVU 2.19

2018 Fac PE RVU:2.19

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

69433 Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia **Global:** 010 **Issue:** Tympanostomy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011

Tab 30 Specialty Developing Recommendation: AAO-HNS

First Identified: April 2011

2017 Est. Medicare Utilization: 49,855

2007 Work RVU: 1.54

2018 Work RVU: 1.57

2007 NF PE RVU: 3.09

2018 NF PE RVU: 3.09

2007 Fac PE RVU: 1.6

2018 Fac PE RVU: 1.6

Result: Maintain

RUC Recommendation: 1.57

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

69801 Labyrinthotomy, with perfusion of vestibuloactive drug(s), transcanal

Global: 000

Issue: Labyrinthotomy

Screen: CMS Fastest Growing / Site of Service Anomaly (99238-Only) / CPT Assistant Analysis

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 21 Specialty Developing Recommendation: AAO-HNS

First Identified: September 2007

2017 Est. Medicare Utilization: 21,943

2007 Work RVU: 8.61

2018 Work RVU: 2.06

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 9.31

2018 Fac PE RVU: 9.31

Result: Decrease

RUC Recommendation: Review action plan at RAW Oct 2015. 2.06

Referred to CPT Feb 2010

Referred to CPT Asst ☒

Published in CPT Asst: May 2011

69802 Labyrinthotomy, with perfusion of vestibuloactive drug(s); with mastoidectomy

Global: 090

Issue: Labryinthotomy

Screen: CMS Fastest Growing / Site of Service Anomaly (99238-Only)

Complete? Yes

Most Recent RUC Meeting: April 2010

Tab 16 Specialty Developing Recommendation: AAO-HNS

First Identified:

2017 Est. Medicare Utilization:

2007 Work RVU: 13.39

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 11.91

2018 Fac PE RVU: 11.91

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2011

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

69930 Cochlear device implantation, with or without mastoidectomy

Global: 090

Issue: Cochlear Device Implantation

Screen: Site of Service Anomaly

Complete? Yes

Most Recent RUC Meeting: February 2008

Tab M

Specialty Developing Recommendation: AAO-HNS

First Identified: September 2007

2017 Est. Medicare Utilization: 3,900

2007 Work RVU: 17.60

2018 Work RVU: 17.73

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 14.06

2018 Fac PE RVU:14.06

Result: Maintain

RUC Recommendation: 17.60

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

70100 Radiologic examination, mandible; partial, less than 4 views

Global: XXX

Issue: RAW

Screen: High Volume Growth2

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab 18

Specialty Developing Recommendation:

First Identified: April 2013

2017 Est. Medicare Utilization: 19,566

2007 Work RVU: 0.18

2018 Work RVU: 0.18

2007 NF PE RVU: 0.59

2018 NF PE RVU: 0.59

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: RUC to submit letter to CMS specifying the innapropriate reporting of this service with the hand-held device in Texas.

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

70210 Radiologic examination, sinuses, paranasal, less than 3 views

Global: XXX

Issue: X-Ray Exam - Sinuses

Screen: CMS-Other - Utilization over 30,000

Complete? Yes

Most Recent RUC Meeting: April 2018

Tab 15

Specialty Developing Recommendation: AAFP, ACP, ACR, ASNR

First Identified: October 2017

2017 Est. Medicare Utilization: 39,471

2007 Work RVU: 0.17

2018 Work RVU: 0.17

2007 NF PE RVU: 0.65

2018 NF PE RVU: 0.65

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.17

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

70220 Radiologic examination, sinuses, paranasal, complete, minimum of 3 views **Global:** XXX **Issue:** X-Ray Exam - Sinuses **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018

Tab 15 **Specialty Developing Recommendation:** AAFP, ACP, ACR, ASNR

First Identified: October 2017

2017 Est. Medicare Utilization: 69,960

2007 Work RVU: 0.25

2018 Work RVU: 0.25

2007 NF PE RVU: 0.82

2018 NF PE RVU: 0.82

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.25

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

70250 Radiologic examination, skull; less than 4 views

Global: XXX

Issue: X-Ray Exam – Skull

Screen: CMS-Other - Utilization over 30,000

Complete? Yes

Most Recent RUC Meeting: April 2018

Tab 16 **Specialty Developing Recommendation:** ACR, ASNR

First Identified: October 2017

2017 Est. Medicare Utilization: 46,476

2007 Work RVU: 0.24

2018 Work RVU: 0.24

2007 NF PE RVU: 0.7

2018 NF PE RVU: 0.7

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 0.23

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

70260 Radiologic examination, skull; complete, minimum of 4 views

Global: XXX

Issue: X-Ray Exam – Skull

Screen: CMS-Other - Utilization over 30,000

Complete? Yes

Most Recent RUC Meeting: April 2018

Tab 16 **Specialty Developing Recommendation:** ACR, ASNR

First Identified: January 2018

2017 Est. Medicare Utilization: 10,828

2007 Work RVU: 0.34

2018 Work RVU: 0.34

2007 NF PE RVU: 0.96

2018 NF PE RVU: 0.96

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 0.32

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

70310 Radiologic examination, teeth; partial examination, less than full mouth **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013	Tab 18	Specialty Developing Recommendation:	First Identified: April 2013	2017 Est. Medicare Utilization: 2,554	2007 Work RVU: 0.16 2007 NF PE RVU: 0.58 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 0.16 2018 NF PE RVU: 0.58 2018 Fac PE RVU: NA
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RUC Recommendation: RUC to submit letter to CMS specifying the innapropriate reporting of this service with the hand-held device in Texas.

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

70360 Radiologic examination; neck, soft tissue **Global:** XXX **Issue:** X-Ray Exam – Neck **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018	Tab 15	Specialty Developing Recommendation: AAFP, ACP, ACR, ASNR	First Identified: October 2017	2017 Est. Medicare Utilization: 70,431	2007 Work RVU: 0.17 2007 NF PE RVU: 0.5 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 0.17 2018 NF PE RVU: 0.5 2018 Fac PE RVU: NA
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RUC Recommendation: New PE Inputs. 0.17

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

70371 Complex dynamic pharyngeal and speech evaluation by cine or video recording **Global:** XXX **Issue:** Laryngography **Screen:** Codes Reported Together 75% or More- Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: October 2012	Tab	Specialty Developing Recommendation: ACR, AAFP	First Identified: October 2012	2017 Est. Medicare Utilization: 4,323	2007 Work RVU: 0.84 2007 NF PE RVU: 2.14 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 0.84 2018 NF PE RVU: 2.14 2018 Fac PE RVU: NA
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RUC Recommendation: CPT Assistant article published.

Referred to CPT

Referred to CPT Asst ☒ **Published in CPT Asst:** July 2014

Status Report: CMS Requests and Relativity Assessment Issues

70373	Laryngography, contrast, radiological supervision and interpretation			Global: XXX	Issue: Laryngography	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting:	October 2012	Tab	Specialty Developing Recommendation: ACR, AAFP	First Identified: October 2012	2017 Est. Medicare Utilization:	2007 Work RVU: 0.44 2007 NF PE RVU: 1.83 2007 Fac PE RVU: NA Result: Maintain	2018 Work RVU: 2018 NF PE RVU: 1.83 2018 Fac PE RVU:NA
RUC Recommendation: CPT Assistant article published.				Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: July 2014		
70450	Computed tomography, head or brain; without contrast material			Global: XXX	Issue: CT Head/Brain	Screen: CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting:	October 2012	Tab 19	Specialty Developing Recommendation: ACR, ASNR	First Identified: April 2011	2017 Est. Medicare Utilization: 5,888,846	2007 Work RVU: 0.85 2007 NF PE RVU: 4.91 2007 Fac PE RVU: NA Result: Maintain	2018 Work RVU: 0.85 2018 NF PE RVU: 4.91 2018 Fac PE RVU:NA
RUC Recommendation: 0.85				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
70460	Computed tomography, head or brain; with contrast material(s)			Global: XXX	Issue: CT Head/Brain	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting:	October 2012	Tab 19	Specialty Developing Recommendation: ACR, ASNR	First Identified: April 2013	2017 Est. Medicare Utilization: 32,094	2007 Work RVU: 1.13 2007 NF PE RVU: 6.06 2007 Fac PE RVU: NA Result: Maintain	2018 Work RVU: 1.13 2018 NF PE RVU: 6.06 2018 Fac PE RVU:NA
RUC Recommendation: 1.13				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

70470 Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections **Global:** XXX **Issue:** CT Head/Brain **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012

Tab 19 Specialty Developing Recommendation: ACR, ASNR

First Identified: October 2009

2017 Est. Medicare Utilization: 110,713

2007 Work RVU: 1.27

2018 Work RVU: 1.27

2007 NF PE RVU: 7.49

2018 NF PE RVU: 7.49

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Maintain

RUC Recommendation: 1.27. Survey for work and PE for April 2013 RUC meeting (Identified as part of 70450 family).

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

70480 Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material **Global:** XXX **Issue:** CT – Orbit/Ear/Fossa

Screen: CMS-Other - Utilization over 30,000

Complete? Yes

Most Recent RUC Meeting: October 2018

Tab 16 Specialty Developing Recommendation: ACR, ASNR

First Identified: October 2017

2017 Est. Medicare Utilization: 54,050

2007 Work RVU: 1.28

2018 Work RVU: 1.28

2007 NF PE RVU: 5.86

2018 NF PE RVU: 5.86

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Maintain

RUC Recommendation: 1.28

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

70481 Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s) **Global:** XXX **Issue:** CT – Orbit/Ear/Fossa

Screen: CMS-Other - Utilization over 30,000

Complete? Yes

Most Recent RUC Meeting: October 2018

Tab 16 Specialty Developing Recommendation: ACR, ASNR

First Identified: January 2018

2017 Est. Medicare Utilization: 9,981

2007 Work RVU: 1.38

2018 Work RVU: 1.38

2007 NF PE RVU: 6.95

2018 NF PE RVU: 6.95

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Decrease

RUC Recommendation: 1.13

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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 **Global:** XXX **Issue:** CT – Orbit/Ear/Fossa **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018

Tab 16 **Specialty Developing Recommendation:** ACR, ASNR

First Identified: January 2018

2017 Est. Medicare Utilization: 5,200

2007 Work RVU: 1.45

2018 Work RVU: 1.45

2007 NF PE RVU: 8.36

2018 NF PE RVU: 8.36

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 1.27

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

70486 Computed tomography, maxillofacial area; without contrast material **Global:** XXX **Issue:** CT – Maxillofacial **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 41 **Specialty Developing Recommendation:** ACR, ASNR

First Identified: April 2013

2017 Est. Medicare Utilization: 529,161

2007 Work RVU: 1.14

2018 Work RVU: 0.85

2007 NF PE RVU: 5.42

2018 NF PE RVU: 5.42

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 0.85

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

70487 Computed tomography, maxillofacial area; with contrast material(s) **Global:** XXX **Issue:** CT – Maxillofacial **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 41 **Specialty Developing Recommendation:** ACR, ASNR

First Identified: April 2014

2017 Est. Medicare Utilization: 27,565

2007 Work RVU: 1.30

2018 Work RVU: 1.13

2007 NF PE RVU: 6.55

2018 NF PE RVU: 6.55

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 1.17

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70488 Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections **Global:** XXX **Issue:** CT – Maxillofacial **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 41 Specialty Developing Recommendation: ACR, ASNR

First Identified: April 2014

2017 Est. Medicare Utilization: 3,796

2007 Work RVU: 1.42

2018 Work RVU: 1.27

2007 NF PE RVU: 8.11

2018 NF PE RVU: 8.11

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Decrease

RUC Recommendation: 1.30

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

70490 Computed tomography, soft tissue neck; without contrast material

Global: XXX

Issue: CT Soft Tissue Neck

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: January 2017

Tab 21 Specialty Developing Recommendation: ACR, ASNR

First Identified: July 2015

2017 Est. Medicare Utilization: 70,948

2007 Work RVU: 1.28

2018 Work RVU: 1.28

2007 NF PE RVU: 5.39

2018 NF PE RVU: 5.39

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Maintain

RUC Recommendation: 1.28

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

70491 Computed tomography, soft tissue neck; with contrast material(s)

Global: XXX

Issue: CT Soft Tissue Neck

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: January 2017

Tab 21 Specialty Developing Recommendation: ACR, ASNR

First Identified: July 2015

2017 Est. Medicare Utilization: 266,206

2007 Work RVU: 1.38

2018 Work RVU: 1.38

2007 NF PE RVU: 6.48

2018 NF PE RVU: 6.48

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Maintain

RUC Recommendation: 1.38

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

70492 Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections

Global: XXX

Issue: CT Soft Tissue Neck

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: January 2017

Tab 21 Specialty Developing Recommendation: ACR, ASNR

First Identified: July 2015

2017 Est. Medicare Utilization: 24,456

2007 Work RVU: 1.45

2018 Work RVU: 1.62

2007 NF PE RVU: 8.04

2018 NF PE RVU: 8.04

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Increase

RUC Recommendation: 1.62

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

70496	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Global: XXX	Issue: CT Angiography – Head & Neck	Screen: High Volume Growth1 / CMS Fastest Growing / High Volume Growth2 / High Volume Growth5	Complete? No
Most Recent RUC Meeting: April 2014	Tab 39	Specialty Developing Recommendation: ACR, ASNR	First Identified: February 2008	2017 Est. Medicare Utilization: 355,601	2007 Work RVU: 1.75 2007 NF PE RVU: 12.43 2007 Fac PE RVU NA Result: Maintain 2018 Work RVU: 1.75 2018 NF PE RVU: 12.43 2018 Fac PE RVU: NA
RUC Recommendation: Review action plan 1.75			Referred to CPT Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		
70498	Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Global: XXX	Issue: CT Angiography – Head & Neck	Screen: High Volume Growth1 / CMS Fastest Growing / High Volume Growth5	Complete? No
Most Recent RUC Meeting: April 2014	Tab 39	Specialty Developing Recommendation: ACR, ASNR	First Identified: February 2008	2017 Est. Medicare Utilization: 378,159	2007 Work RVU: 1.75 2007 NF PE RVU: 12.45 2007 Fac PE RVU NA Result: Maintain 2018 Work RVU: 1.75 2018 NF PE RVU: 12.45 2018 Fac PE RVU: NA
RUC Recommendation: Review action plan. 1.75			Referred to CPT Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		
70540	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)	Global: XXX	Issue: MRI Face and Neck	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 39	Specialty Developing Recommendation: ACR, ASNR	First Identified: July 2015	2017 Est. Medicare Utilization: 10,925	2007 Work RVU: 1.35 2007 NF PE RVU: 12.11 2007 Fac PE RVU NA Result: Maintain 2018 Work RVU: 1.35 2018 NF PE RVU: 12.11 2018 Fac PE RVU: NA
RUC Recommendation: 1.35			Referred to CPT Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

70542	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)	Global: XXX	Issue: MRI Face and Neck	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 39	Specialty Developing Recommendation: ACR, ASNR	First Identified: July 2015	2017 Est. Medicare Utilization: 1,309	2007 Work RVU: 1.62 2018 Work RVU: 1.62 2007 NF PE RVU: 14.09 2018 NF PE RVU: 14.09 2007 Fac PE RVU: NA 2018 Fac PE RVU: NA Result: Maintain
RUC Recommendation: 1.62			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

70543	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences	Global: XXX	Issue: MRI Face and Neck	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 39	Specialty Developing Recommendation: ACR, ASNR	First Identified: July 2015	2017 Est. Medicare Utilization: 58,056	2007 Work RVU: 2.15 2018 Work RVU: 2.15 2007 NF PE RVU: 23.65 2018 NF PE RVU: 23.65 2007 Fac PE RVU: NA 2018 Fac PE RVU: NA Result: Maintain
RUC Recommendation: 2.15			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

70544	Magnetic resonance angiography, head; without contrast material(s)	Global: XXX	Issue: Magnetic Resonance Angiography (MR) Head/Neck	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 18	Specialty Developing Recommendation: ACR, ASNR	First Identified: July 2015	2017 Est. Medicare Utilization: 274,961	2007 Work RVU: 1.20 2018 Work RVU: 1.20 2007 NF PE RVU: 12.46 2018 NF PE RVU: 12.46 2007 Fac PE RVU: NA 2018 Fac PE RVU: NA Result: Maintain
RUC Recommendation: 1.20			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

70545	Magnetic resonance angiography, head; with contrast material(s)	Global: XXX	Issue: Magnetic Resonance Angiography (MR) Head/Neck	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 18	Specialty Developing Recommendation: ACR, ASNR	First Identified: July 2015	2017 Est. Medicare Utilization: 4,007	2007 Work RVU: 1.20 2018 Work RVU: 1.20 2007 NF PE RVU: 12.44 2018 NF PE RVU: 12.44 2007 Fac PE RVU: NA 2018 Fac PE RVU: NA Result: Maintain
RUC Recommendation: 1.20			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

70546	Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences	Global: XXX	Issue: Magnetic Resonance Angiography (MR) Head/Neck	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 18	Specialty Developing Recommendation: ACR, ASNR	First Identified: July 2015	2017 Est. Medicare Utilization: 18,088	2007 Work RVU: 1.80 2018 Work RVU: 1.48 2007 NF PE RVU: 22.97 2018 NF PE RVU: 22.97 2007 Fac PE RVU: NA 2018 Fac PE RVU: NA Result: Decrease
RUC Recommendation: 1.48			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

70547	Magnetic resonance angiography, neck; without contrast material(s)	Global: XXX	Issue: Magnetic Resonance Angiography (MR) Head/Neck	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 19	Specialty Developing Recommendation: ACR, ASNR	First Identified: July 2015	2017 Est. Medicare Utilization: 84,689	2007 Work RVU: 1.20 2018 Work RVU: 1.20 2007 NF PE RVU: 12.45 2018 NF PE RVU: 12.45 2007 Fac PE RVU: NA 2018 Fac PE RVU: NA Result: Maintain
RUC Recommendation: 1.20			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

70548	Magnetic resonance angiography, neck; with contrast material(s)	Global: XXX	Issue: Magnetic Resonance Angiography (MR) Head/Neck	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 19	Specialty Developing Recommendation: ACR, ASNR	First Identified: July 2015	2017 Est. Medicare Utilization: 22,775	2007 Work RVU: 1.20 2007 NF PE RVU: 12.65 2007 Fac PE RVU NA Result: Increase
RUC Recommendation: 1.50			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.50 2018 NF PE RVU: 12.65 2018 Fac PE RVU: NA

70549	Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences	Global: XXX	Issue: Magnetic Resonance Angiography (MR) Head/Neck	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 19	Specialty Developing Recommendation: ACR, ASNR	First Identified: July 2015	2017 Est. Medicare Utilization: 69,813	2007 Work RVU: 1.80 2007 NF PE RVU: 22.96 2007 Fac PE RVU NA Result: Maintain
RUC Recommendation: 1.80			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.80 2018 NF PE RVU: 22.96 2018 Fac PE RVU: NA

70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material	Global: XXX	Issue: MRI-Brain	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: January 2013	Tab 26	Specialty Developing Recommendation: ACR, ASNR	First Identified: September 2011	2017 Est. Medicare Utilization: 1,126,803	2007 Work RVU: 1.48 2007 NF PE RVU: 12.2 2007 Fac PE RVU NA Result: Maintain
RUC Recommendation: 1.48			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.48 2018 NF PE RVU: 12.2 2018 Fac PE RVU: NA

Status Report: CMS Requests and Relativity Assessment Issues

70552	Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)	Global: XXX	Issue: MRI-Brain	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: January 2013	Tab 26	Specialty Developing Recommendation: ACR, ASNR	First Identified: September 2011	2017 Est. Medicare Utilization: 25,797	2007 Work RVU: 1.78 2007 NF PE RVU: 14.22 2007 Fac PE RVU: NA Result: Maintain
RUC Recommendation: 1.78			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.78 2018 NF PE RVU: 14.22 2018 Fac PE RVU: NA

70553	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences	Global: XXX	Issue: MRI-Brain	Screen: CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: January 2013	Tab 26	Specialty Developing Recommendation: ACR, ASNR	First Identified: April 2011	2017 Est. Medicare Utilization: 1,012,674	2007 Work RVU: 2.36 2007 NF PE RVU: 23.53 2007 Fac PE RVU: NA Result: Maintain
RUC Recommendation: 2.36			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2.29 2018 NF PE RVU: 23.53 2018 Fac PE RVU: NA

71010	Radiologic examination, chest; single view, frontal	Global: XXX	Issue: Chest X-Rays	Screen: Low Value-High Volume / CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 07	Specialty Developing Recommendation: ACR	First Identified: October 2010	2017 Est. Medicare Utilization: 16,900,299	2007 Work RVU: 0.18 2007 NF PE RVU: 0.5 2007 Fac PE RVU: NA Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT February 2016 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: 0.5 2018 Fac PE RVU: NA

Status Report: CMS Requests and Relativity Assessment Issues

71015 Radiologic examination, chest; stereo, frontal

Global: XXX **Issue:** Chest X-Rays

Screen: CMS High Expenditure
Procedural Codes2

Complete? Yes

Most Recent **Tab** 07 **Specialty Developing** ACR
RUC Meeting: April 2016 **Recommendation:**

First
Identified: July 2015

2017 Est.
Medicare
Utilization: 360

2007 Work RVU: 0.21

2018 Work RVU:

2007 NF PE RVU: 0.58

2018 NF PE RVU: 0.58

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT February 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

71020 Radiologic examination, chest, 2 views, frontal and lateral;

Global: XXX **Issue:** Chest X-Rays

Screen: MPC List / CMS High
Expenditure Procedural
Codes2

Complete? Yes

Most Recent **Tab** 07 **Specialty Developing** ACR
RUC Meeting: April 2016 **Recommendation:**

First
Identified: October 2010

2017 Est.
Medicare
Utilization: 11,683,125

2007 Work RVU: 0.22

2018 Work RVU:

2007 NF PE RVU: 0.66

2018 NF PE RVU: 0.66

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT February 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

71021 Radiologic examination, chest, 2 views, frontal and lateral; with apical lordotic procedure

Global: XXX **Issue:** Chest X-Rays

Screen: CMS High Expenditure
Procedural Codes2

Complete? Yes

Most Recent **Tab** 07 **Specialty Developing** ACR
RUC Meeting: April 2016 **Recommendation:**

First
Identified: July 2015

2017 Est.
Medicare
Utilization: 5,410

2007 Work RVU: 0.27

2018 Work RVU:

2007 NF PE RVU: 0.79

2018 NF PE RVU: 0.79

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT February 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

71022 Radiologic examination, chest, 2 views, frontal and lateral; with oblique projections **Global:** XXX **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR

First Identified: July 2015 **2017 Est. Medicare Utilization:** 17,314

2007 Work RVU: 0.31 **2018 Work RVU:**
2007 NF PE RVU: 0.84 **2018 NF PE RVU:** 0.84
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

71023 Radiologic examination, chest, 2 views, frontal and lateral; with fluoroscopy **Global:** XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR

First Identified: July 2015 **2017 Est. Medicare Utilization:** 3,157

2007 Work RVU: 0.38 **2018 Work RVU:**
2007 NF PE RVU: 1.06 **2018 NF PE RVU:** 1.06
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

71030 Radiologic examination, chest, complete, minimum of 4 views; **Global:** XXX **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR

First Identified: July 2015 **2017 Est. Medicare Utilization:** 8,426

2007 Work RVU: 0.31 **2018 Work RVU:**
2007 NF PE RVU: 0.88 **2018 NF PE RVU:** 0.88
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

71034 Radiologic examination, chest, complete, minimum of 4 views; with fluoroscopy **Global:** XXX **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR

First Identified: July 2015 **2017 Est. Medicare Utilization:** 525

2007 Work RVU: 0.46 **2018 Work RVU:**
2007 NF PE RVU: 1.69 **2018 NF PE RVU:** 1.69
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71035 Radiologic examination, chest, special views (eg, lateral decubitus, Bucky studies) **Global:** XXX **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 77,606 **2007 Work RVU:** 0.18 **2018 Work RVU:** **2007 NF PE RVU:** 0.62 **2018 NF PE RVU:** 0.62 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

71045 Radiologic examination, chest; single view **Global:** XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR **First Identified:** February 2016 **2017 Est. Medicare Utilization:** **2007 Work RVU:** **2018 Work RVU:** 0.18 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 0.18 **Referred to CPT** February 2016 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

71046 Radiologic examination, chest; 2 views **Global:** XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR **First Identified:** February 2016 **2017 Est. Medicare Utilization:** **2007 Work RVU:** **2018 Work RVU:** 0.22 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 0.22 **Referred to CPT** February 2016 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

71047 Radiologic examination, chest; 3 views **Global:** XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 07 **Specialty Developing Recommendation:** ACR **First Identified:** February 2016 **2017 Est. Medicare Utilization:** **2007 Work RVU:** **2018 Work RVU:** 0.27 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 0.27 **Referred to CPT** February 2016 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71048	Radiologic examination, chest; 4 or more views	Global: XXX	Issue: Chest X-Ray	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 07 Specialty Developing Recommendation: ACR	First Identified: February 2016	2017 Est. Medicare Utilization:	2007 Work RVU:	2018 Work RVU: 0.31
RUC Recommendation: 0.31		Referred to CPT February 2016		2007 NF PE RVU:	2018 NF PE RVU:
		Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU	2018 Fac PE RVU:
				Result: Decrease	

71090	Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation	Global: XXX	Issue: Insertion/Removal of Pacemaker or Pacing Cardioverter-Defibrillator	Screen: Codes Reported Together 75% or More- Part1	Complete? Yes
Most Recent RUC Meeting: April 2011	Tab 10 Specialty Developing Recommendation: ACC	First Identified: February 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 0.00	2018 Work RVU:
RUC Recommendation: Deleted from CPT		Referred to CPT February 2011		2007 NF PE RVU: NA	2018 NF PE RVU: NA
		Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU NA	2018 Fac PE RVU: NA
				Result: Deleted from CPT	

71100	Radiologic examination, ribs, unilateral; 2 views	Global: XXX	Issue: X-Ray of Ribs	Screen: CMS-Other - Utilization over 250,000 / CMS- Other - Utilization over 250,000-Part2	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 30 Specialty Developing Recommendation: ACR	First Identified: April 2013	2017 Est. Medicare Utilization: 199,259	2007 Work RVU: 0.22	2018 Work RVU: 0.22
RUC Recommendation: 0.22		Referred to CPT		2007 NF PE RVU: 0.63	2018 NF PE RVU: 0.63
		Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU NA	2018 Fac PE RVU: NA
				Result: Maintain	

Status Report: CMS Requests and Relativity Assessment Issues

71101 Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of 3 views

Global: XXX

Issue: X-Ray of Ribs

Screen: CMS-Other - Utilization over 250,000-Part2

Complete? Yes

Most Recent RUC Meeting: April 2016

Tab 30

Specialty Developing Recommendation: ACR

First Identified: October 2015

2017 Est. Medicare Utilization: 296,064

2007 Work RVU: 0.27

2018 Work RVU: 0.27

2007 NF PE RVU: 0.75

2018 NF PE RVU: 0.75

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.27

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

71110 Radiologic examination, ribs, bilateral; 3 views

Global: XXX

Issue: X-Ray of Ribs

Screen: CMS-Other - Utilization over 250,000-Part2

Complete? Yes

Most Recent RUC Meeting: April 2016

Tab 30

Specialty Developing Recommendation: ACR

First Identified: October 2015

2017 Est. Medicare Utilization: 28,042

2007 Work RVU: 0.27

2018 Work RVU: 0.29

2007 NF PE RVU: 0.84

2018 NF PE RVU: 0.84

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.29

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

71111 Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views

Global: XXX

Issue: X-Ray of Ribs

Screen: CMS-Other - Utilization over 250,000-Part2

Complete? Yes

Most Recent RUC Meeting: April 2016

Tab 30

Specialty Developing Recommendation: ACR

First Identified: October 2015

2017 Est. Medicare Utilization: 30,355

2007 Work RVU: 0.32

2018 Work RVU: 0.32

2007 NF PE RVU: 1

2018 NF PE RVU: 1

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.32

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

71250 Computed tomography, thorax; without contrast material

Global: XXX

Issue: CT Chest

Screen: CMS Fastest Growing /
CMS High Expenditure
Procedural Codes2

Complete? Yes

**Most Recent
RUC Meeting:** April 2016

Tab 31

**Specialty Developing
Recommendation:** ACR

**First
Identified:** October 2008

**2017 Est.
Medicare
Utilization:** 2,139,989

2007 Work RVU: 1.16

2018 Work RVU: 1.16

2007 NF PE RVU: 6.24

2018 NF PE RVU: 6.24

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Increase

RUC Recommendation: 1.16

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

71260 Computed tomography, thorax; with contrast material(s)

Global: XXX

Issue: CT Chest

Screen: CMS High Expenditure
Procedural Codes2

Complete? Yes

**Most Recent
RUC Meeting:** April 2016

Tab 31

**Specialty Developing
Recommendation:** ACR

**First
Identified:** July 2015

**2017 Est.
Medicare
Utilization:** 1,792,748

2007 Work RVU: 1.24

2018 Work RVU: 1.24

2007 NF PE RVU: 7.5

2018 NF PE RVU: 7.5

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 1.38

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

71270 Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections

Global: XXX

Issue: CT Chest

Screen: CMS High Expenditure
Procedural Codes2

Complete? Yes

**Most Recent
RUC Meeting:** April 2016

Tab 31

**Specialty Developing
Recommendation:** ACR

**First
Identified:** July 2015

**2017 Est.
Medicare
Utilization:** 78,247

2007 Work RVU: 1.38

2018 Work RVU: 1.38

2007 NF PE RVU: 9.36

2018 NF PE RVU: 9.36

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 1.24

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

71275 Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing **Global:** XXX **Issue:** CT Angiography-Chest **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 27 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2008 **2017 Est. Medicare Utilization:** 1,146,331 **2007 Work RVU:** 1.92 **2018 Work RVU:** 1.82 **2007 NF PE RVU:** 12.53 **2018 NF PE RVU:** 12.53 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **RUC Recommendation:** 1.82 **Referred to CPT** **Referred to CPT Asst** ☒ **Published in CPT Asst:** Jun 2009 **Result:** Decrease

72020 Radiologic examination, spine, single view, specify level **Global:** XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 20 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** April 2016 **2017 Est. Medicare Utilization:** 158,937 **2007 Work RVU:** 0.15 **2018 Work RVU:** 0.15 **2007 NF PE RVU:** 0.46 **2018 NF PE RVU:** 0.46 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **RUC Recommendation:** 0.15 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

72040 Radiologic examination, spine, cervical; 2 or 3 views **Global:** XXX **Issue:** X-Ray Spine **Screen:** Low Value-High Volume / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 20 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2010 **2017 Est. Medicare Utilization:** 642,007 **2007 Work RVU:** 0.22 **2018 Work RVU:** 0.22 **2007 NF PE RVU:** 0.69 **2018 NF PE RVU:** 0.69 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **RUC Recommendation:** 0.22 **Referred to CPT** October 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

Status Report: CMS Requests and Relativity Assessment Issues

72050 Radiologic examination, spine, cervical; 4 or 5 views **Global:** XXX **Issue:** X-Ray Spine **Screen:** Low Value-High Volume / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 20 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2010 **2017 Est. Medicare Utilization:** 393,769 **2007 Work RVU:** 0.31 **2018 Work RVU:** 0.31 **2007 NF PE RVU:** 1 **2018 NF PE RVU:** 1 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Maintain

RUC Recommendation: 0.31 **Referred to CPT** October 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

72052 Radiologic examination, spine, cervical; 6 or more views **Global:** XXX **Issue:** X-Ray Spine **Screen:** Low Value-High Volume / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 20 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2010 **2017 Est. Medicare Utilization:** 91,140 **2007 Work RVU:** 0.36 **2018 Work RVU:** 0.36 **2007 NF PE RVU:** 1.27 **2018 NF PE RVU:** 1.27 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Decrease

RUC Recommendation: 0.35 **Referred to CPT** October 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

72070 Radiologic examination, spine; thoracic, 2 views **Global:** XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 250,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 20 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** April 2013 **2017 Est. Medicare Utilization:** 309,157 **2007 Work RVU:** 0.22 **2018 Work RVU:** 0.22 **2007 NF PE RVU:** 0.69 **2018 NF PE RVU:** 0.69 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Maintain

RUC Recommendation: 0.22 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72072 Radiologic examination, spine; thoracic, 3 views

Global: XXX

Issue: X-Ray Spine

Screen: CMS-Other - Utilization
over 100,000

Complete? Yes

**Most Recent
RUC Meeting:** April 2017

Tab 20

**Specialty Developing
Recommendation:**

AAOS, ACR,
ASNR

**First
Identified:** April 2016

**2017 Est.
Medicare
Utilization:** 197,539

2007 Work RVU: 0.22

2018 Work RVU: 0.22

2007 NF PE RVU: 0.78

2018 NF PE RVU: 0.78

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.22

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

72074 Radiologic examination, spine; thoracic, minimum of 4 views

Global: XXX

Issue: X-Ray Spine

Screen: CMS-Other - Utilization
over 100,000

Complete? Yes

**Most Recent
RUC Meeting:** April 2017

Tab 20

**Specialty Developing
Recommendation:**

AAOS, ACR,
ASNR

**First
Identified:** October 2016

**2017 Est.
Medicare
Utilization:** 14,535

2007 Work RVU: 0.22

2018 Work RVU: 0.22

2007 NF PE RVU: 0.96

2018 NF PE RVU: 0.96

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.22

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

72080 Radiologic examination, spine; thoracolumbar junction, minimum of 2 views

Global: XXX

Issue: X-Ray Spine

Screen: CMS-Other - Utilization
over 100,000

Complete? Yes

**Most Recent
RUC Meeting:** April 2017

Tab 20

**Specialty Developing
Recommendation:**

AAOS, ACR,
ASNR

**First
Identified:** October 2016

**2017 Est.
Medicare
Utilization:** 44,081

2007 Work RVU: 0.22

2018 Work RVU: 0.22

2007 NF PE RVU: 0.72

2018 NF PE RVU: 0.72

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.22

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

72100	Radiologic examination, spine, lumbosacral; 2 or 3 views	Global: XXX	Issue: X-Ray Spine	Screen: Harvard Valued - Utilization over 100,000 / Low Value-High Volume / CMS-Other - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 20	Specialty Developing Recommendation: AAOS, ACR, ASNR	First Identified: February 2010	2017 Est. Medicare Utilization: 1,884,896	2007 Work RVU: 0.22 2007 NF PE RVU: 0.75 2007 Fac PE RVU NA Result: Maintain
RUC Recommendation: 0.22			Referred to CPT October 2010	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:

72110	Radiologic examination, spine, lumbosacral; minimum of 4 views	Global: XXX	Issue: X-Ray Spine	Screen: Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 20	Specialty Developing Recommendation: AAOS, ACR, ASNR	First Identified: October 2009	2017 Est. Medicare Utilization: 859,433	2007 Work RVU: 0.31 2007 NF PE RVU: 1.03 2007 Fac PE RVU NA Result: Maintain
RUC Recommendation: 0.31			Referred to CPT October 2010	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:

72114	Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views	Global: XXX	Issue: X-Ray Spine	Screen: Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 20	Specialty Developing Recommendation: AAOS, ACR, ASNR	First Identified: February 2010	2017 Est. Medicare Utilization: 98,299	2007 Work RVU: 0.36 2007 NF PE RVU: 1.36 2007 Fac PE RVU NA Result: Decrease
RUC Recommendation: 0.31			Referred to CPT October 2010	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

72120 Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views **Global:** XXX **Issue:** X-Ray Spine **Screen:** Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 20 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** February 2010 **2017 Est. Medicare Utilization:** 48,230 **2007 Work RVU:** 0.22 **2018 Work RVU:** 0.22
2007 NF PE RVU: 0.98 **2018 NF PE RVU:** 0.98
2007 Fac PE RVU: NA **2018 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: 0.22 **Referred to CPT** October 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

72125 Computed tomography, cervical spine; without contrast material **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2008 **2017 Est. Medicare Utilization:** 1,189,776 **2007 Work RVU:** 1.16 **2018 Work RVU:** 1.07
2007 NF PE RVU: 6.24 **2018 NF PE RVU:** 6.24
2007 Fac PE RVU: NA **2018 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: 1.07 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

72126 Computed tomography, cervical spine; with contrast material **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2017 Est. Medicare Utilization:** 20,916 **2007 Work RVU:** 1.22 **2018 Work RVU:** 1.22
2007 NF PE RVU: 7.49 **2018 NF PE RVU:** 7.49
2007 Fac PE RVU: NA **2018 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: 1.22 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

72127 Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2017 Est. Medicare Utilization:** 2,180 **2007 Work RVU:** 1.27 **2018 Work RVU:** 1.27
2007 NF PE RVU: 9.3 **2018 NF PE RVU:** 9.3
2007 Fac PE RVU: NA **2018 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: 1.27 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72128	Computed tomography, thoracic spine; without contrast material	Global: XXX	Issue: CT Spine	Screen: CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 18 Specialty Developing Recommendation: ACR, ASNR	First Identified: October 2008	2017 Est. Medicare Utilization: 171,017	2007 Work RVU: 1.16 2007 NF PE RVU: 6.24 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 1.00 2018 NF PE RVU: 6.24 2018 Fac PE RVU:NA
RUC Recommendation: 1.00		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

72129	Computed tomography, thoracic spine; with contrast material	Global: XXX	Issue: CT Spine	Screen: CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 18 Specialty Developing Recommendation: ACR, ASNR	First Identified: February 2009	2017 Est. Medicare Utilization: 20,971	2007 Work RVU: 1.22 2007 NF PE RVU: 7.49 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 1.22 2018 NF PE RVU: 7.49 2018 Fac PE RVU:NA
RUC Recommendation: 1.22		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

72130	Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections	Global: XXX	Issue: CT Spine	Screen: CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 18 Specialty Developing Recommendation: ACR, ASNR	First Identified: February 2009	2017 Est. Medicare Utilization: 1,430	2007 Work RVU: 1.27 2007 NF PE RVU: 9.29 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 1.27 2018 NF PE RVU: 9.29 2018 Fac PE RVU:NA
RUC Recommendation: 1.27		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

72131	Computed tomography, lumbar spine; without contrast material	Global: XXX	Issue: CT Spine	Screen: CMS Fastest Growing / CMS-Other - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 18 Specialty Developing Recommendation: ACR, ASNR	First Identified: February 2009	2017 Est. Medicare Utilization: 477,507	2007 Work RVU: 1.16 2007 NF PE RVU: 6.24 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 1.00 2018 NF PE RVU: 6.24 2018 Fac PE RVU:NA
RUC Recommendation: 1.00		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

72132 Computed tomography, lumbar spine; with contrast material

Global: XXX **Issue:** CT Spine

Screen: CMS Fastest Growing / CMS-Other - Utilization over 30,000

Complete? Yes

Most Recent RUC Meeting: April 2018

Tab 18 Specialty Developing Recommendation: ACR, ASNR

First Identified: February 2009

2017 Est. Medicare Utilization: 59,730

2007 Work RVU: 1.22

2018 Work RVU: 1.22

2007 NF PE RVU: 7.49

2018 NF PE RVU: 7.49

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 1.22

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

72133 Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections

Global: XXX **Issue:** CT Spine

Screen: CMS Fastest Growing / CMS-Other - Utilization over 30,000

Complete? Yes

Most Recent RUC Meeting: April 2018

Tab 18 Specialty Developing Recommendation: ACR, ASNR

First Identified: February 2009

2017 Est. Medicare Utilization: 4,815

2007 Work RVU: 1.27

2018 Work RVU: 1.27

2007 NF PE RVU: 9.34

2018 NF PE RVU: 9.34

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 1.27

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

72141 Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material

Global: XXX **Issue:** MRI Neck and Lumbar Spine

Screen: CMS High Expenditure Procedural Codes1

Complete? Yes

Most Recent RUC Meeting: April 2013

Tab 25 Specialty Developing Recommendation: ACR

First Identified: September 2011

2017 Est. Medicare Utilization: 591,644

2007 Work RVU: 1.60

2018 Work RVU: 1.48

2007 NF PE RVU: 11.76

2018 NF PE RVU: 11.76

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 1.48

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)	Global: XXX	Issue: MRI Neck and Lumbar Spine	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 25	Specialty Developing Recommendation: ACR	First Identified: April 2013	2017 Est. Medicare Utilization: 4,313	2007 Work RVU: 1.92 2007 NF PE RVU: 14.26 2007 Fac PE RVU NA Result: Decrease
RUC Recommendation: 1.78			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.78 2018 NF PE RVU: 14.26 2018 Fac PE RVU: NA

72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material	Global: XXX	Issue: MRI Neck and Lumbar Spine	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 25	Specialty Developing Recommendation: ACR	First Identified: April 2013	2017 Est. Medicare Utilization: 213,423	2007 Work RVU: 1.60 2007 NF PE RVU: 12.69 2007 Fac PE RVU NA Result: Decrease
RUC Recommendation: 1.48			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.48 2018 NF PE RVU: 12.69 2018 Fac PE RVU: NA

72147	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)	Global: XXX	Issue: MRI Neck and Lumbar Spine	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 25	Specialty Developing Recommendation: ACR	First Identified: April 2013	2017 Est. Medicare Utilization: 3,873	2007 Work RVU: 1.92 2007 NF PE RVU: 13.76 2007 Fac PE RVU NA Result: Decrease
RUC Recommendation: 1.78			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.78 2018 NF PE RVU: 13.76 2018 Fac PE RVU: NA

Status Report: CMS Requests and Relativity Assessment Issues

72148 Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material **Global:** XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 25

Specialty Developing Recommendation:

AAOS, AUR, ACR, NASS, ASNR

First Identified: April 2011

2017 Est. Medicare Utilization: 1,340,040

2007 Work RVU: 1.48

2018 Work RVU: 1.48

2007 NF PE RVU: 12.66

2018 NF PE RVU: 12.66

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 1.48

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

72149 Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s) **Global:** XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 25

Specialty Developing Recommendation:

First Identified: April 2013

2017 Est. Medicare Utilization: 6,957

2007 Work RVU: 1.78

2018 Work RVU: 1.78

2007 NF PE RVU: 14.23

2018 NF PE RVU: 14.23

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 1.78

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

72156 Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical **Global:** XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 25

Specialty Developing Recommendation:

First Identified: April 2013

2017 Est. Medicare Utilization: 121,610

2007 Work RVU: 2.57

2018 Work RVU: 2.29

2007 NF PE RVU: 23.52

2018 NF PE RVU: 23.52

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 2.29

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

72157	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic	Global: XXX	Issue: MRI Neck and Lumbar Spine	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 25 Specialty Developing Recommendation:	First Identified: April 2013	2017 Est. Medicare Utilization: 95,073	2007 Work RVU: 2.57 2007 NF PE RVU: 23.12 2007 Fac PE RVU NA Result: Decrease	2018 Work RVU: 2.29 2018 NF PE RVU: 23.12 2018 Fac PE RVU: NA
RUC Recommendation: 2.29		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar	Global: XXX	Issue: MRI Neck and Lumbar Spine	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 25 Specialty Developing Recommendation:	First Identified: April 2013	2017 Est. Medicare Utilization: 260,109	2007 Work RVU: 2.36 2007 NF PE RVU: 23.45 2007 Fac PE RVU NA Result: Decrease	2018 Work RVU: 2.29 2018 NF PE RVU: 23.45 2018 Fac PE RVU: NA
RUC Recommendation: 2.29		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
72170	Radiologic examination, pelvis; 1 or 2 views	Global: XXX	Issue: X-Ray Exam – Pelvis	Screen: Low Value-High Volume / Codes Reported Together 75% or More-Part2 / CMS-Other - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 19 Specialty Developing Recommendation: AAOS, ACR	First Identified: October 2010	2017 Est. Medicare Utilization: 814,151	2007 Work RVU: 0.17 2007 NF PE RVU: 0.56 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 0.17 2018 NF PE RVU: 0.56 2018 Fac PE RVU: NA
RUC Recommendation: 0.17		Referred to CPT October 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

72190	Radiologic examination, pelvis; complete, minimum of 3 views	Global: XXX	Issue: X-Ray Exam – Pelvis	Screen: CMS-Other - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 19	Specialty Developing Recommendation: AAOS, ACR	First Identified: October 2017	2017 Est. Medicare Utilization: 54,713	2007 Work RVU: 0.21 2007 NF PE RVU: 0.76 2007 Fac PE RVU NA Result: Maintain 2018 Work RVU: 0.21 2018 NF PE RVU: 0.76 2018 Fac PE RVU: NA
RUC Recommendation: 0.21			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

72191	Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Global: XXX	Issue: CT Angiography	Screen: High Volume Growth1 / CMS Fastest Growing / Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013	Complete? Yes
Most Recent RUC Meeting: October 2013	Tab 12	Specialty Developing Recommendation: ACR, SIR	First Identified: February 2008	2017 Est. Medicare Utilization: 2,255	2007 Work RVU: 1.81 2007 NF PE RVU: 12.15 2007 Fac PE RVU NA Result: Maintain 2018 Work RVU: 1.81 2018 NF PE RVU: 12.15 2018 Fac PE RVU: NA
RUC Recommendation: 1.81			Referred to CPT October 2010 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

72192	Computed tomography, pelvis; without contrast material	Global: XXX	Issue: CT Pelvis	Screen: Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - Final Rule for 2012	Complete? Yes
Most Recent RUC Meeting: October 2008	Tab 26	Specialty Developing Recommendation: ACR	First Identified: October 2008	2017 Est. Medicare Utilization: 169,559	2007 Work RVU: 1.09 2007 NF PE RVU: 6.12 2007 Fac PE RVU NA Result: Maintain 2018 Work RVU: 1.09 2018 NF PE RVU: 6.12 2018 Fac PE RVU: NA
RUC Recommendation: 1.09			Referred to CPT October 2009 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

72193	Computed tomography, pelvis; with contrast material(s)	Global: XXX	Issue: CT Pelvis	Screen: Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - Final Rule for 2012	Complete? Yes
Most Recent RUC Meeting: October 2008	Tab 26	Specialty Developing Recommendation: ACR	First Identified: October 2008	2017 Est. Medicare Utilization: 35,725	2007 Work RVU: 1.16 2007 NF PE RVU: 7.2 2007 Fac PE RVU NA 2018 Work RVU: 1.16 2018 NF PE RVU: 7.2 2018 Fac PE RVU: NA
RUC Recommendation: 1.16			Referred to CPT October 2009 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain

72194	Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections	Global: XXX	Issue: CT Abdomen and Pelvis	Screen: Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 44	Specialty Developing Recommendation: ACR	First Identified: February 2008	2017 Est. Medicare Utilization: 5,801	2007 Work RVU: 1.22 2007 NF PE RVU: 9.06 2007 Fac PE RVU NA 2018 Work RVU: 1.22 2018 NF PE RVU: 9.06 2018 Fac PE RVU: NA
RUC Recommendation: 1.22			Referred to CPT October 2009 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain

72195	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)	Global: XXX	Issue: MRI Pelvis	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 21	Specialty Developing Recommendation: ACR	First Identified: July 2015	2017 Est. Medicare Utilization: 79,698	2007 Work RVU: 1.46 2007 NF PE RVU: 12.19 2007 Fac PE RVU NA 2018 Work RVU: 1.46 2018 NF PE RVU: 12.19 2018 Fac PE RVU: NA
RUC Recommendation: 1.46			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

72196	Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)	Global: XXX	Issue: MRI Pelvis	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 21 Specialty Developing Recommendation: ACR	First Identified: July 2015	2017 Est. Medicare Utilization: 3,029	2007 Work RVU: 1.73 2007 NF PE RVU: 14.18 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 1.73 2018 NF PE RVU: 14.18 2018 Fac PE RVU:NA
RUC Recommendation: 1.73		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

72197	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences	Global: XXX	Issue: MRI Pelvis	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 21 Specialty Developing Recommendation: ACR	First Identified: July 2015	2017 Est. Medicare Utilization: 161,478	2007 Work RVU: 2.26 2007 NF PE RVU: 23.71 2007 Fac PE RVU NA Result: Decrease	2018 Work RVU: 2.20 2018 NF PE RVU: 23.71 2018 Fac PE RVU:NA
RUC Recommendation: 2.20		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

72200	Radiologic examination, sacroiliac joints; less than 3 views	Global: XXX	Issue: X-Ray Sacrum	Screen: CMS-Other - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 21 Specialty Developing Recommendation: AAOS, ACR	First Identified: October 2016	2017 Est. Medicare Utilization: 15,140	2007 Work RVU: 0.17 2007 NF PE RVU: 0.58 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 0.17 2018 NF PE RVU: 0.58 2018 Fac PE RVU:NA
RUC Recommendation: 0.17		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

72202	Radiologic examination, sacroiliac joints; 3 or more views	Global: XXX	Issue: X-Ray Sacrum	Screen: CMS-Other - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 21 Specialty Developing Recommendation: AAOS, ACR	First Identified: October 2016	2017 Est. Medicare Utilization: 35,048	2007 Work RVU: 0.19 2007 NF PE RVU: 0.69 2007 Fac PE RVU NA Result: Decrease	2018 Work RVU: 0.19 2018 NF PE RVU: 0.69 2018 Fac PE RVU:NA
RUC Recommendation: 0.18		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

72220	Radiologic examination, sacrum and coccyx, minimum of 2 views	Global: XXX	Issue: X-Ray Sacrum	Screen: CMS-Other - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 21	Specialty Developing Recommendation: AAOS, ACR	First Identified: April 2016	2017 Est. Medicare Utilization: 119,535	2007 Work RVU: 0.17 2018 Work RVU: 0.17 2007 NF PE RVU: 0.61 2018 NF PE RVU: 0.61 2007 Fac PE RVU: NA 2018 Fac PE RVU: NA Result: Maintain
RUC Recommendation: 0.17			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

72240	Myelography, cervical, radiological supervision and interpretation	Global: XXX	Issue: Myelography	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 17	Specialty Developing Recommendation: ACR, ASNR	First Identified: October 2012	2017 Est. Medicare Utilization: 838	2007 Work RVU: 0.91 2018 Work RVU: 0.91 2007 NF PE RVU: 4.37 2018 NF PE RVU: 4.37 2007 Fac PE RVU: NA 2018 Fac PE RVU: NA Result: Maintain
RUC Recommendation: 0.91			Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

72255	Myelography, thoracic, radiological supervision and interpretation	Global: XXX	Issue: Myelography	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 17	Specialty Developing Recommendation: ACR, ASNR	First Identified: October 2013	2017 Est. Medicare Utilization: 138	2007 Work RVU: 0.91 2018 Work RVU: 0.91 2007 NF PE RVU: 3.98 2018 NF PE RVU: 3.98 2007 Fac PE RVU: NA 2018 Fac PE RVU: NA Result: Maintain
RUC Recommendation: 0.91			Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

72265	Myelography, lumbosacral, radiological supervision and interpretation			Global: XXX	Issue: Myelography	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 17	Specialty Developing Recommendation:	ACR, ASNR	First Identified: October 2012	2017 Est. Medicare Utilization: 4,022	2007 Work RVU: 0.83 2007 NF PE RVU: 3.83 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 0.83 2018 NF PE RVU: 3.83 2018 Fac PE RVU: NA
RUC Recommendation: 0.83				Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
72270	Myelography, 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical), radiological supervision and interpretation			Global: XXX	Issue: Myelography	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 17	Specialty Developing Recommendation:	ACR, ASNR	First Identified: October 2012	2017 Est. Medicare Utilization: 1,120	2007 Work RVU: 1.33 2007 NF PE RVU: 5.81 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 1.33 2018 NF PE RVU: 5.81 2018 Fac PE RVU: NA
RUC Recommendation: 1.33				Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
72275	Epidurography, radiological supervision and interpretation			Global: XXX	Issue: Epidurography	Screen: Different Performing Specialty from Survey	Complete? Yes
Most Recent RUC Meeting: February 2010	Tab 31	Specialty Developing Recommendation:	ASA, AAPM, AAMPR, NASS	First Identified: October 2009	2017 Est. Medicare Utilization: 74,185	2007 Work RVU: 0.76 2007 NF PE RVU: 2.15 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 0.76 2018 NF PE RVU: 2.15 2018 Fac PE RVU: NA
RUC Recommendation: 0.76, CPT Assistant article published.				Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/> Published in CPT Asst: Oct 2009 and Q&A - May 2010			

Status Report: CMS Requests and Relativity Assessment Issues

72291 Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance **Global:** XXX **Issue:** Percutaneous Vertebroplasty with Radiological S&I **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 06

Specialty Developing Recommendation:

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU: 0

2018 Fac PE RVU: 0

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

72292 Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under CT guidance **Global:** XXX **Issue:** Percutaneous Vertebroplasty with Radiological S&I **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 06

Specialty Developing Recommendation:

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU: 0

2018 Fac PE RVU: 0

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

73000 Radiologic examination; clavicle, complete

Global: XXX

Issue: X-Ray – Clavicle/Shoulder

Screen: CMS-Other - Utilization over 30,000

Complete? Yes

Most Recent RUC Meeting: October 2018

Tab 17

Specialty Developing Recommendation: ACR, AAOS

First Identified: October 2017

2017 Est. Medicare Utilization: 98,412

2007 Work RVU: 0.16

2018 Work RVU: 0.16

2007 NF PE RVU: 0.56

2018 NF PE RVU: 0.56

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Maintain

RUC Recommendation: 0.16

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73010 Radiologic examination; scapula, complete **Global:** XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018	Tab 17	Specialty Developing Recommendation:	ACR, AAOS	First Identified: October 2017	2017 Est. Medicare Utilization: 54,351	2007 Work RVU: 0.17 2007 NF PE RVU: 0.58 2007 Fac PE RVU: NA Result: Maintain	2018 Work RVU: 0.17 2018 NF PE RVU: 0.58 2018 Fac PE RVU: NA
RUC Recommendation: 0.17				Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

73020 Radiologic examination, shoulder; 1 view **Global:** XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018	Tab 17	Specialty Developing Recommendation:	ACR, AAOS	First Identified: October 2017	2017 Est. Medicare Utilization: 126,564	2007 Work RVU: 0.15 2007 NF PE RVU: 0.5 2007 Fac PE RVU: NA Result: Maintain	2018 Work RVU: 0.15 2018 NF PE RVU: 0.5 2018 Fac PE RVU: NA
RUC Recommendation: 0.15				Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

73030 Radiologic examination, shoulder; complete, minimum of 2 views **Global:** XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** Low Value-High Volume / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018	Tab 17	Specialty Developing Recommendation:	ACR, AAOS	First Identified: October 2010	2017 Est. Medicare Utilization: 2,651,000	2007 Work RVU: 0.18 2007 NF PE RVU: 0.61 2007 Fac PE RVU: NA Result: Maintain	2018 Work RVU: 0.18 2018 NF PE RVU: 0.61 2018 Fac PE RVU: NA
RUC Recommendation: 0.18				Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

73050 Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction **Global:** XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018

Tab 17 **Specialty Developing Recommendation:** ACR, AAOS

First Identified: January 2018

2017 Est. Medicare Utilization: 9,976

2007 Work RVU: 0.20

2018 Work RVU: 0.20

2007 NF PE RVU: 0.73

2018 NF PE RVU: 0.73

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 0.18

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

73060 Radiologic examination; humerus, minimum of 2 views

Global: XXX

Issue: X-Ray Exams

Screen: CMS-Other - Utilization over 250,000

Complete? Yes

Most Recent RUC Meeting: September 2014

Tab 17 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: April 2013

2017 Est. Medicare Utilization: 347,483

2007 Work RVU: 0.17

2018 Work RVU: 0.16

2007 NF PE RVU: 0.61

2018 NF PE RVU: 0.61

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 0.16

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

73070 Radiologic examination, elbow; 2 views

Global: XXX

Issue: X-Ray Elbow/Forearm

Screen: CMS-Other - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: April 2017

Tab 22 **Specialty Developing Recommendation:** AAOS, ACR, ASSH

First Identified: April 2016

2017 Est. Medicare Utilization: 228,465

2007 Work RVU: 0.15

2018 Work RVU: 0.15

2007 NF PE RVU: 0.56

2018 NF PE RVU: 0.56

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.15

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

73080 Radiologic examination, elbow; complete, minimum of 3 views **Global:** XXX **Issue:** X-Ray Elbow/Forearm **Screen:** Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 22 **Specialty Developing Recommendation:** AAOS, ACR, ASSH **First Identified:** October 2009 **2017 Est. Medicare Utilization:** 386,325 **2007 Work RVU:** 0.17 **2018 Work RVU:** 0.17
2007 NF PE RVU: 0.66 **2018 NF PE RVU:** 0.66
2007 Fac PE RVU: NA **2018 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: 0.17

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

73090 Radiologic examination; forearm, 2 views **Global:** XXX **Issue:** X-Ray Elbow/Forearm **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 22 **Specialty Developing Recommendation:** AAOS, ACR, ASSH **First Identified:** April 2016 **2017 Est. Medicare Utilization:** 235,351 **2007 Work RVU:** 0.16 **2018 Work RVU:** 0.16
2007 NF PE RVU: 0.56 **2018 NF PE RVU:** 0.56
2007 Fac PE RVU: NA **2018 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: 0.16

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

73100 Radiologic examination, wrist; 2 views **Global:** XXX **Issue:** X-Ray Wrist **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 32 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 299,232 **2007 Work RVU:** 0.16 **2018 Work RVU:** 0.16
2007 NF PE RVU: 0.55 **2018 NF PE RVU:** 0.55
2007 Fac PE RVU: NA **2018 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: 0.16

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73110 Radiologic examination, wrist; complete, minimum of 3 views

Global: XXX **Issue:** X-Ray Wrist

Screen: Low Value-High Volume
/ CMS High Expenditure
Procedural Codes2 **Complete?** Yes

Most Recent **Tab** 32 **Specialty Developing** ACR
RUC Meeting: April 2016 **Recommendation:**

First **2017 Est.**
Identified: October 2010 **Medicare**
Utilization: 1,035,064

2007 Work RVU: 0.17 **2018 Work RVU:** 0.17
2007 NF PE RVU: 0.63 **2018 NF PE RVU:** 0.63
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 0.17

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

73120 Radiologic examination, hand; 2 views

Global: XXX **Issue:** X-Ray of Hand/Fingers

Screen: CMS High Expenditure
Procedural Codes2 **Complete?** Yes

Most Recent **Tab** 33 **Specialty Developing** ACR
RUC Meeting: April 2016 **Recommendation:**

First **2017 Est.**
Identified: July 2015 **Medicare**
Utilization: 278,039

2007 Work RVU: 0.16 **2018 Work RVU:** 0.16
2007 NF PE RVU: 0.54 **2018 NF PE RVU:** 0.54
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 0.16

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

73130 Radiologic examination, hand; minimum of 3 views

Global: XXX **Issue:** X-Ray of Hand/Fingers

Screen: Low Value-High Volume
/ CMS High Expenditure
Procedural Codes2 **Complete?** Yes

Most Recent **Tab** 33 **Specialty Developing** ACR
RUC Meeting: April 2016 **Recommendation:**

First **2017 Est.**
Identified: October 2010 **Medicare**
Utilization: 1,188,165

2007 Work RVU: 0.17 **2018 Work RVU:** 0.17
2007 NF PE RVU: 0.6 **2018 NF PE RVU:** 0.6
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 0.17

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73140 Radiologic examination, finger(s), minimum of 2 views

Global: XXX

Issue: X-Ray of Hand/Fingers

Screen: CMS High Expenditure
Procedural Codes2

Complete? Yes

**Most Recent
RUC Meeting:** April 2016

**Tab 33 Specialty Developing
Recommendation:** ACR

**First
Identified:** July 2015

**2017 Est.
Medicare
Utilization:** 377,393

2007 Work RVU: 0.13

2018 Work RVU: 0.13

2007 NF PE RVU: 0.51

2018 NF PE RVU: 0.51

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.13

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

73200 Computed tomography, upper extremity; without contrast material

Global: XXX

Issue: CT Upper Extremity

Screen: CMS Fastest Growing

Complete? Yes

**Most Recent
RUC Meeting:** October 2009

**Tab 23 Specialty Developing
Recommendation:** ACR

**First
Identified:** October 2008

**2017 Est.
Medicare
Utilization:** 106,130

2007 Work RVU: 1.09

2018 Work RVU: 1.00

2007 NF PE RVU: 5.5

2018 NF PE RVU: 5.5

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 1.09

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

73201 Computed tomography, upper extremity; with contrast material(s)

Global: XXX

Issue: CT Upper Extremity

Screen: CMS Fastest Growing

Complete? Yes

**Most Recent
RUC Meeting:** October 2009

**Tab 40 Specialty Developing
Recommendation:** ACR

**First
Identified:** February 2009

**2017 Est.
Medicare
Utilization:** 18,544

2007 Work RVU: 1.16

2018 Work RVU: 1.16

2007 NF PE RVU: 6.58

2018 NF PE RVU: 6.58

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Remove from Screen

RUC Recommendation: Remove from screen

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

73202 Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections

Global: XXX

Issue: CT Upper Extremity

Screen: CMS Fastest Growing

Complete? Yes

**Most Recent
RUC Meeting:** October 2009

**Tab 40 Specialty Developing
Recommendation:** ACR

**First
Identified:** February 2009

**2017 Est.
Medicare
Utilization:** 1,891

2007 Work RVU: 1.22

2018 Work RVU: 1.22

2007 NF PE RVU: 8.38

2018 NF PE RVU: 8.38

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Remove from Screen

RUC Recommendation: Remove from screen

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

73206	Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Global: XXX	Issue: CT Angiography	Screen: CMS Request - Final Rule for 2013	Complete? Yes
Most Recent RUC Meeting: October 2013	Tab 12 Specialty Developing Recommendation: ACR, SIR	First Identified: May 2013	2017 Est. Medicare Utilization: 4,976	2007 Work RVU: 1.81 2007 NF PE RVU: 11.22 2007 Fac PE RVU: NA Result: Remove from Screen	2018 Work RVU: 1.81 2018 NF PE RVU: 11.22 2018 Fac PE RVU: NA
RUC Recommendation: Survey with all CTA codes for October 2013.		Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

73218	Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)	Global: XXX	Issue: MRI	Screen: CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: October 2013	Tab 18 Specialty Developing Recommendation: ACR	First Identified: October 2008	2017 Est. Medicare Utilization: 31,980	2007 Work RVU: 1.35 2007 NF PE RVU: 12.24 2007 Fac PE RVU: NA Result: Maintain	2018 Work RVU: 1.35 2018 NF PE RVU: 12.24 2018 Fac PE RVU: NA
RUC Recommendation: CPT Assistant published.		Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>		Published in CPT Asst: Feb 2011	

73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)	Global: XXX	Issue: MRI	Screen: CMS Fastest Growing / CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: January 2012	Tab 20 Specialty Developing Recommendation: ACR	First Identified: October 2008	2017 Est. Medicare Utilization: 461,167	2007 Work RVU: 1.35 2007 NF PE RVU: 11.98 2007 Fac PE RVU: NA Result: Maintain	2018 Work RVU: 1.35 2018 NF PE RVU: 11.98 2018 Fac PE RVU: NA
RUC Recommendation: 1.35		Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

73500 Radiologic examination, hip, unilateral; 1 view **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** CMS-Other - Utilization over 500,000 / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab 14** **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2011 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 0.17 **2018 Work RVU:** **2007 NF PE RVU:** 0.52 **2018 NF PE RVU:** 0.52 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **RUC Recommendation:** Deleted from CPT **Referred to CPT** October 2014 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

73501 Radiologic examination, hip, unilateral, with pelvis when performed; 1 view **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab 14** **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2017 Est. Medicare Utilization:** 342,296 **2007 Work RVU:** **2018 Work RVU:** 0.18 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** 0.17 **Referred to CPT** October 2014 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

73502 Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab 14** **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2017 Est. Medicare Utilization:** 2,644,766 **2007 Work RVU:** **2018 Work RVU:** 0.22 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** 0.22 **Referred to CPT** October 2014 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

Status Report: CMS Requests and Relativity Assessment Issues

73503 Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015

Tab 14 Specialty Developing Recommendation: AAOS, ACR

First Identified: October 2014

2017 Est. Medicare Utilization: 47,976

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 0.27
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.27

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

73510 Radiologic examination, hip, unilateral; complete, minimum of 2 views

Global: XXX

Issue: Radiologic Exam-Hip and Pelvis

Screen: Havard Valued - Utilization over 1 Million / Low Value-High Volume

Complete? Yes

Most Recent RUC Meeting: April 2015

Tab 14 Specialty Developing Recommendation: AAOS, ACR

First Identified: October 2008

2017 Est. Medicare Utilization:

2007 Work RVU: 0.21
2007 NF PE RVU: 0.67
2007 Fac PE RVU NA
Result: Deleted from CPT

2018 Work RVU:
2018 NF PE RVU: 0.67
2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

73520 Radiologic examination, hips, bilateral, minimum of 2 views of each hip, including anteroposterior view of pelvis

Global: XXX

Issue: Radiologic Exam-Hip and Pelvis

Screen: CMS-Other - Utilization over 250,000

Complete? Yes

Most Recent RUC Meeting: April 2015

Tab 14 Specialty Developing Recommendation: AAOS, ACR

First Identified: April 2013

2017 Est. Medicare Utilization:

2007 Work RVU: 0.26
2007 NF PE RVU: 0.76
2007 Fac PE RVU NA
Result: Deleted from CPT

2018 Work RVU:
2018 NF PE RVU: 0.76
2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73521 Radiologic examination, hips, bilateral, with pelvis when performed; 2 views **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015

Tab 14

Specialty Developing Recommendation: AAOS, ACR

First Identified: October 2014

2017 Est. Medicare Utilization: 183,065

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 0.22
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.22

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

73522 Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015

Tab 14

Specialty Developing Recommendation: AAOS, ACR

First Identified: October 2014

2017 Est. Medicare Utilization: 178,160

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 0.29
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.29

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

73523 Radiologic examination, hips, bilateral, with pelvis when performed; minimum of 5 views **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015

Tab 14

Specialty Developing Recommendation: AAOS, ACR

First Identified: October 2014

2017 Est. Medicare Utilization: 92,027

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 0.31
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.31

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73540	Radiologic examination, pelvis and hips, infant or child, minimum of 2 views	Global: XXX	Issue: Radiologic Exam-Hip and Pelvis	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2015	Tab 14	Specialty Developing Recommendation: AAOS, ACR	First Identified: October 2014	2017 Est. Medicare Utilization:	2007 Work RVU: 0.20 2007 NF PE RVU: 0.68 2007 Fac PE RVU NA 2018 Work RVU: 2018 NF PE RVU: 0.68 2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT			Referred to CPT October 2014 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		Result: Deleted from CPT
<hr/>					
73542	Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation	Global: XXX	Issue: Sacroiliac Joint Arthrography	Screen: Different Performing Specialty from Survey	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 45	Specialty Developing Recommendation: ASA, AAPM, AAMPR, NASS, ACR, AUR, ISIS, ASNR	First Identified: October 2009	2017 Est. Medicare Utilization:	2007 Work RVU: 0.59 2007 NF PE RVU: 1.98 2007 Fac PE RVU NA 2018 Work RVU: 2018 NF PE RVU: 1.98 2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT			Referred to CPT February 2011 Referred to CPT Asst <input checked="" type="checkbox"/> Published in CPT Asst: Deleted from CPT		Result: Deleted from CPT
<hr/>					
73550	Radiologic examination, femur, 2 views	Global: XXX	Issue: Radiologic Exam-Hip and Pelvis	Screen: CMS-Other - Utilization over 500,000	Complete? Yes
Most Recent RUC Meeting: April 2015	Tab 14	Specialty Developing Recommendation: AAOS, ACR	First Identified: April 2011	2017 Est. Medicare Utilization:	2007 Work RVU: 0.17 2007 NF PE RVU: 0.61 2007 Fac PE RVU NA 2018 Work RVU: 2018 NF PE RVU: 0.61 2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT			Referred to CPT October 2014 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

73551 Radiologic examination, femur; 1 view **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2017 Est. Medicare Utilization:** 39,346 **2007 Work RVU:** **2018 Work RVU:** 0.16 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Decrease **2018 Fac PE RVU:**

RUC Recommendation: 0.16 **Referred to CPT** October 2014 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

73552 Radiologic examination, femur; minimum 2 views **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2017 Est. Medicare Utilization:** 536,700 **2007 Work RVU:** **2018 Work RVU:** 0.18 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Decrease **2018 Fac PE RVU:**

RUC Recommendation: 0.18 **Referred to CPT** October 2014 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

73560 Radiologic examination, knee; 1 or 2 views **Global:** XXX **Issue:** X-Ray Exams **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 17 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2010 **2017 Est. Medicare Utilization:** 1,924,698 **2007 Work RVU:** 0.17 **2018 Work RVU:** 0.16 **2007 NF PE RVU:** 0.58 **2018 NF PE RVU:** 0.58 **2007 Fac PE RVU NA** **2018 Fac PE RVU:NA** **Result:** Decrease

RUC Recommendation: 0.16 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

73562 Radiologic examination, knee; 3 views **Global:** XXX **Issue:** X-Ray Exams **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 17 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2010 **2017 Est. Medicare Utilization:** 2,441,672 **2007 Work RVU:** 0.18 **2018 Work RVU:** 0.18 **2007 NF PE RVU:** 0.65 **2018 NF PE RVU:** 0.65 **2007 Fac PE RVU NA** **2018 Fac PE RVU:NA** **Result:** Maintain

RUC Recommendation: 0.18 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73564 Radiologic examination, knee; complete, 4 or more views

Global: XXX

Issue: X-Ray Exams

Screen: Low Value-High Volume

Complete? Yes

Most Recent RUC Meeting: September 2014

Tab 17

Specialty Developing Recommendation: AAOS, ACR

First Identified: October 2010

2017 Est. Medicare Utilization: 1,507,410

2007 Work RVU: 0.22

2018 Work RVU: 0.22

2007 NF PE RVU: 0.73

2018 NF PE RVU: 0.73

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.22

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

73565 Radiologic examination, knee; both knees, standing, anteroposterior

Global: XXX

Issue: X-Ray Exams

Screen: CMS-Other - Utilization over 250,000

Complete? Yes

Most Recent RUC Meeting: September 2014

Tab 17

Specialty Developing Recommendation: AAOS, ACR

First Identified: April 2013

2017 Est. Medicare Utilization: 265,671

2007 Work RVU: 0.17

2018 Work RVU: 0.16

2007 NF PE RVU: 0.57

2018 NF PE RVU: 0.57

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 0.16

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

73580 Radiologic examination, knee, arthrography, radiological supervision and interpretation

Global: XXX

Issue: Contrast X-Ray of Knee Joint

Screen: High Volume Growth1 / CMS Fastest Growing / CPT Assistant Analysis / High Volume Growth3

Complete? Yes

Most Recent RUC Meeting: October 2017

Tab 19

Specialty Developing Recommendation: AAOS

First Identified: February 2008

2017 Est. Medicare Utilization: 45,883

2007 Work RVU: 0.54

2018 Work RVU: 0.54

2007 NF PE RVU: 2.67

2018 NF PE RVU: 2.67

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: Review October 2020 via action plan. Show data for the total joint replacement codes in correlation with this service.

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Jun 2012

Status Report: CMS Requests and Relativity Assessment Issues

73590	Radiologic examination; tibia and fibula, 2 views	Global: XXX	Issue: X-Ray Exams	Screen: CMS-Other - Utilization over 250,000	Complete? Yes
Most Recent RUC Meeting: September 2014	Tab 17	Specialty Developing Recommendation: AAOS, ACR	First Identified: April 2013	2017 Est. Medicare Utilization: 503,720	2007 Work RVU: 0.17 2007 NF PE RVU: 0.57 2007 Fac PE RVU: NA Result: Decrease
RUC Recommendation: 0.16			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.16 2018 NF PE RVU: 0.57 2018 Fac PE RVU: NA

73600	Radiologic examination, ankle; 2 views	Global: XXX	Issue: X-Ray Exams	Screen: CMS-Other - Utilization over 250,000	Complete? Yes
Most Recent RUC Meeting: September 2014	Tab 17	Specialty Developing Recommendation: AAOS, ACR, APMA	First Identified: April 2013	2017 Est. Medicare Utilization: 250,658	2007 Work RVU: 0.16 2007 NF PE RVU: 0.54 2007 Fac PE RVU: NA Result: Maintain
RUC Recommendation: 0.16			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.16 2018 NF PE RVU: 0.54 2018 Fac PE RVU: NA

73610	Radiologic examination, ankle; complete, minimum of 3 views	Global: XXX	Issue: Radiologic Examination	Screen: Havard Valued - Utilization over 1 Million / Low Value-High Volume	Complete? Yes
Most Recent RUC Meeting: October 2009	Tab 24	Specialty Developing Recommendation: ACR, AAOS, APMA, AOFAS	First Identified: October 2008	2017 Est. Medicare Utilization: 1,273,756	2007 Work RVU: 0.17 2007 NF PE RVU: 0.61 2007 Fac PE RVU: NA Result: Maintain
RUC Recommendation: 0.17			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.17 2018 NF PE RVU: 0.61 2018 Fac PE RVU: NA

73620	Radiologic examination, foot; 2 views	Global: XXX	Issue: X-Ray Exam of Foot	Screen: Low Value-High Volume	Complete? Yes
Most Recent RUC Meeting: April 2011	Tab 27	Specialty Developing Recommendation: ACR, AAOS, APMA	First Identified: October 2010	2017 Est. Medicare Utilization: 646,665	2007 Work RVU: 0.16 2007 NF PE RVU: 0.54 2007 Fac PE RVU: NA Result: Maintain
RUC Recommendation: 0.16			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.16 2018 NF PE RVU: 0.54 2018 Fac PE RVU: NA

Status Report: CMS Requests and Relativity Assessment Issues

73630 Radiologic examination, foot; complete, minimum of 3 views

Global: XXX

Issue: Radiologic Examination

Screen: Havard Valued - Utilization over 1 Million / Low Value-High Volume

Complete? Yes

Most Recent RUC Meeting: October 2009

Tab 24

Specialty Developing Recommendation:

ACR, AAOS, APMA, AOFAS

First Identified: October 2008

2017 Est. Medicare Utilization: 2,731,913

2007 Work RVU: 0.17

2018 Work RVU: 0.17

2007 NF PE RVU: 0.6

2018 NF PE RVU: 0.6

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.17

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

73650 Radiologic examination; calcaneus, minimum of 2 views

Global: XXX

Issue: X-Ray Heel

Screen: CMS-Other - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: April 2017

Tab 23

Specialty Developing Recommendation:

AAOS, ACR, APMA, AOFAS

First Identified: April 2016

2017 Est. Medicare Utilization: 90,184

2007 Work RVU: 0.16

2018 Work RVU: 0.16

2007 NF PE RVU: 0.53

2018 NF PE RVU: 0.53

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.16

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

73660 Radiologic examination; toe(s), minimum of 2 views

Global: XXX

Issue: X-Ray Toe

Screen: CMS-Other - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: April 2017

Tab 24

Specialty Developing Recommendation:

AAOS, ACR, APMA, AOFAS

First Identified: April 2016

2017 Est. Medicare Utilization: 118,786

2007 Work RVU: 0.13

2018 Work RVU: 0.13

2007 NF PE RVU: 0.5

2018 NF PE RVU: 0.5

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.13

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

73700 Computed tomography, lower extremity; without contrast material

Global: XXX

Issue: CT Lower Extremity

Screen: CMS Fastest Growing

Complete? Yes

Most Recent RUC Meeting: April 2018

Tab 21

Specialty Developing Recommendation:

ACR

First Identified: October 2008

2017 Est. Medicare Utilization: 285,352

2007 Work RVU: 1.09

2018 Work RVU: 1.00

2007 NF PE RVU: 5.5

2018 NF PE RVU: 5.5

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 1.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

73701	Computed tomography, lower extremity; with contrast material(s)	Global: XXX	Issue: CT Lower Extremity	Screen: High Volume Growth1 / CMS-Other - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 21 Specialty Developing Recommendation: ACR	First Identified: February 2009	2017 Est. Medicare Utilization: 40,157	2007 Work RVU: 1.16 2007 NF PE RVU: 6.6 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 1.16 2018 NF PE RVU: 6.6 2018 Fac PE RVU: NA
RUC Recommendation: 1.16		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
73702	Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections	Global: XXX	Issue: CT Lower Extremity	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 21 Specialty Developing Recommendation: ACR	First Identified: February 2009	2017 Est. Medicare Utilization: 5,112	2007 Work RVU: 1.22 2007 NF PE RVU: 8.4 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 1.22 2018 NF PE RVU: 8.4 2018 Fac PE RVU: NA
RUC Recommendation: 1.22		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
73706	Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing	Global: XXX	Issue: CT Angiography	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: October 2013	Tab 12 Specialty Developing Recommendation: ACR, SIR	First Identified: February 2008	2017 Est. Medicare Utilization: 14,286	2007 Work RVU: 1.90 2007 NF PE RVU: 11.61 2007 Fac PE RVU NA Result: Remove from Screen	2018 Work RVU: 1.90 2018 NF PE RVU: 11.61 2018 Fac PE RVU: NA
RUC Recommendation: Survey for October 2013. Remove from screen		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

73718	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)	Global: XXX	Issue: MRI Lower Extremity	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 20 Specialty Developing Recommendation: ACR	First Identified: July 2015	2017 Est. Medicare Utilization: 140,230	2007 Work RVU: 1.35 2007 NF PE RVU: 12.14 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 1.35 2018 NF PE RVU: 12.14 2018 Fac PE RVU: NA
RUC Recommendation: 1.35		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

73719	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s)	Global: XXX	Issue: MRI Lower Extremity	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 20 Specialty Developing Recommendation: ACR	First Identified: July 2015	2017 Est. Medicare Utilization: 1,693	2007 Work RVU: 1.62 2007 NF PE RVU: 14.12 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 1.62 2018 NF PE RVU: 14.12 2018 Fac PE RVU: NA
RUC Recommendation: 1.62		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

73720	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences	Global: XXX	Issue: MRI Lower Extremity	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 20 Specialty Developing Recommendation: ACR	First Identified: July 2015	2017 Est. Medicare Utilization: 60,457	2007 Work RVU: 2.15 2007 NF PE RVU: 23.7 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 2.15 2018 NF PE RVU: 23.7 2018 Fac PE RVU: NA
RUC Recommendation: 2.15		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

73721 Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material **Global:** XXX **Issue:** MRI of Lower Extremity Joint **Screen:** MPC List **Complete?** Yes

Most Recent **Tab** 20 **Specialty Developing** ACR
RUC Meeting: January 2012 **Recommendation:**

First Identified: October 2010

2017 Est. Medicare Utilization: 672,328

2007 Work RVU: 1.35

2018 Work RVU: 1.35

2007 NF PE RVU: 12.05

2018 NF PE RVU: 12.05

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 1.35

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

74000 Radiologic examination, abdomen; single anteroposterior view

Global: XXX

Issue: Abdominal X-Ray

Screen: Low Value-High Volume / CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent **Tab** 08 **Specialty Developing** ACR
RUC Meeting: April 2016 **Recommendation:**

First Identified: October 2010

2017 Est. Medicare Utilization: 2,194,964

2007 Work RVU: 0.18

2018 Work RVU:

2007 NF PE RVU: 0.55

2018 NF PE RVU: 0.55

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2016

Referred to CPT Asst ☐

Published in CPT Asst:

74010 Radiologic examination, abdomen; anteroposterior and additional oblique and cone views

Global: XXX

Issue: Abdominal X-Ray

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent **Tab** 08 **Specialty Developing** ACR
RUC Meeting: April 2016 **Recommendation:**

First Identified: July 2015

2017 Est. Medicare Utilization: 35,335

2007 Work RVU: 0.23

2018 Work RVU:

2007 NF PE RVU: 0.68

2018 NF PE RVU: 0.68

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2016

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

74018 Radiologic examination, abdomen; 1 view

Global: XXX Issue: Abdominal X-Ray

Screen: CMS High Expenditure
Procedural Codes2

Complete? Yes

Most Recent Tab 08 Specialty Developing ACR
RUC Meeting: April 2016 Recommendation:

First Identified: February 2016

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU: 0.18

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 0.18

Referred to CPT February 2016

Referred to CPT Asst ☐ Published in CPT Asst:

74019 Radiologic examination, abdomen; 2 views

Global: XXX Issue: Abdominal X-Ray

Screen: CMS High Expenditure
Procedural Codes2

Complete? Yes

Most Recent Tab 08 Specialty Developing ACR
RUC Meeting: April 2016 Recommendation:

First Identified: February 2016

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU: 0.23

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 0.23

Referred to CPT February 2016

Referred to CPT Asst ☐ Published in CPT Asst:

74020 Radiologic examination, abdomen; complete, including decubitus and/or erect views

Global: XXX Issue: Abdominal X-Ray

Screen: CMS High Expenditure
Procedural Codes2

Complete? Yes

Most Recent Tab 08 Specialty Developing ACR
RUC Meeting: April 2016 Recommendation:

First Identified: July 2015

2017 Est.
Medicare
Utilization: 540,116

2007 Work RVU: 0.27

2018 Work RVU:

2007 NF PE RVU: 0.72

2018 NF PE RVU: 0.72

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2016

Referred to CPT Asst ☐ Published in CPT Asst:

74021 Radiologic examination, abdomen; 3 or more views

Global: XXX Issue: Abdominal X-Ray

Screen: CMS High Expenditure
Procedural Codes2

Complete? Yes

Most Recent Tab 08 Specialty Developing ACR
RUC Meeting: April 2016 Recommendation:

First Identified: February 2016

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU: 0.27

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 0.27

Referred to CPT February 2016

Referred to CPT Asst ☐ Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

74022 Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest **Global:** XXX **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent **Tab** 08 **Specialty Developing** ACR
RUC Meeting: April 2016 **Recommendation:**

First Identified: July 2015 **2017 Est. Medicare Utilization:** 418,236

2007 Work RVU: 0.32 **2018 Work RVU:** 0.32
2007 NF PE RVU: 0.85 **2018 NF PE RVU:** 0.85
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 0.32

Referred to CPT February 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

74150 Computed tomography, abdomen; without contrast material

Global: XXX **Issue:** CT Abdomen

Screen: Codes Reported Together 95% or More / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent **Tab** S **Specialty Developing** ACR
RUC Meeting: February 2008 **Recommendation:**

First Identified: February 2008 **2017 Est. Medicare Utilization:** 87,230

2007 Work RVU: 1.19 **2018 Work RVU:** 1.19
2007 NF PE RVU: 5.97 **2018 NF PE RVU:** 5.97
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: Review PE. 0.35

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

74160 Computed tomography, abdomen; with contrast material(s)

Global: XXX **Issue:** CT Abdomen and Pelvis

Screen: Codes Reported Together 95% or More / MPC List / CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent **Tab** 44 **Specialty Developing** ACR
RUC Meeting: April 2014 **Recommendation:**

First Identified: February 2008 **2017 Est. Medicare Utilization:** 118,061

2007 Work RVU: 1.27 **2018 Work RVU:** 1.27
2007 NF PE RVU: 7.53 **2018 NF PE RVU:** 7.53
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 0.42

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74170 Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections **Global:** XXX **Issue:** CT Abdomen **Screen:** Codes Reported Together 95% or More / CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: April 2012

Tab 34 **Specialty Developing Recommendation:** ACR

First Identified: February 2008

2017 Est. Medicare Utilization: 104,828

2007 Work RVU: 1.40

2018 Work RVU: 1.40

2007 NF PE RVU: 9.6

2018 NF PE RVU: 9.6

2007 Fac PE RVU NA

2018 Fac PE RVU: NA

Result: Maintain

RUC Recommendation: 1.40

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

74174 Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing

Global: XXX **Issue:** CT Angiography

Screen: Codes Reported Together 75% or More- Part1 / CMS Request - Final Rule for 2013

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab 12 **Specialty Developing Recommendation:** ACR, SIR

First Identified:

2017 Est. Medicare Utilization: 235,553

2007 Work RVU:

2018 Work RVU: 2.20

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 2.20

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74175 Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing

Global: XXX **Issue:** CT Angiography

Screen: CMS Fastest Growing / Codes Reported Together 75% or More- Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab 12 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2008

2017 Est. Medicare Utilization: 41,616

2007 Work RVU: 1.90

2018 Work RVU: 1.82

2007 NF PE RVU: 12.39

2018 NF PE RVU: 12.39

2007 Fac PE RVU NA

2018 Fac PE RVU: NA

Result: Decrease

RUC Recommendation: 1.82

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74176 Computed tomography, abdomen and pelvis; without contrast material **Global:** XXX **Issue:** CT Abdomen/CT Pelvis **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent
RUC Meeting: February 2010 **Tab** 16 **Specialty Developing** ACR
Recommendation:

First
Identified: October 2009 **2017 Est.**
Medicare
Utilization: 2,300,924

2007 Work RVU: **2018 Work RVU:** 1.74
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU **2018 Fac PE RVU:**
Result: Decrease

RUC Recommendation: 1.74

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

74177 Computed tomography, abdomen and pelvis; with contrast material(s) **Global:** XXX **Issue:** CT Abdomen and Pelvis **Screen:** CMS Fastest Growing / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent
RUC Meeting: April 2014 **Tab** 44 **Specialty Developing** ACR
Recommendation:

First
Identified: October 2009 **2017 Est.**
Medicare
Utilization: 3,075,389

2007 Work RVU: **2018 Work RVU:** 1.82
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU **2018 Fac PE RVU:**
Result: Decrease

RUC Recommendation: 1.82

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **Global:** XXX **Issue:** CT Abdomen/CT Pelvis **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent
RUC Meeting: February 2010 **Tab** 16 **Specialty Developing** ACR
Recommendation:

First
Identified: October 2009 **2017 Est.**
Medicare
Utilization: 541,901

2007 Work RVU: **2018 Work RVU:** 2.01
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU **2018 Fac PE RVU:**
Result: Decrease

RUC Recommendation: 2.01

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74181	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)	Global: XXX	Issue: MRI of Abdomen	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 21	Specialty Developing Recommendation: ACR	First Identified: July 2015	2017 Est. Medicare Utilization: 115,192	2007 Work RVU: 1.46 2007 NF PE RVU: 11.71 2007 Fac PE RVU NA Result: Maintain
RUC Recommendation: 1.46			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.46 2018 NF PE RVU: 11.71 2018 Fac PE RVU: NA

74182	Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s)	Global: XXX	Issue: MRI of Abdomen	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 21	Specialty Developing Recommendation: ACR	First Identified: July 2015	2017 Est. Medicare Utilization: 5,652	2007 Work RVU: 1.73 2007 NF PE RVU: 14.63 2007 Fac PE RVU NA Result: Maintain
RUC Recommendation: 1.73			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.73 2018 NF PE RVU: 14.63 2018 Fac PE RVU: NA

74183	Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences	Global: XXX	Issue: MRI of Abdomen	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 21	Specialty Developing Recommendation: ACR	First Identified: July 2015	2017 Est. Medicare Utilization: 298,744	2007 Work RVU: 2.26 2007 NF PE RVU: 23.72 2007 Fac PE RVU NA Result: Decrease
RUC Recommendation: 2.20			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2.20 2018 NF PE RVU: 23.72 2018 Fac PE RVU: NA

74210	Radiologic examination; pharynx and/or cervical esophagus	Global: XXX	Issue: X-Ray Esophagus	Screen: CMS-Other - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 25	Specialty Developing Recommendation: ACR	First Identified: October 2016	2017 Est. Medicare Utilization: 1,614	2007 Work RVU: 0.36 2007 NF PE RVU: 1.4 2007 Fac PE RVU NA Result: Increase
RUC Recommendation: 0.59			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.36 2018 NF PE RVU: 1.4 2018 Fac PE RVU: NA

Status Report: CMS Requests and Relativity Assessment Issues

74220 Radiologic examination; esophagus

Global: XXX

Issue: X-Ray Esophagus

Screen: CMS-Other - Utilization over 100,000

Complete? Yes

Most Recent
RUC Meeting: April 2017

Tab 25

Specialty Developing
Recommendation: ACR

First
Identified: April 2016

2017 Est.
Medicare
Utilization: 197,284

2007 Work RVU: 0.46

2018 Work RVU: 0.46

2007 NF PE RVU: 1.48

2018 NF PE RVU: 1.48

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Increase

RUC Recommendation: 0.67

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

74230 Swallowing function, with cineradiography/videoradiography

Global: XXX

Issue: X-Ray Esophagus

Screen: CMS-Other - Utilization over 250,000 / CMS-Other - Utilization over 100,000

Complete? Yes

Most Recent
RUC Meeting: April 2017

Tab 25

Specialty Developing
Recommendation: ACR

First
Identified: April 2013

2017 Est.
Medicare
Utilization: 379,722

2007 Work RVU: 0.53

2018 Work RVU: 0.53

2007 NF PE RVU: 1.57

2018 NF PE RVU: 1.57

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.53

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

74240 Radiologic examination, gastrointestinal tract, upper; with or without delayed images, without KUB

Global: XXX

Issue: X-Ray Exam – Upper GI

Screen: CMS-Other - Utilization over 30,000

Complete? No

Most Recent
RUC Meeting: January 2019

Tab

Specialty Developing
Recommendation: ACR

First
Identified: October 2017

2017 Est.
Medicare
Utilization: 57,218

2007 Work RVU: 0.69

2018 Work RVU: 0.69

2007 NF PE RVU: 1.8

2018 NF PE RVU: 1.8

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result:

RUC Recommendation: Refer to CPT

Referred to CPT May 2018

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

74241	Radiologic examination, gastrointestinal tract, upper; with or without delayed images, with KUB	Global: XXX	Issue: X-Ray Exam – Upper GI	Screen: CMS-Other - Utilization over 30,000	Complete? No
Most Recent RUC Meeting: January 2019	Tab	Specialty Developing Recommendation: ACR	First Identified: January 2018	2017 Est. Medicare Utilization: 26,035	2007 Work RVU: 0.69 2007 NF PE RVU: 1.89 2007 Fac PE RVU NA 2018 Work RVU: 0.69 2018 NF PE RVU: 1.89 2018 Fac PE RVU: NA
RUC Recommendation: Refer to CPT			Referred to CPT May 2018 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result:

74245	Radiologic examination, gastrointestinal tract, upper; with small intestine, includes multiple serial images	Global: XXX	Issue: X-Ray Exam – Upper GI	Screen: CMS-Other - Utilization over 30,000	Complete? No
Most Recent RUC Meeting: January 2019	Tab	Specialty Developing Recommendation: ACR	First Identified: January 2018	2017 Est. Medicare Utilization: 15,939	2007 Work RVU: 0.91 2007 NF PE RVU: 2.94 2007 Fac PE RVU NA 2018 Work RVU: 0.91 2018 NF PE RVU: 2.94 2018 Fac PE RVU: NA
RUC Recommendation: Refer to CPT			Referred to CPT May 2018 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result:

74246	Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed images, without KUB	Global: XXX	Issue: X-Ray Exam – Upper GI	Screen: CMS-Other - Utilization over 30,000	Complete? No
Most Recent RUC Meeting: January 2019	Tab	Specialty Developing Recommendation: ACR	First Identified: October 2017	2017 Est. Medicare Utilization: 39,139	2007 Work RVU: 0.69 2007 NF PE RVU: 2.06 2007 Fac PE RVU NA 2018 Work RVU: 0.69 2018 NF PE RVU: 2.06 2018 Fac PE RVU: NA
RUC Recommendation: Refer to CPT			Referred to CPT May 2018 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result:

Status Report: CMS Requests and Relativity Assessment Issues

74247 Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed images, with KUB **Global:** XXX **Issue:** X-Ray Exam – Upper GI **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** No

Most Recent **Tab** **Specialty Developing** ACR
RUC Meeting: January 2019 **Recommendation:**

First Identified: April 2011 **2017 Est. Medicare Utilization:** 23,735

2007 Work RVU: 0.69 **2018 Work RVU:** 0.69
2007 NF PE RVU: 2.18 **2018 NF PE RVU:** 2.18
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: Refer to CPT. 0.69

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

74249 Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with small intestine follow-through **Global:** XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** No

Most Recent **Tab** **Specialty Developing** ACR
RUC Meeting: January 2019 **Recommendation:**

First Identified: January 2018 **2017 Est. Medicare Utilization:** 16,711

2007 Work RVU: 0.91 **2018 Work RVU:** 0.91
2007 NF PE RVU: 3.17 **2018 NF PE RVU:** 3.17
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result:

RUC Recommendation: Refer to CPT

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

74250 Radiologic examination, small intestine, includes multiple serial images; **Global:** XXX **Issue:** Lower Gastrointestinal Tract Imaging **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent **Tab** 11 **Specialty Developing** ACR
RUC Meeting: October 2018 **Recommendation:**

First Identified: October 2017 **2017 Est. Medicare Utilization:** 53,669

2007 Work RVU: 0.47 **2018 Work RVU:** 0.47
2007 NF PE RVU: 1.68 **2018 NF PE RVU:** 1.68
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Increase

RUC Recommendation: 0.81

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74251 Radiologic examination, small intestine, includes multiple serial images; via enteroclysis tube **Global:** XXX **Issue:** Lower Gastrointestinal Tract Imaging **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 11 **Specialty Developing Recommendation:** ACR

First Identified: January 2018

2017 Est. Medicare Utilization: 335

2007 Work RVU: 0.69 **2018 Work RVU:** 0.69
2007 NF PE RVU: 3.52 **2018 NF PE RVU:** 3.52
2007 Fac PE RVU: NA **2018 Fac PE RVU:** NA
Result: Increase

RUC Recommendation: 1.17

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

74260 Duodenography, hypotonic

Global: XXX **Issue:** X-Ray Exam – Small Intestine/Colon

Screen: CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 11 **Specialty Developing Recommendation:** ACR

First Identified: January 2018

2017 Est. Medicare Utilization: 25

2007 Work RVU: 0.50 **2018 Work RVU:** 0.50
2007 NF PE RVU: 3.21 **2018 NF PE RVU:** 3.21
2007 Fac PE RVU: NA **2018 Fac PE RVU:** NA
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

74270 Radiologic examination, colon; contrast (eg, barium) enema, with or without KUB

Global: XXX **Issue:** Lower Gastrointestinal Tract Imaging

Screen: CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 11 **Specialty Developing Recommendation:** ACR

First Identified: October 2017

2017 Est. Medicare Utilization: 34,105

2007 Work RVU: 0.69 **2018 Work RVU:** 0.69
2007 NF PE RVU: 2.29 **2018 NF PE RVU:** 2.29
2007 Fac PE RVU: NA **2018 Fac PE RVU:** NA
Result: Increase

RUC Recommendation: 1.04

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

74280 Radiologic examination, colon; air contrast with specific high density barium, with or without glucagon

Global: XXX **Issue:** Lower Gastrointestinal Tract Imaging

Screen: Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 11 **Specialty Developing Recommendation:** ACR

First Identified: April 2011

2017 Est. Medicare Utilization: 12,232

2007 Work RVU: 0.99 **2018 Work RVU:** 0.99
2007 NF PE RVU: 3.07 **2018 NF PE RVU:** 3.07
2007 Fac PE RVU: NA **2018 Fac PE RVU:** NA
Result: Increase

RUC Recommendation: 1.26

Referred to CPT May 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74300 Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation

Global: XXX

Issue:

Screen: CMS-Other - Utilization over 30,000

Complete? No

Most Recent RUC Meeting: October 2018

Tab 27

Specialty Developing Recommendation:

First Identified: October 2018

2017 Est. Medicare Utilization: 35,564

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU: 0

2018 Fac PE RVU: 0

Result:

RUC Recommendation: Review action plan

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

74305 Cholangiography and/or pancreatography; through existing catheter, radiological supervision and interpretation

Global: XXX

Issue: Percutaneous Biliary Procedures Bundling

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 06

Specialty Developing Recommendation: ACR, SIR

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Referred to CPT Asst ☐

Published in CPT Asst:

74320 Cholangiography, percutaneous, transhepatic, radiological supervision and interpretation

Global: XXX

Issue: Percutaneous Biliary Procedures Bundling

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 06

Specialty Developing Recommendation: ACR, SIR

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 0.54

2018 Work RVU:

2007 NF PE RVU: 3

2018 NF PE RVU: 3

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

74327	Postoperative biliary duct calculus removal, percutaneous via T-tube tract, basket, or snare (eg, Burhenne technique), radiological supervision and interpretation	Global: XXX	Issue: Percutaneous Biliary Procedures Bundling	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 06 Specialty Developing Recommendation: ACR, SIR	First Identified: February 2015	2017 Est. Medicare Utilization:	2007 Work RVU: 0.70 2007 NF PE RVU: 2.19 2007 Fac PE RVU NA Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 2.19 2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT		Referred to CPT February 2015 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	Global: XXX	Issue:	Screen: CMS-Other - Utilization over 30,000	Complete? No
Most Recent RUC Meeting: October 2018	Tab 27 Specialty Developing Recommendation:	First Identified: October 2018	2017 Est. Medicare Utilization: 60,516	2007 Work RVU: 0.00 2007 NF PE RVU: NA 2007 Fac PE RVU NA Result:	2018 Work RVU: 0.00 2018 NF PE RVU: NA 2018 Fac PE RVU: NA
RUC Recommendation: Review action plan		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
74400	Urography (pyelography), intravenous, with or without KUB, with or without tomography	Global: XXX	Issue: Contrast X-Ray Exams	Screen: Harvard Valued - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: September 2011	Tab 31 Specialty Developing Recommendation: ACR	First Identified: April 2011	2017 Est. Medicare Utilization: 8,912	2007 Work RVU: 0.49 2007 NF PE RVU: 2 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 0.49 2018 NF PE RVU: 2 2018 Fac PE RVU: NA
RUC Recommendation: 0.49		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

74420	Urography, retrograde, with or without KUB	Global: XXX	Issue: X-Ray Urinary Tract	Screen: CMS-Other - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 26	Specialty Developing Recommendation: ACR, AUA	First Identified: April 2016	2017 Est. Medicare Utilization: 163,420	2007 Work RVU: 0.00 2007 NF PE RVU: NA 2007 Fac PE RVU: NA Result: Increase
RUC Recommendation: 0.52			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.00 2018 NF PE RVU: NA 2018 Fac PE RVU: NA

74425	Urography, antegrade (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation	Global: XXX	Issue: Urography	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: October 2018	Tab 18	Specialty Developing Recommendation: ACR, AUA, SIR	First Identified: October 2012	2017 Est. Medicare Utilization: 4,295	2007 Work RVU: 0.00 2007 NF PE RVU: NA 2007 Fac PE RVU: NA Result: Increase
RUC Recommendation: Referred to CPT for editorial changes. 0.51			Referred to CPT May 2019 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.00 2018 NF PE RVU: NA 2018 Fac PE RVU: NA

74475	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation	Global: XXX	Issue: Genitourinary Catheter Procedures	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: January 2015	Tab 09	Specialty Developing Recommendation: ACR, SIR	First Identified: October 2012	2017 Est. Medicare Utilization:	2007 Work RVU: 0.54 2007 NF PE RVU: 3.69 2007 Fac PE RVU: NA Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT October 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: 3.69 2018 Fac PE RVU: NA

Status Report: CMS Requests and Relativity Assessment Issues

74480 Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation **Global:** XXX **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015

Tab 09 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 0.54

2018 Work RVU:

2007 NF PE RVU: 3.69

2018 NF PE RVU: 3.69

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

74485 Dilatation of nephrostomy, ureters, or urethra, radiological supervision and interpretation

Global: XXX **Issue:** Dilatation of Urinary Tract

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: January 2018

Tab 12 **Specialty Developing Recommendation:**

First Identified: September 2017

2017 Est. Medicare Utilization: 3,113

2007 Work RVU: 0.54

2018 Work RVU: 0.54

2007 NF PE RVU: 3.03

2018 NF PE RVU: 3.03

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Increase

RUC Recommendation: 0.83

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75574 Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)

Global: XXX **Issue:** CT Angiography

Screen: CMS Request - Final Rule for 2013

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab 12 **Specialty Developing Recommendation:** ACR, SIR, ACC

First Identified: May 2013

2017 Est. Medicare Utilization: 59,227

2007 Work RVU:

2018 Work RVU: 2.40

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Remove from Screen

RUC Recommendation: Survey with all CTA codes for October 2013.

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75625 Aortography, abdominal, by serialography, radiological supervision and interpretation **Global:** XXX **Issue:** Abdominal Aortography **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 19 **Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS **First Identified:** October 2017 **2017 Est. Medicare Utilization:** 98,880 **2007 Work RVU:** 1.14 **2018 Work RVU:** 1.14 **2007 NF PE RVU:** 10.55 **2018 NF PE RVU:** 10.55 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Increase

RUC Recommendation: 1.75 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

75630 Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation **Global:** XXX **Issue:** Abdominal Aortography **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 19 **Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS **First Identified:** January 2018 **2017 Est. Medicare Utilization:** 29,277 **2007 Work RVU:** 1.79 **2018 Work RVU:** 1.79 **2007 NF PE RVU:** 11.24 **2018 NF PE RVU:** 11.24 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Increase

RUC Recommendation: 2.00 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

75635 Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing **Global:** XXX **Issue:** CT Angiography of Abdominal Arteries **Screen:** High Volume Growth1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 34 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2017 Est. Medicare Utilization:** 105,764 **2007 Work RVU:** 2.40 **2018 Work RVU:** 2.40 **2007 NF PE RVU:** 15.56 **2018 NF PE RVU:** 15.56 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Maintain

RUC Recommendation: 2.40 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75650	Angiography, carotid, cervical, bilateral, radiological supervision and interpretation			Global: XXX	Issue: Carotid Angiography	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 45	Specialty Developing Recommendation:	ACC, ACR, ASNR, AUR, SIR, SVS	First Identified: February 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 1.49 2007 NF PE RVU: 10.66 2007 Fac PE RVU NA Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 10.66 2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT				Referred to CPT February 2012 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
75671	Angiography, carotid, cerebral, bilateral, radiological supervision and interpretation			Global: XXX	Issue: Carotid Angiography	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 45	Specialty Developing Recommendation:	AANS/CNS, ACC, ACR, ASNR, AUR, SIR, SVS	First Identified: February 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 1.66 2007 NF PE RVU: 11.08 2007 Fac PE RVU NA Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 11.08 2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT				Referred to CPT February 2012 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
75680	Angiography, carotid, cervical, bilateral, radiological supervision and interpretation			Global: XXX	Issue: Carotid Angiography	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 45	Specialty Developing Recommendation:	AANS/CNS, ACC, ACR, ASNR, AUR, SIR, SVS	First Identified: February 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 1.66 2007 NF PE RVU: 10.96 2007 Fac PE RVU NA Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 10.96 2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT				Referred to CPT February 2012 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			

Status Report: CMS Requests and Relativity Assessment Issues

75710 Angiography, extremity, unilateral, radiological supervision and interpretation **Global:** XXX **Issue:** Angiography of Extremities **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** No

Most Recent RUC Meeting: October 2016 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACC, RPA, SCAI, SIR, SVS **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 149,563

2007 Work RVU: 1.14 **2018 Work RVU:** 1.75
2007 NF PE RVU: 10.72 **2018 NF PE RVU:** 10.72
2007 Fac PE RVU: NA **2018 Fac PE RVU:** NA
Result: Increase

RUC Recommendation: 1.75 and review utilization in October 2020

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75716 Angiography, extremity, bilateral, radiological supervision and interpretation **Global:** XXX **Issue:** Angiography of Extremities **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACC, RPA, SCAI, SIR, SVS **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 78,524

2007 Work RVU: 1.31 **2018 Work RVU:** 1.97
2007 NF PE RVU: 10.96 **2018 NF PE RVU:** 10.96
2007 Fac PE RVU: NA **2018 Fac PE RVU:** NA
Result: Increase

RUC Recommendation: 1.97

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75722 Angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation **Global:** XXX **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2017 Est. Medicare Utilization:**

2007 Work RVU: 1.14 **2018 Work RVU:**
2007 NF PE RVU: 10.7 **2018 NF PE RVU:** 10.7
2007 Fac PE RVU: NA **2018 Fac PE RVU:** NA
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75724 Angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation **Global:** XXX **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 45

Specialty Developing Recommendation:

ACC, ACR, ASNR, AUR, SIR, SVS

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 1.49

2018 Work RVU:

2007 NF PE RVU: 11.15

2018 NF PE RVU: 11.15

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX

Issue: Angiography

Screen: CMS-Other - Utilization over 30,000

Complete? Yes

Most Recent RUC Meeting: October 2018

Tab 20

Specialty Developing Recommendation:

SCAI, SIR, SVS

First Identified: October 2017

2017 Est. Medicare Utilization: 42,057

2007 Work RVU: 1.14

2018 Work RVU: 1.14

2007 NF PE RVU: 10.61

2018 NF PE RVU: 10.61

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Increase

RUC Recommendation: 2.05

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: ZZZ

Issue: Angiography

Screen: CMS-Other - Utilization over 30,000

Complete? Yes

Most Recent RUC Meeting: October 2018

Tab 20

Specialty Developing Recommendation:

SCAI, SIR, SVS

First Identified: October 2017

2017 Est. Medicare Utilization: 74,398

2007 Work RVU: 0.36

2018 Work RVU: 0.36

2007 NF PE RVU: 10.15

2018 NF PE RVU: 10.15

2007 Fac PE RVU 10.15

2018 Fac PE RVU:10.15

Result: Increase

RUC Recommendation: 1.01

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75790	Deleted from CPT			Global: XXX	Issue: Arteriovenous Shunt Imaging	Screen: Codes Reported Together 95% or More	Complete? Yes
Most Recent RUC Meeting:	April 2009	Tab 9	Specialty Developing Recommendation:	SVS, SIR, ACR	First Identified: February 2008	2017 Est. Medicare Utilization:	
RUC Recommendation:	Deleted from CPT				Referred to CPT February 2009	2007 Work RVU: 1.84	2018 Work RVU:
					Referred to CPT Asst <input type="checkbox"/>	2007 NF PE RVU: 2.2	2018 NF PE RVU: 2.2
					Published in CPT Asst:	2007 Fac PE RVU NA	2018 Fac PE RVU: NA
						Result: Deleted from CPT	

75791	Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and interpretation			Global: XXX	Issue: Dialysis Circuit -1	Screen: Codes Reported Together 95% or More	Complete? Yes
Most Recent RUC Meeting:	January 2016	Tab 14	Specialty Developing Recommendation:	ACR, RPA, SIR, SVS	First Identified:	2017 Est. Medicare Utilization:	
RUC Recommendation:	Deleted from CPT				Referred to CPT October 2015	2007 Work RVU:	2018 Work RVU:
					Referred to CPT Asst <input type="checkbox"/>	2007 NF PE RVU:	2018 NF PE RVU:
					Published in CPT Asst:	2007 Fac PE RVU	2018 Fac PE RVU:
						Result: Deleted from CPT	

75885	Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation			Global: XXX	Issue: Interventional Radiology Procedures	Screen: CMS Request - Practice Expense Review	Complete? Yes
Most Recent RUC Meeting:	February 2009	Tab 21	Specialty Developing Recommendation:	ACR, SIR	First Identified: NA	2017 Est. Medicare Utilization: 325	
RUC Recommendation:	New PE inputs				Referred to CPT	2007 Work RVU: 1.44	2018 Work RVU: 1.44
					Referred to CPT Asst <input type="checkbox"/>	2007 NF PE RVU: 10.54	2018 NF PE RVU: 10.54
					Published in CPT Asst:	2007 Fac PE RVU NA	2018 Fac PE RVU: NA
						Result: PE Only	

Status Report: CMS Requests and Relativity Assessment Issues

75887 Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation **Global:** XXX **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent **Tab** 21 **Specialty Developing** ACR, SIR **First** **2017 Est.** **2007 Work RVU:** 1.44 **2018 Work RVU:** 1.44
RUC Meeting: February 2009 **Recommendation:** **Identified:** NA **Medicare** **2007 NF PE RVU:** 10.6 **2018 NF PE RVU:** 10.6
Utilization: 496 **2007 Fac PE RVU** NA **2018 Fac PE RVU:** NA

RUC Recommendation: New PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

75894 Transcatheter therapy, embolization, any method, radiological supervision and interpretation **Global:** XXX **Issue:** Transcatheter Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** No

Most Recent **Tab** 35 **Specialty Developing** ACC, ACR, SIR, SVS **First** **2017 Est.** **2007 Work RVU:** 0.00 **2018 Work RVU:** 0.00
RUC Meeting: October 2016 **Recommendation:** **Identified:** February 2010 **Medicare** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA
Utilization: 8,136 **2007 Fac PE RVU** NA **2018 Fac PE RVU:** NA

RUC Recommendation: Review action plan

Referred to CPT RAW will assess Oct 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

75896 Transcatheter therapy, infusion, other than for thrombolysis, radiological supervision and interpretation **Global:** XXX **Issue:** Intracranial Endovascular Intervention **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent **Tab** 09 **Specialty Developing** AANS/CNS, ACR, ASNR, SCAI, SIR **First** **2017 Est.** **2007 Work RVU:** 0.00 **2018 Work RVU:**
RUC Meeting: April 2015 **Recommendation:** **Identified:** February 2010 **Medicare** **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA
Utilization: **2007 Fac PE RVU** NA **2018 Fac PE RVU:** NA

RUC Recommendation: Code Deleted from CPT

Referred to CPT February 2014 February 2015 May 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

75898 Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis **Global:** XXX **Issue:** Intracranial Endovascular Intervention **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** No

Most Recent RUC Meeting: October 2016

Tab 35

Specialty Developing Recommendation: AANS/CNS, ACR, ASNR, SCAI, SIR

First Identified: February 2010

2017 Est. Medicare Utilization: 9,753

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Contractor Price

RUC Recommendation: Review action plan

Referred to CPT February 2014 February 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

75940 Percutaneous placement of IVC filter, radiological supervision and interpretation

Global: XXX

Issue: Major Vein Revision

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2010

Tab 45

Specialty Developing Recommendation: ACR, SIR, SVS

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

75945 Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; initial vessel

Global: XXX

Issue: Intravascular Ultrasound

Screen: Final Rule for 2015

Complete? Yes

Most Recent RUC Meeting: January 2015

Tab 07

Specialty Developing Recommendation: ACC, SCAI, SIR, SVS

First Identified: July 2014

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75946 Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; each additional non-coronary vessel (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 07 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 0.00 **2018 Work RVU:** **2007 NF PE RVU:** 0 **2018 NF PE RVU:** 0 **2007 Fac PE RVU:** 0 **2018 Fac PE RVU:** 0 **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

75952 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation **Global:** XXX **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 16,392 **2007 Work RVU:** 0.00 **2018 Work RVU:** **2007 NF PE RVU:** 0 **2018 NF PE RVU:** 0 **2007 Fac PE RVU:** 0 **2018 Fac PE RVU:** 0 **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

75953 Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery aneurysm, pseudoaneurysm, or dissection, radiological supervision and interpretation **Global:** XXX **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 10,827 **2007 Work RVU:** 0.00 **2018 Work RVU:** **2007 NF PE RVU:** 0 **2018 NF PE RVU:** 0 **2007 Fac PE RVU:** 0 **2018 Fac PE RVU:** 0 **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75954 Endovascular repair of iliac artery aneurysm, pseudoaneurysm, arteriovenous malformation, or trauma, using ilio-iliac tube endoprosthesis, radiological supervision and interpretation **Global:** XXX **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 10

Specialty Developing Recommendation: SVS, SIR, STS, AATS

First Identified: January 2017

2017 Est. Medicare Utilization: 740

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU: 0

2018 Fac PE RVU: 0

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

75960 Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel

Global: XXX

Issue: RAW

Screen: High Volume Growth1 / Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: October 2012

Tab 27

Specialty Developing Recommendation: ACC, ACR, SIR, SVS

First Identified:

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2013

Referred to CPT Asst ☐

Published in CPT Asst:

75961 Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision and interpretation

Global: XXX

Issue: Transcatheter Procedures

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2010

Tab 45

Specialty Developing Recommendation: ACC, ACR, SIR, SVS

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 4.24

2018 Work RVU:

2007 NF PE RVU: 9.99

2018 NF PE RVU: 9.99

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT June 2011

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

75962 Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation **Global:** XXX **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 15 Specialty Developing Recommendation: ACR, SIR, SVS

First Identified: April 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 0.54

2018 Work RVU:

2007 NF PE RVU: 12.8

2018 NF PE RVU: 12.8

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

75964 Transluminal balloon angioplasty, each additional peripheral artery other than renal or other visceral artery, iliac or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 15 Specialty Developing Recommendation: ACR, SIR, SVS

First Identified:

2017 Est. Medicare Utilization:

2007 Work RVU: 0.36

2018 Work RVU:

2007 NF PE RVU: 6.96

2018 NF PE RVU: 6.96

2007 Fac PE RVU 6.96

2018 Fac PE RVU:6.96

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

75966 Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation **Global:** XXX **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 15 Specialty Developing Recommendation: ACR, SIR, SVS

First Identified: January 2015

2017 Est. Medicare Utilization:

2007 Work RVU: 1.31

2018 Work RVU:

2007 NF PE RVU: 13.18

2018 NF PE RVU: 13.18

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75968 Transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 15

Specialty Developing Recommendation: ACR, SIR, SVS

First Identified: January 2015

2017 Est. Medicare Utilization:

2007 Work RVU: 0.36

2018 Work RVU:

2007 NF PE RVU: 6.99

2018 NF PE RVU: 6.99

2007 Fac PE RVU 6.99

2018 Fac PE RVU:6.99

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

75978 Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation

Global: XXX

Issue: Open and Percutaneous Transluminal Angioplasty

Screen: CMS-Other - Utilization over 250,000 / CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part3 / CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab 15

Specialty Developing Recommendation: ACR, SIR, SVS

First Identified: April 2013

2017 Est. Medicare Utilization:

2007 Work RVU: 0.54

2018 Work RVU:

2007 NF PE RVU: 12.72

2018 NF PE RVU: 12.72

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

75980 Percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation

Global: XXX

Issue: Percutaneous Biliary Procedures Bundling

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 06

Specialty Developing Recommendation: ACR, SIR

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75982 Percutaneous placement of drainage catheter for combined internal and external biliary drainage or of a drainage stent for internal biliary drainage in patients with an inoperable mechanical biliary obstruction, radiological supervision and interpretation **Global:** XXX **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent **Tab** 06 **Specialty Developing** ACR, SIR
RUC Meeting: October 2015 **Recommendation:**

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU 0

2018 Fac PE RVU:0

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

75984 Change of percutaneous tube or drainage catheter with contrast monitoring (eg, genitourinary system, abscess), radiological supervision and interpretation **Global:** XXX **Issue:** Introduction of Catheter or Stent - Renal **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** No

Most Recent **Tab** 35 **Specialty Developing** ACR, SIR
RUC Meeting: October 2016 **Recommendation:**

First Identified: October 2012

2017 Est. Medicare Utilization: 18,790

2007 Work RVU: 0.72

2018 Work RVU: 0.72

2007 NF PE RVU: 2.18

2018 NF PE RVU: 2.18

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result:

RUC Recommendation: Review action plan

Referred to CPT RAW will assess Oct 2018

Referred to CPT Asst ☐ **Published in CPT Asst:**

75992 Deleted from CPT **Global:** XXX **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent **Tab** 57 **Specialty Developing** SIR, ACR, SVS
RUC Meeting: April 2008 **Recommendation:**

First Identified: February 2008

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75993 Deleted from CPT

Global: ZZZ Issue: Transluminal Arthroctomy Screen: High Volume Growth1 Complete? Yes

Most Recent Tab 57 Specialty Developing SIR, ACR,
RUC Meeting: April 2008 Recommendation: SVS

First
Identified: February 2008

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Result: Deleted from CPT

Referred to CPT Asst ☐ Published in CPT Asst:

75994 Revised to Category III

Global: XXX Issue: Transluminal Arthroctomy Screen: High Volume Growth1 Complete? Yes

Most Recent Tab 57 Specialty Developing SIR, ACR,
RUC Meeting: April 2008 Recommendation: SVS

First
Identified: April 2008

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Result: Deleted from CPT

Referred to CPT Asst ☐ Published in CPT Asst:

75995 Revised to Category III

Global: XXX Issue: Transluminal Arthroctomy Screen: High Volume Growth1 Complete? Yes

Most Recent Tab 57 Specialty Developing SIR, ACR,
RUC Meeting: April 2008 Recommendation: SVS

First
Identified: April 2008

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Result: Deleted from CPT

Referred to CPT Asst ☐ Published in CPT Asst:

75996 Revised to Category III

Global: ZZZ Issue: Transluminal Arthroctomy Screen: High Volume Growth1 Complete? Yes

Most Recent Tab 57 Specialty Developing SIR, ACR,
RUC Meeting: April 2008 Recommendation: SVS

First
Identified: April 2008

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Result: Deleted from CPT

Referred to CPT Asst ☐ Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

76000 Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time **Global:** XXX **Issue:** Fluoroscopy **Screen:** Low Value-Billed in Multiple Units / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017

Tab 27 Specialty Developing Recommendation: ACR, APMA

First Identified: October 2010

2017 Est. Medicare Utilization: 120,941

2007 Work RVU: 0.17

2018 Work RVU: 0.17

2007 NF PE RVU: 1.68

2018 NF PE RVU: 1.68

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Increase

RUC Recommendation: 0.30

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

76001 Fluoroscopy, physician or other qualified health care professional time more than 1 hour, assisting a nonradiologic physician or other qualified health care professional (eg, nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)

Global: XXX **Issue:** Fluoroscopy

Screen: CMS-Other - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: April 2017

Tab 27 Specialty Developing Recommendation: ACR

First Identified: October 2016

2017 Est. Medicare Utilization: 5,162

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT September 2017

Referred to CPT Asst ☐

Published in CPT Asst:

76098 Radiological examination, surgical specimen

Global: XXX **Issue:** X-Ray Exam Specimen

Screen: CMS-Other - Utilization over 30,000

Complete? Yes

Most Recent RUC Meeting: October 2018

Tab 21 Specialty Developing Recommendation: ACR

First Identified: October 2017

2017 Est. Medicare Utilization: 61,892

2007 Work RVU: 0.16

2018 Work RVU: 0.16

2007 NF PE RVU: 0.43

2018 NF PE RVU: 0.43

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Increase

RUC Recommendation: 0.31

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

76100	Radiologic examination, single plane body section (eg, tomography), other than with urography	Global: XXX	Issue: Fluroscopy	Screen: CMS Request - Practice Expense Review	Complete? Yes
Most Recent RUC Meeting: April 2009	Tab 27	Specialty Developing Recommendation: ACR, ISIS	First Identified: April 2009	2017 Est. Medicare Utilization: 5,322	2007 Work RVU: 0.58 2007 NF PE RVU: 1.93 2007 Fac PE RVU: NA Result: PE Only
RUC Recommendation: New PE inputs			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.58 2018 NF PE RVU: 1.93 2018 Fac PE RVU: NA
<hr/>					
76101	Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral	Global: XXX	Issue: Fluroscopy	Screen: CMS Request - Practice Expense Review	Complete? Yes
Most Recent RUC Meeting: April 2009	Tab 27	Specialty Developing Recommendation: ACR, ISIS	First Identified: April 2009	2017 Est. Medicare Utilization: 3	2007 Work RVU: 0.58 2007 NF PE RVU: 2.5 2007 Fac PE RVU: NA Result: PE Only
RUC Recommendation: New PE inputs			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.58 2018 NF PE RVU: 2.5 2018 Fac PE RVU: NA
<hr/>					
76102	Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; bilateral	Global: XXX	Issue: Fluroscopy	Screen: CMS Request - Practice Expense Review	Complete? Yes
Most Recent RUC Meeting: April 2009	Tab 27	Specialty Developing Recommendation: ACR, ISIS	First Identified: April 2009	2017 Est. Medicare Utilization: 1,775	2007 Work RVU: 0.58 2007 NF PE RVU: 3.35 2007 Fac PE RVU: NA Result: PE Only
RUC Recommendation: New PE inputs			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.58 2018 NF PE RVU: 3.35 2018 Fac PE RVU: NA
<hr/>					

Status Report: CMS Requests and Relativity Assessment Issues

76376 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation **Global:** XXX **Issue:** 3D Rendering **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018

Tab 23

Specialty Developing Recommendation: ACR, ASNR

First Identified: April 2017

2017 Est. Medicare Utilization: 235,366

2007 Work RVU: 0.20

2018 Work RVU: 0.20

2007 NF PE RVU: 2.95

2018 NF PE RVU: 2.95

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.20

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

76510 Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter **Global:** XXX **Issue:** Ophthalmic Ultrasound **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016

Tab 23

Specialty Developing Recommendation: AAO, ASRS, AOA (optometry)

First Identified: April 2016

2017 Est. Medicare Utilization: 14,528

2007 Work RVU: 1.55

2018 Work RVU: 0.70

2007 NF PE RVU: 2.73

2018 NF PE RVU: 2.73

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 0.70

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

76511 Ophthalmic ultrasound, diagnostic; quantitative A-scan only **Global:** XXX **Issue:** Ophthalmic Ultrasound **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016

Tab 23

Specialty Developing Recommendation: AAO, ASRS, AOA (optometry)

First Identified: April 2016

2017 Est. Medicare Utilization: 3,664

2007 Work RVU: 0.94

2018 Work RVU: 0.64

2007 NF PE RVU: 2.17

2018 NF PE RVU: 2.17

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 0.64

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

76512 Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan) **Global:** XXX **Issue:** Ophthalmic Ultrasound **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 23 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 215,213 **2007 Work RVU:** 0.94 **2018 Work RVU:** 0.56 **2007 NF PE RVU:** 1.97 **2018 NF PE RVU:** 1.97 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Decrease

RUC Recommendation: 0.56 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

76513 Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy **Global:** XXX **Issue:** Ophthalmic Ultrasound **Screen:** High Volume Growth1 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab** 51 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** February 2008 **2017 Est. Medicare Utilization:** 27,385 **2007 Work RVU:** 0.66 **2018 Work RVU:** 0.66 **2007 NF PE RVU:** 1.75 **2018 NF PE RVU:** 1.75 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Maintain

RUC Recommendation: 0.66 and CPT Assistant article published **Referred to CPT** May 2008 **Referred to CPT Asst** ☒ **Published in CPT Asst:** Apr 2013

76514 Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness) **Global:** XXX **Issue:** Echo Exam of Eye Thickness **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 12 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2017 **2017 Est. Medicare Utilization:** 487,181 **2007 Work RVU:** 0.17 **2018 Work RVU:** 0.17 **2007 NF PE RVU:** 0.15 **2018 NF PE RVU:** 0.15 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Maintain

RUC Recommendation: 0.17 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76516 Ophthalmic biometry by ultrasound echography, A-scan;

Global: XXX

Issue: Ophthalmic Biometry

Screen: CMS High Expenditure
Procedural Codes2

Complete? Yes

**Most Recent
RUC Meeting:** April 2016

Tab 36

**Specialty Developing
Recommendation:** AAO, AOA
(optometry)

**First
Identified:** April 2016

**2017 Est.
Medicare
Utilization:** 3,145

2007 Work RVU: 0.54

2018 Work RVU: 0.40

2007 NF PE RVU: 1.39

2018 NF PE RVU: 1.39

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 0.40

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

76519 Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens
power calculation

Global: XXX

Issue: Ophthalmic Biometry

Screen: CMS High Expenditure
Procedural Codes2

Complete? Yes

**Most Recent
RUC Meeting:** April 2016

Tab 36

**Specialty Developing
Recommendation:** AAO, AOA
(optometry)

**First
Identified:** July 2015

**2017 Est.
Medicare
Utilization:** 250,782

2007 Work RVU: 0.54

2018 Work RVU: 0.54

2007 NF PE RVU: 1.49

2018 NF PE RVU: 1.49

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.54

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

76536 Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid),
real time with image documentation

Global: XXX

Issue: Soft Tissue Ultrasound

Screen: CMS Fastest Growing

Complete? Yes

**Most Recent
RUC Meeting:** April 2009

Tab 29

**Specialty Developing
Recommendation:** ACR, ASNR,
TES, AACE

**First
Identified:** October 2008

**2017 Est.
Medicare
Utilization:** 893,912

2007 Work RVU: 0.56

2018 Work RVU: 0.56

2007 NF PE RVU: 1.83

2018 NF PE RVU: 1.83

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.56

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

76604 Ultrasound, chest (includes mediastinum), real time with image documentation

Global: XXX

Issue: Ultrasound Exam - Chest

Screen: CMS-Other - Utilization
over 30,000

Complete? Yes

**Most Recent
RUC Meeting:** April 2018

Tab 24

**Specialty Developing
Recommendation:** ACR

**First
Identified:** October 2017

**2017 Est.
Medicare
Utilization:** 92,205

2007 Work RVU: 0.55

2018 Work RVU: 0.55

2007 NF PE RVU: 1.54

2018 NF PE RVU: 1.54

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Increase

RUC Recommendation: 0.59

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

76641 Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete **Global:** XXX **Issue:** Breast Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent **Tab** 13 **Specialty Developing** ACR
RUC Meeting: January 2014 **Recommendation:**

First **2017 Est.**
Identified: January 2014 **Medicare**
Utilization: 562,679

2007 Work RVU: **2018 Work RVU:** 0.73
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU **2018 Fac PE RVU:**
Result: Increase

RUC Recommendation: 0.73

Referred to CPT October 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

76642 Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited **Global:** XXX **Issue:** Breast Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent **Tab** 13 **Specialty Developing** ACR
RUC Meeting: January 2014 **Recommendation:**

First **2017 Est.**
Identified: January 2014 **Medicare**
Utilization: 752,787

2007 Work RVU: **2018 Work RVU:** 0.68
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU **2018 Fac PE RVU:**
Result: Increase

RUC Recommendation: 0.68

Referred to CPT October 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

76645 Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation **Global:** XXX **Issue:** Breast Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent **Tab** 13 **Specialty Developing** ACR
RUC Meeting: January 2014 **Recommendation:**

First **2017 Est.**
Identified: April 2011 **Medicare**
Utilization:

2007 Work RVU: 0.54 **2018 Work RVU:**
2007 NF PE RVU: 1.41 **2018 NF PE RVU:** 1.41
2007 Fac PE RVU NA **2018 Fac PE RVU:** NA
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

76700 Ultrasound, abdominal, real time with image documentation; complete **Global:** XXX **Issue:** Ultrasound **Screen:** MPC List **Complete?** Yes

Most Recent **Tab** 13 **Specialty Developing** ACR
RUC Meeting: October 2013 **Recommendation:**

First **2017 Est.**
Identified: October 2010 **Medicare**
Utilization: 969,254

2007 Work RVU: 0.81 **2018 Work RVU:** 0.81
2007 NF PE RVU: 2.39 **2018 NF PE RVU:** 2.39
2007 Fac PE RVU NA **2018 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: 0.81

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76705 Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up) **Global:** XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013

Tab 13 **Specialty Developing Recommendation:** ACR, ASBS

First Identified: April 2011

2017 Est. Medicare Utilization: 1,101,702

2007 Work RVU: 0.59

2018 Work RVU: 0.59

2007 NF PE RVU: 1.77

2018 NF PE RVU: 1.77

2007 Fac PE RVU NA

2018 Fac PE RVU: NA

Result: Maintain

RUC Recommendation: 0.59

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

76706 Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)

Global: XXX

Issue: Abdominal Aorta Ultrasound Screening

Screen: Final Rule for 2015

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 12 **Specialty Developing Recommendation:** ACR, SIR, SVS

First Identified: May 2015

2017 Est. Medicare Utilization: 139,200

2007 Work RVU:

2018 Work RVU: 0.55

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 0.55

Referred to CPT May 2015

Referred to CPT Asst ☒

Published in CPT Asst: Jan 2017

76770 Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete

Global: XXX

Issue: Ultrasound

Screen: CMS-Other - Utilization over 500,000

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab 13 **Specialty Developing Recommendation:** ACR

First Identified: April 2011

2017 Est. Medicare Utilization: 1,316,171

2007 Work RVU: 0.74

2018 Work RVU: 0.74

2007 NF PE RVU: 2.36

2018 NF PE RVU: 2.36

2007 Fac PE RVU NA

2018 Fac PE RVU: NA

Result: Maintain

RUC Recommendation: 0.74

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

76775 Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited

Global: XXX

Issue: Ultrasound

Screen: CMS-Other - Utilization over 500,000

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab 13 **Specialty Developing Recommendation:** ACR

First Identified: April 2011

2017 Est. Medicare Utilization: 588,987

2007 Work RVU: 0.58

2018 Work RVU: 0.58

2007 NF PE RVU: 1.81

2018 NF PE RVU: 1.81

2007 Fac PE RVU NA

2018 Fac PE RVU: NA

Result: Maintain

RUC Recommendation: 0.58

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

76819 Fetal biophysical profile; without non-stress testing

Global: XXX Issue: RAW

Screen: High Volume Growth2

Complete? Yes

Most Recent Tab 18 Specialty Developing
RUC Meeting: October 2013 Recommendation:

First
Identified: April 2013

2017 Est.
Medicare
Utilization: 13,055

2007 Work RVU: 0.77

2018 Work RVU: 0.77

2007 NF PE RVU: 1.81

2018 NF PE RVU: 1.81

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Remove from screen

RUC Recommendation: Remove from screen

Referred to CPT

Referred to CPT Asst

☐

Published in CPT Asst:

76830 Ultrasound, transvaginal

Global: XXX

Issue: Transvaginal and
Transrectal Ultrasound

Screen: CMS High Expenditure
Procedural Codes1

Complete? Yes

Most Recent Tab 44 Specialty Developing ACOG, ACR,
RUC Meeting: April 2012 Recommendation: AUA

First
Identified: September 2011

2017 Est.
Medicare
Utilization: 461,569

2007 Work RVU: 0.69

2018 Work RVU: 0.69

2007 NF PE RVU: 1.97

2018 NF PE RVU: 1.97

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.69

Referred to CPT

Referred to CPT Asst

☐

Published in CPT Asst:

76856 Ultrasound, pelvic (nonobstetric), real time with image documentation; complete

Global: XXX

Issue: Ultrasound

Screen: CMS-Other - Utilization
over 500,000

Complete? Yes

Most Recent Tab 13 Specialty Developing ACR
RUC Meeting: October 2013 Recommendation:

First
Identified: April 2011

2017 Est.
Medicare
Utilization: 463,036

2007 Work RVU: 0.69

2018 Work RVU: 0.69

2007 NF PE RVU: 1.99

2018 NF PE RVU: 1.99

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.69

Referred to CPT

Referred to CPT Asst

☐

Published in CPT Asst:

76857 Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)

Global: XXX

Issue: Ultrasound

Screen: CMS-Other - Utilization
over 250,000

Complete? Yes

Most Recent Tab 13 Specialty Developing ACR
RUC Meeting: October 2013 Recommendation:

First
Identified: April 2013

2017 Est.
Medicare
Utilization: 214,591

2007 Work RVU: 0.38

2018 Work RVU: 0.50

2007 NF PE RVU: 1.99

2018 NF PE RVU: 1.99

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 0.50

Referred to CPT

Referred to CPT Asst

☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

76870 Ultrasound, scrotum and contents **Global:** XXX **Issue:** Ultrasound Exam - Scrotum **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017	Tab 28	Specialty Developing Recommendation: ACR, AUA	First Identified: April 2016	2017 Est. Medicare Utilization: 142,065	2007 Work RVU: 0.64 2007 NF PE RVU: 1.97 2007 Fac PE RVU: NA Result: Maintain	2018 Work RVU: 0.64 2018 NF PE RVU: 1.97 2018 Fac PE RVU: NA
RUC Recommendation: 0.64			Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

76872 Ultrasound, transrectal; **Global:** XXX **Issue:** Transvaginal and Transrectal Ultrasound **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012	Tab 44	Specialty Developing Recommendation: ACOG, ACR, AUA	First Identified: September 2011	2017 Est. Medicare Utilization: 202,256	2007 Work RVU: 0.69 2007 NF PE RVU: 2.52 2007 Fac PE RVU: NA Result: Maintain	2018 Work RVU: 0.69 2018 NF PE RVU: 2.52 2018 Fac PE RVU: NA
RUC Recommendation: 0.69			Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

76880 Deleted from CPT **Global:** XXX **Issue:** Lower Extremity Ultrasound **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009	Tab 26	Specialty Developing Recommendation: APMA, ACR	First Identified: October 2008	2017 Est. Medicare Utilization:	2007 Work RVU: 0.59 2007 NF PE RVU: 1.97 2007 Fac PE RVU: NA Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 1.97 2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT			Referred to CPT February 2010 Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

76881 Ultrasound, complete joint (ie, joint space and peri-articular soft tissue structures) real-time with image documentation **Global:** XXX **Issue:** Ultrasound of Extremity **Screen:** CMS Fastest Growing / New Technology/New Services **Complete?** No

Most Recent RUC Meeting: January 2017	Tab 22	Specialty Developing Recommendation: AAOS, ACR, ACRh, APMA	First Identified: April 2010	2017 Est. Medicare Utilization: 218,314	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU:	2018 Work RVU: 0.63 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: Revised PE. RAW review in Oct 2019.			Referred to CPT June 2017 Referred to CPT Asst <input checked="" type="checkbox"/>		Published in CPT Asst: Clinical Examples of Radiology Winter 2011; Apr 2016	

Status Report: CMS Requests and Relativity Assessment Issues

76882 Ultrasound, limited, joint or other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft tissue structure[s], or soft tissue mass[es]), real-time with image documentation **Global:** XXX **Issue:** Ultrasound of Extremity **Screen:** CMS Fastest Growing / New Technology/New Services **Complete?** No

Most Recent RUC Meeting: January 2017

Tab 22

Specialty Developing Recommendation: AAOS, ACR, ACRh, APMA

First Identified: April 2010

2017 Est. Medicare Utilization: 257,213

2007 Work RVU:

2018 Work RVU: 0.49

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: Revised PE. RAW review in Oct 2019.

Referred to CPT June 2017

Referred to CPT Asst ☒

Published in CPT Asst: Clinical Examples of Radiology Summer and Winter 2011; Apr 2016

76930 Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation

Global: XXX

Issue: Pericardiocentesis and Pericardial Drainage

Screen: CMS Request - Final Rule for 2014

Complete? Yes

Most Recent RUC Meeting: April 2014

Tab 34

Specialty Developing Recommendation: ACC

First Identified: July 2013

2017 Est. Medicare Utilization: 2,429

2007 Work RVU: 0.67

2018 Work RVU: 0.00

2007 NF PE RVU: 1.85

2018 NF PE RVU: 1.85

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018

Referred to CPT Asst ☐

Published in CPT Asst:

76932 Ultrasonic guidance for endomyocardial biopsy, imaging supervision and interpretation

Global: YYY

Issue: Ultrasound Guidance

Screen: CMS Request - Final Rule for 2014

Complete? Yes

Most Recent RUC Meeting: April 2014

Tab 34

Specialty Developing Recommendation: ACC

First Identified: July 2013

2017 Est. Medicare Utilization: 1,351

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.67

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

76936 Ultrasound guided compression repair of arterial pseudoaneurysm or arteriovenous fistulae (includes diagnostic ultrasound evaluation, compression of lesion and imaging) **Global:** XXX **Issue:** RAW **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: October 2013

Tab 18 **Specialty Developing Recommendation:**

First Identified: July 2013

2017 Est. Medicare Utilization: 1,036

2007 Work RVU: 1.99

2018 Work RVU: 1.99

2007 NF PE RVU: 6.67

2018 NF PE RVU: 6.67

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: Maintain

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

76937 Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)

Global: ZZZ

Issue: PICC Line Procedures

Screen: Identified in RUC review of other services

Complete? No

Most Recent RUC Meeting: January 2018

Tab 09 **Specialty Developing Recommendation:**

First Identified: January 2018

2017 Est. Medicare Utilization: 665,263

2007 Work RVU: 0.30

2018 Work RVU: 0.30

2007 NF PE RVU: 0.51

2018 NF PE RVU: 0.51

2007 Fac PE RVU 0.51

2018 Fac PE RVU:0.51

Result:

RUC Recommendation: Review in 2 years (Oct 2021)

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

76940 Ultrasound guidance for, and monitoring of, parenchymal tissue ablation

Global: YYY

Issue: Ultrasound Guidance

Screen: CMS Request - Final Rule for 2014

Complete? Yes

Most Recent RUC Meeting: January 2015

Tab 29 **Specialty Developing Recommendation:** ACS, ACR, SIR

First Identified: July 2013

2017 Est. Medicare Utilization: 1,374

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 2.00

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Global: XXX	Issue: Ultrasound Guidance for Needle Placement	Screen: CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 / High Volume Growth3	Complete? No
Most Recent RUC Meeting: April 2014	Tab 35	Specialty Developing Recommendation: AACE, AAOS, AAPMR, ACR, ACRh, APMA, ASA, ASBS, ASIPP, AUA, SIR, TES	First Identified: April 2011	2017 Est. Medicare Utilization: 1,216,007	2007 Work RVU: 0.67 2007 NF PE RVU: 3.43 2007 Fac PE RVU NA 2018 Work RVU: 0.67 2018 NF PE RVU: 3.43 2018 Fac PE RVU: NA
RUC Recommendation: 0.67			Referred to CPT May 2019 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain
76948	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation	Global: XXX	Issue: Echo Guidance for Ova Aspiration	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: January 2015	Tab 25	Specialty Developing Recommendation: ACOG	First Identified: July 2013	2017 Est. Medicare Utilization: 9	2007 Work RVU: 0.38 2007 NF PE RVU: 1.34 2007 Fac PE RVU NA 2018 Work RVU: 0.67 2018 NF PE RVU: 1.34 2018 Fac PE RVU: NA
RUC Recommendation: 0.85			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Increase
76950	Ultrasonic guidance for placement of radiation therapy fields	Global: XXX	Issue: Ultrasound Guidance	Screen: Codes Reported Together 75% or More- Part1 / CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 34	Specialty Developing Recommendation:	First Identified: February 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 0.58 2007 NF PE RVU: 1.43 2007 Fac PE RVU NA 2018 Work RVU: 2018 NF PE RVU: 1.43 2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT			Referred to CPT October 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

76965	Ultrasonic guidance for interstitial radioelement application	Global: XXX	Issue: Ultrasound Guidance	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: September 2014	Tab 21	Specialty Developing Recommendation: NO INTERESET	First Identified: July 2013	2017 Est. Medicare Utilization: 6,193	2007 Work RVU: 1.34 2007 NF PE RVU: 4.8 2007 Fac PE RVU: NA 2018 Work RVU: 1.34 2018 NF PE RVU: 4.8 2018 Fac PE RVU: NA
RUC Recommendation: Maintain			Referred to CPT	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
<hr/>					
76970	Ultrasound study follow-up (specify)	Global: XXX	Issue: IMRT with Ultrasound Guidance	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: February 2009	Tab 38	Specialty Developing Recommendation: ACS, ACR, AACE	First Identified: February 2008	2017 Est. Medicare Utilization: 28,152	2007 Work RVU: 0.40 2007 NF PE RVU: 1.41 2007 Fac PE RVU: NA 2018 Work RVU: 0.40 2018 NF PE RVU: 1.41 2018 Fac PE RVU: NA
RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS			Referred to CPT	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
<hr/>					
77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: PICC Line Procedures	Screen: MPC List / CMS Request - Final Rule for 2013 / Final Rule for 2015	Complete? Yes
Most Recent RUC Meeting: January 2018	Tab 09	Specialty Developing Recommendation: AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS	First Identified: January 2012	2017 Est. Medicare Utilization: 416,353	2007 Work RVU: 0.38 2007 NF PE RVU: 1.73 2007 Fac PE RVU: NA 2018 Work RVU: 0.38 2018 NF PE RVU: 1.73 2018 Fac PE RVU: NA
RUC Recommendation: 0.38			Referred to CPT October 2015	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
<hr/>					
			Result: Maintain		

Status Report: CMS Requests and Relativity Assessment Issues

77002 Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Fluoroscopic Guidance **Screen:** MPC List / CMS Request - Final Rule for 2013 / CMS Request - Final Rule for 2015 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2015

Tab 13

Specialty Developing Recommendation:

AANS,
AANEM,
AAPM,
AAPM&R,
ACR, ASIPP,
ASA, ASNR,
CNS, ISIS,
NASS

First Identified: January 2012

2017 Est. Medicare Utilization: 481,426

2007 Work RVU: 0.54

2018 Work RVU: 0.54

2007 NF PE RVU: 1.4

2018 NF PE RVU: 1.4

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: 0.54

Referred to CPT October 2015

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Fluoroscopic Guidance **Screen:** MPC List / CMS Request - Final Rule for 2013 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015

Tab 13

Specialty Developing Recommendation:

AANS,
AANEM,
AAPM,
AAPM&R,
ACR, ASIPP,
ASA, ASNR,
CNS, ISIS,
NASS

First Identified: October 2010

2017 Est. Medicare Utilization: 68,387

2007 Work RVU: 0.60

2018 Work RVU: 0.60

2007 NF PE RVU: 1.28

2018 NF PE RVU: 1.28

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: 0.60

Referred to CPT October 2015

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77011 Computed tomography guidance for stereotactic localization

Global: XXX

Issue: IMRT with CT Guidance

Screen: CMS Request - Practice Expense Review

Complete? Yes

Most Recent
RUC Meeting: October 2010

Tab 15

Specialty Developing
Recommendation: ASTRO, ACRO

First
Identified:

2017 Est.
Medicare
Utilization: 5,177

2007 Work RVU: 1.21

2018 Work RVU: 1.21

2007 NF PE RVU: 11.38

2018 NF PE RVU: 11.38

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: PE Only

RUC Recommendation: New PE inputs

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

77012 Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation

Global: XXX

Issue: CT Scan for Needle Biopsy

Screen: CMS-Other - Utilization over 100,000 / Codes Reported Together 75%or More-Part4

Complete? No

Most Recent
RUC Meeting: January 2018

Tab 31

Specialty Developing
Recommendation: ACR, SIR

First
Identified: April 2016

2017 Est.
Medicare
Utilization: 208,711

2007 Work RVU: 1.16

2018 Work RVU: 1.16

2007 NF PE RVU: 7.02

2018 NF PE RVU: 7.02

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Increase

RUC Recommendation: Refer to CPT to bundle. 1.50

Referred to CPT February 2019

Referred to CPT Asst ☐

Published in CPT Asst:

77014 Computed tomography guidance for placement of radiation therapy fields

Global: XXX

Issue: IMRT with CT Guidance

Screen: CMS Request - Practice Expense Review / CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 / High Volume Growth3

Complete? No

Most Recent
RUC Meeting: January 2016

Tab 54

Specialty Developing
Recommendation: ASTRO, ACR

First
Identified: October 2010

2017 Est.
Medicare
Utilization: 1,988,024

2007 Work RVU: 0.85

2018 Work RVU: 0.85

2007 NF PE RVU: 3.53

2018 NF PE RVU: 3.53

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result:

RUC Recommendation: Referred to CPT, but CMS has not addressed. RAW review action plan (Oct 2019).

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

77031 Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation **Global:** XXX **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 04

Specialty Developing Recommendation:

First Identified: January 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 1.59

2018 Work RVU:

2007 NF PE RVU: 6.19

2018 NF PE RVU: 6.19

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

77032 Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation **Global:** XXX **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013

Tab 04

Specialty Developing Recommendation:

First Identified: January 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 0.56

2018 Work RVU:

2007 NF PE RVU: 1.26

2018 NF PE RVU: 1.26

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

77051 Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** CMS-Other - Utilization over 250,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 20

Specialty Developing Recommendation: ACR

First Identified:

2017 Est. Medicare Utilization:

2007 Work RVU: 0.06

2018 Work RVU:

2007 NF PE RVU: 0.38

2018 NF PE RVU: 0.38

2007 Fac PE RVU 0.38

2018 Fac PE RVU:0.38

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77052 Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent **Tab** 20 **Specialty Developing** ACR
RUC Meeting: January 2016 **Recommendation:**

First
Identified: October 2010

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.06

2018 Work RVU:

2007 NF PE RVU: 0.38

2018 NF PE RVU: 0.38

2007 Fac PE RVU 0.38

2018 Fac PE RVU:0.38

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

77055 Mammography; unilateral

Global: XXX

Issue: Mammography-Computer Aided Detection Bundling

Screen: CMS-Other - Utilization over 250,000 / Final Rule for 2015

Complete? Yes

Most Recent **Tab** 20 **Specialty Developing** ACR
RUC Meeting: January 2016 **Recommendation:**

First
Identified: January 2014

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.70

2018 Work RVU:

2007 NF PE RVU: 1.34

2018 NF PE RVU: 1.34

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

77056 Mammography; bilateral

Global: XXX

Issue: Mammography-Computer Aided Detection Bundling

Screen: CMS-Other - Utilization over 250,000 / Final Rule for 2015

Complete? Yes

Most Recent **Tab** 20 **Specialty Developing** ACR
RUC Meeting: January 2016 **Recommendation:**

First
Identified: January 2014

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.87

2018 Work RVU:

2007 NF PE RVU: 1.68

2018 NF PE RVU: 1.68

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77057 Screening mammography, bilateral (2-view study of each breast)

Global: XXX

Issue: Mammography-Computer Aided Detection Bundling

Screen: CMS-Other - Utilization over 250,000 / Final Rule for 2015

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab 20

Specialty Developing Recommendation: ACR

First Identified: January 2014

2017 Est. Medicare Utilization:

2007 Work RVU: 0.70

2018 Work RVU:

2007 NF PE RVU: 1.43

2018 NF PE RVU: 1.43

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

77058 Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral

Global: XXX

Issue: Breast MRI with Computer-Aided Detection

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: October 2017

Tab 06

Specialty Developing Recommendation: ACR

First Identified: July 2015

2017 Est. Medicare Utilization: 1,724

2007 Work RVU: 1.63

2018 Work RVU: 1.63

2007 NF PE RVU: 18.76

2018 NF PE RVU: 18.76

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Code Deleted from CPT

Referred to CPT June 2017

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

77059 Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral

Global: XXX

Issue: Breast MRI with Computer-Aided Detection

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: October 2017

Tab 06

Specialty Developing Recommendation: ACR

First Identified: July 2015

2017 Est. Medicare Utilization: 77,951

2007 Work RVU: 1.63

2018 Work RVU: 1.63

2007 NF PE RVU: 23.46

2018 NF PE RVU: 23.46

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Code Deleted from CPT

Referred to CPT June 2017

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

77065 Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral **Global:** XXX **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2015 **2017 Est. Medicare Utilization:** **2007 Work RVU:** **2018 Work RVU:** 0.81 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Increase **2018 Fac PE RVU:**

RUC Recommendation: 0.81 **Referred to CPT** October 2015 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

77066 Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral **Global:** XXX **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2015 **2017 Est. Medicare Utilization:** **2007 Work RVU:** **2018 Work RVU:** 1.00 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Increase **2018 Fac PE RVU:**

RUC Recommendation: 1.00 **Referred to CPT** October 2015 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

77067 Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed **Global:** XXX **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2015 **2017 Est. Medicare Utilization:** **2007 Work RVU:** **2018 Work RVU:** 0.76 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Maintain **2018 Fac PE RVU:**

RUC Recommendation: 0.76 **Referred to CPT** October 2015 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

77073 Bone length studies (orthoroentgenogram, scanogram) **Global:** XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 25 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2017 **2017 Est. Medicare Utilization:** 51,669 **2007 Work RVU:** 0.27 **2018 Work RVU:** 0.27 **2007 NF PE RVU:** 0.81 **2018 NF PE RVU:** 0.81 **2007 Fac PE RVU NA** **2018 Fac PE RVU:NA** **Result:** Decrease

RUC Recommendation: 0.26 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77074 Radiologic examination, osseous survey; limited (eg, for metastases) **Global:** XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 25 **Specialty Developing Recommendation:** ACR

First Identified: January 2018

2017 Est. Medicare Utilization: 7,279

2007 Work RVU: 0.45

2018 Work RVU: 0.45

2007 NF PE RVU: 1.2

2018 NF PE RVU: 1.2

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 0.44

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

77075 Radiologic examination, osseous survey; complete (axial and appendicular skeleton) **Global:** XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 25 **Specialty Developing Recommendation:** ACR

First Identified: October 2017

2017 Est. Medicare Utilization: 50,186

2007 Work RVU: 0.54

2018 Work RVU: 0.54

2007 NF PE RVU: 1.76

2018 NF PE RVU: 1.76

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Increase

RUC Recommendation: 0.55

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

77076 Radiologic examination, osseous survey, infant **Global:** XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 25 **Specialty Developing Recommendation:** ACR

First Identified: January 2018

2017 Est. Medicare Utilization: 60

2007 Work RVU: 0.70

2018 Work RVU: 0.70

2007 NF PE RVU: 1.2

2018 NF PE RVU: 1.2

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.70

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

77077 Joint survey, single view, 2 or more joints (specify) **Global:** XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 25 **Specialty Developing Recommendation:** ACR

First Identified: October 2017

2017 Est. Medicare Utilization: 36,715

2007 Work RVU: 0.31

2018 Work RVU: 0.31

2007 NF PE RVU: 1.07

2018 NF PE RVU: 1.07

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Increase

RUC Recommendation: 0.33

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

77079 Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel) **Global:** XXX **Issue:** CT Bone Density Study **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010

Tab 31 Specialty Developing Recommendation: ACR, AAFP, ACP

First Identified: October 2009

2017 Est. Medicare Utilization:

2007 Work RVU: 0.22

2018 Work RVU:

2007 NF PE RVU: 2.45

2018 NF PE RVU: 2.45

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

77080 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine) **Global:** XXX **Issue:** Dual Energy X-Ray

Screen: CMS Request - Final Rule for 2012 / Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab 07 Specialty Developing Recommendation: AACE, ACNM, ACR, ACRh, SNMMI, TES

First Identified: September 2011

2017 Est. Medicare Utilization: 2,444,180

2007 Work RVU: 0.20

2018 Work RVU: 0.20

2007 NF PE RVU: 2.59

2018 NF PE RVU: 2.59

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

RUC Recommendation: 0.20

Referred to CPT May 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

77081 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel) **Global:** XXX **Issue:** Dual-energy X-Ray Absorptiometry (DXA)

Screen: Negative IWPUT

Complete? Yes

Most Recent RUC Meeting: January 2018

Tab 25 Specialty Developing Recommendation:

First Identified: April 2017

2017 Est. Medicare Utilization: 37,607

2007 Work RVU: 0.22

2018 Work RVU: 0.22

2007 NF PE RVU: 0.8

2018 NF PE RVU: 0.8

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

RUC Recommendation: 0.20

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

77082 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment **Global:** XXX **Issue:** Dual Energy X-Ray **Screen:** CMS Request - Final Rule for 2012 / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2013

Tab 07

Specialty Developing Recommendation:

AACE, ACNM, ACR, ACRh, SNMMI, TES

First Identified: September 2011

2017 Est. Medicare Utilization:

2007 Work RVU: 0.17

2018 Work RVU:

2007 NF PE RVU: 0.71

2018 NF PE RVU: 0.71

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT May 2013

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Deleted from CPT

77083 Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites **Global:** XXX **Issue:** Radiographic Absorptiometry **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010

Tab 31

Specialty Developing Recommendation:

ACR, ACP

First Identified: October 2009

2017 Est. Medicare Utilization:

2007 Work RVU: 0.20

2018 Work RVU:

2007 NF PE RVU: 0.71

2018 NF PE RVU: 0.71

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Deleted from CPT

77085 Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment **Global:** XXX **Issue:** Dual Energy X-Ray **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2013

Tab 07

Specialty Developing Recommendation:

AACE, ACNM, ACR, ACRh, SNMMI, TES

First Identified:

2017 Est. Medicare Utilization: 114,101

2007 Work RVU:

2018 Work RVU: 0.30

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: 0.30

Referred to CPT May 2013

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

77086 Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA) **Global:** XXX **Issue:** Dual Energy X-Ray **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2013

Tab 07

Specialty Developing Recommendation: AACE, ACNM, ACR, ACRh, SNMMI, TES

First Identified:

2017 Est. Medicare Utilization: 2,727

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 0.17
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.17

Referred to CPT May 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

77261 Therapeutic radiology treatment planning; simple

Global: XXX

Issue: Radiation Therapy Planning **Screen:** CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: April 2016

Tab 37

Specialty Developing Recommendation: ASTRO

First Identified: July 2015

2017 Est. Medicare Utilization: 7,676

2007 Work RVU: 1.39
2007 NF PE RVU: 0.51
2007 Fac PE RVU 0.51
Result: Decrease

2018 Work RVU: 1.30
2018 NF PE RVU: 0.51
2018 Fac PE RVU:0.51

RUC Recommendation: 1.30

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77262 Therapeutic radiology treatment planning; intermediate

Global: XXX

Issue: Radiation Therapy Planning **Screen:** CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: April 2016

Tab 37

Specialty Developing Recommendation: ASTRO

First Identified: July 2015

2017 Est. Medicare Utilization: 3,403

2007 Work RVU: 2.11
2007 NF PE RVU: 0.74
2007 Fac PE RVU 0.74
Result: Decrease

2018 Work RVU: 2.00
2018 NF PE RVU: 0.74
2018 Fac PE RVU:0.74

RUC Recommendation: 2.00

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77263 Therapeutic radiology treatment planning; complex **Global:** XXX **Issue:** Radiation Therapy Planning **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 37 **Specialty Developing Recommendation:** ASTRO **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 282,694 **2007 Work RVU:** 3.14 **2018 Work RVU:** 3.14 **2007 NF PE RVU:** 1.1 **2018 NF PE RVU:** 1.1 **2007 Fac PE RVU:** 1.1 **2018 Fac PE RVU:** 1.1 **RUC Recommendation:** 3.14 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

77280 Therapeutic radiology simulation-aided field setting; simple **Global:** XXX **Issue:** Set Radiation Therapy Field **Screen:** Harvard Valued - Utilization over 30,000 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** April 2011 **2017 Est. Medicare Utilization:** 310,059 **2007 Work RVU:** 0.70 **2018 Work RVU:** 0.70 **2007 NF PE RVU:** 3.89 **2018 NF PE RVU:** 3.89 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **RUC Recommendation:** 0.70 **Referred to CPT** October 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

77285 Therapeutic radiology simulation-aided field setting; intermediate **Global:** XXX **Issue:** Respiratory Motion Management Simulation **Screen:** Harvard Valued - Utilization over 30,000 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 4,539 **2007 Work RVU:** 1.05 **2018 Work RVU:** 1.05 **2007 NF PE RVU:** 6.45 **2018 NF PE RVU:** 6.45 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **RUC Recommendation:** 1.05 **Referred to CPT** October 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

Status Report: CMS Requests and Relativity Assessment Issues

77290 Therapeutic radiology simulation-aided field setting; complex **Global:** XXX **Issue:** Respiratory Motion Management Simulation **Screen:** MPC List / Harvard Valued - Utilization over 30,000 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2017 Est. Medicare Utilization:** 225,177 **2007 Work RVU:** 1.56 **2018 Work RVU:** 1.56 **2007 NF PE RVU:** 8.63 **2018 NF PE RVU:** 8.63 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Maintain

RUC Recommendation: 1.56 **Referred to CPT** October 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

77293 Respiratory motion management simulation (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Respiratory Motion Management Simulation **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** **2017 Est. Medicare Utilization:** 23,989 **2007 Work RVU:** **2018 Work RVU:** 2.00 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 2.00 **Referred to CPT** October 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

77295 3-dimensional radiotherapy plan, including dose-volume histograms **Global:** XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 145,596 **2007 Work RVU:** 4.56 **2018 Work RVU:** 4.29 **2007 NF PE RVU:** 23.92 **2018 NF PE RVU:** 23.92 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Decrease

RUC Recommendation: 4.29 **Referred to CPT** October 2012, October 2014 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77300 Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician **Global:** XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** MPC List / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 20 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2017 Est. Medicare Utilization:** 1,341,680 **2007 Work RVU:** 0.62 **2018 Work RVU:** 0.62 **2007 NF PE RVU:** 1.45 **2018 NF PE RVU:** 1.45 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Maintain **RUC Recommendation:** 0.62 **Referred to CPT:** February 2014, October 2014 **Referred to CPT Asst:** ☐ **Published in CPT Asst:**

77301 Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications **Global:** XXX **Issue:** IMRT - PE Only **Screen:** CMS Fastest Growing / CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes1 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 28 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2008 **2017 Est. Medicare Utilization:** 120,233 **2007 Work RVU:** 7.99 **2018 Work RVU:** 7.99 **2007 NF PE RVU:** 37.25 **2018 NF PE RVU:** 37.25 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Maintain **RUC Recommendation:** New PE Inputs. 7.99. CPT Assistant article published. **Referred to CPT:** **Referred to CPT Asst:** ☒ **Published in CPT Asst:** Nov 2009

77305 Teletherapy, isodose plan (whether hand or computer calculated); simple (1 or 2 parallel opposed unmodified ports directed to a single area of interest) **Global:** XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 20 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 0.70 **2018 Work RVU:** **2007 NF PE RVU:** 1.79 **2018 NF PE RVU:** 1.79 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Deleted from CPT **RUC Recommendation:** Deleted from CPT **Referred to CPT:** February 2014 **Referred to CPT Asst:** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77306 Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s) **Global:** XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 20

Specialty Developing Recommendation:

First Identified: October 2010

2017 Est. Medicare Utilization: 3,152

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 1.40
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.40

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77307 Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s) **Global:** XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 20

Specialty Developing Recommendation:

First Identified: October 2010

2017 Est. Medicare Utilization: 47,405

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 2.90
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 2.90

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77310 Teletherapy, isodose plan (whether hand or computer calculated); intermediate (3 or more treatment ports directed to a single area of interest) **Global:** XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 20

Specialty Developing Recommendation: ASTRO

First Identified: October 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 1.05
2007 NF PE RVU: 2.32
2007 Fac PE RVU NA
Result: Deleted from CPT

2018 Work RVU:
2018 NF PE RVU: 2.32
2018 Fac PE RVU: NA

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77315 Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations) **Global:** XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 20 **Specialty Developing Recommendation:** ASTRO

First Identified: October 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 1.56

2018 Work RVU:

2007 NF PE RVU: 2.9

2018 NF PE RVU: 2.9

2007 Fac PE RVU NA

2018 Fac PE RVU: NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

77316 Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s) **Global:** XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 20 **Specialty Developing Recommendation:**

First Identified: October 2012

2017 Est. Medicare Utilization: 4,385

2007 Work RVU:

2018 Work RVU: 1.40

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 1.50

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77317 Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s) **Global:** XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 20 **Specialty Developing Recommendation:**

First Identified: October 2012

2017 Est. Medicare Utilization: 3,254

2007 Work RVU:

2018 Work RVU: 1.83

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 1.83

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77318	Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)	Global: XXX	Issue: Isodose Calculation with Isodose Planning Bundle	Screen: Codes Reported Together 75% or More-Part2 / RUC Request	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 21 Specialty Developing Recommendation:	First Identified: October 2012	2017 Est. Medicare Utilization: 5,984	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 2.90 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 2.90		Referred to CPT February 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
77326	Brachytherapy isodose plan; simple (calculation made from single plane, 1 to 4 sources/ribbon application, remote afterloading brachytherapy, 1 to 8 sources)	Global: XXX	Issue: Isodose Calculation with Isodose Planning Bundle	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 20 Specialty Developing Recommendation:	First Identified: October 2012	2017 Est. Medicare Utilization:	2007 Work RVU: 0.93 2007 NF PE RVU: 2.75 2007 Fac PE RVU NA Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 2.75 2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT		Referred to CPT February 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
77327	Brachytherapy isodose plan; intermediate (multiplane dosage calculations, application involving 5 to 10 sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)	Global: XXX	Issue: Isodose Calculation with Isodose Planning Bundle	Screen: Codes Reported Together 75% or More-Part2	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 20 Specialty Developing Recommendation: ASTRO	First Identified: October 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 1.39 2007 NF PE RVU: 3.97 2007 Fac PE RVU NA Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 3.97 2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT		Referred to CPT February 2014 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

77328 Brachytherapy isodose plan; complex (multiplane isodose plan, volume implant calculations, over 10 sources/ribbons used, special spatial reconstruction, remote afterloading brachytherapy, over 12 sources) **Global:** XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 20

Specialty Developing Recommendation:

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 2.09

2018 Work RVU:

2007 NF PE RVU: 5.54

2018 NF PE RVU: 5.54

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

77332 Treatment devices, design and construction; simple (simple block, simple bolus)

Global: XXX

Issue: RAW

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab 40

Specialty Developing Recommendation: ASTRO

First Identified: April 2015

2017 Est. Medicare Utilization: 76,669

2007 Work RVU: 0.54

2018 Work RVU: 0.45

2007 NF PE RVU: 1.53

2018 NF PE RVU: 1.53

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.54

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77333 Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)

Global: XXX

Issue: RAW

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab 40

Specialty Developing Recommendation: ASTRO

First Identified: April 2015

2017 Est. Medicare Utilization: 11,580

2007 Work RVU: 0.84

2018 Work RVU: 0.75

2007 NF PE RVU: 1.75

2018 NF PE RVU: 1.75

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.84

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77334 Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts) **Global:** XXX **Issue:** **Screen:** MPC List / RUC request / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 40 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2017 Est. Medicare Utilization:** 847,543 **2007 Work RVU:** 1.24 **2018 Work RVU:** 1.15 **2007 NF PE RVU:** 3.43 **2018 NF PE RVU:** 3.43 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Maintain

RUC Recommendation: 1.24 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

77336 Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy **Global:** XXX **Issue:** Continuing Medical Physics Consultation-PE Only **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 31 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2012 **2017 Est. Medicare Utilization:** 423,715 **2007 Work RVU:** 0.00 **2018 Work RVU:** 0.00 **2007 NF PE RVU:** 2.52 **2018 NF PE RVU:** 2.52 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** PE Only

RUC Recommendation: New PE Inputs **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

77338 Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan **Global:** XXX **Issue:** IMRT - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 28 **Specialty Developing Recommendation:** **First Identified:** October 2012 **2017 Est. Medicare Utilization:** 140,715 **2007 Work RVU:** **2018 Work RVU:** 4.29 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** PE Only

RUC Recommendation: New PE Inputs **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77371 Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based **Global:** XXX **Issue:** Radiation Treatment Delivery, Stereotactic Radiosurgery **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 30 **Specialty Developing Recommendation:** ASTRO

First Identified: NA

2017 Est. Medicare Utilization: 83

2007 Work RVU: 0.00 **2018 Work RVU:** 0.00
2007 NF PE RVU: 30.25 **2018 NF PE RVU:** 30.25
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: PE Only

RUC Recommendation: New PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77372 Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based **Global:** XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 18 **Specialty Developing Recommendation:**

First Identified:

2017 Est. Medicare Utilization: 892

2007 Work RVU: 0.00 **2018 Work RVU:** 0.00
2007 NF PE RVU: 22.93 **2018 NF PE RVU:** 22.93
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: PE Only

RUC Recommendation: New PE Inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77373 Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions **Global:** XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab** 18 **Specialty Developing Recommendation:** ACR, ASTRO, ACRO

First Identified: July 2012

2017 Est. Medicare Utilization: 26,298

2007 Work RVU: 0.00 **2018 Work RVU:** 0.00
2007 NF PE RVU: 42.87 **2018 NF PE RVU:** 42.87
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: PE Only

RUC Recommendation: New PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77385 Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple **Global:** XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent
RUC Meeting: January 2014

Tab 14

Specialty Developing
Recommendation: ACRO,
ASTRO

First
Identified: January 2014

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU: 0.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: PE Only

RUC Recommendation: PE Only, revised introductory guidelines

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

77386 Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex **Global:** XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent
RUC Meeting: January 2014

Tab 14

Specialty Developing
Recommendation: ACRO,
ASTRO

First
Identified: January 2014

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU: 0.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: PE Only

RUC Recommendation: PE Only, revised introductory guidelines

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

77387 Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed **Global:** XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent
RUC Meeting: January 2014

Tab 14

Specialty Developing
Recommendation: ACRO,
ASTRO

First
Identified: January 2014

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU: 0.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 0.58

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77401	Radiation treatment delivery, superficial and/or ortho voltage, per day			Global: XXX	Issue:	Screen: High Volume Growth5	Complete? No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: October 2018	2017 Est. Medicare Utilization: 143,215	2007 Work RVU: 0.00 2007 NF PE RVU: 1.45 2007 Fac PE RVU NA	2018 Work RVU: 0.00 2018 NF PE RVU: 1.45 2018 Fac PE RVU:NA	
RUC Recommendation: Review action plan			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result:		

77402 Radiation treatment delivery, >=1 MeV; simple			Global: XXX	Issue: Radiation Treatment Delivery - PE Only	Screen: Services with Stand-Alone PE Procedure Time	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 14	Specialty Developing Recommendation: ACRO, ASTRO	First Identified: October 2012	2017 Est. Medicare Utilization:	2007 Work RVU: 0.00 2007 NF PE RVU: 2.37 2007 Fac PE RVU NA	2018 Work RVU: 0.00 2018 NF PE RVU: 2.37 2018 Fac PE RVU:NA
RUC Recommendation: PE Only, revised introductory guidelines			Referred to CPT October 2013 and February 2014		Result: PE Only	
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

77403	Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 6-10 MeV			Global: XXX	Issue: Radiation Treatment Delivery - PE Only	Screen: Services with Stand-Alone PE Procedure Time	Complete? Yes	
Most Recent RUC Meeting:	January 2014	Tab 14	Specialty Developing Recommendation: ACRO, ASTRO	First Identified:	October 2012	2017 Est. Medicare Utilization:	2007 Work RVU: 0.00 2007 NF PE RVU: 2.27 2007 Fac PE RVU NA Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 2.27 2018 Fac PE RVU:NA
RUC Recommendation: Deleted from CPT				Referred to CPT	October 2013	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

77404 Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 11-19 MeV **Global:** XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014

Tab 14

Specialty Developing Recommendation: ACRO, ASTRO

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 2.38

2018 NF PE RVU: 2.38

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

77406 Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 MeV or greater

Global: XXX

Issue: Radiation Treatment Delivery - PE Only

Screen: Services with Stand-Alone PE Procedure Time

Complete? Yes

Most Recent RUC Meeting: January 2014

Tab 14

Specialty Developing Recommendation: ACRO, ASTRO

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 2.38

2018 NF PE RVU: 2.38

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

77407 Radiation treatment delivery, >=1 MeV; intermediate

Global: XXX

Issue: Radiation Treatment Delivery - PE Only

Screen: Services with Stand-Alone PE Procedure Time

Complete? Yes

Most Recent RUC Meeting: January 2014

Tab 14

Specialty Developing Recommendation: ACRO, ASTRO

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: 2.93

2018 NF PE RVU: 2.93

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: PE Only

RUC Recommendation: PE Only, revised introductory guidelines

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77408 Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 6-10 MeV **Global:** XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014

Tab 14

Specialty Developing Recommendation: ACRO, ASTRO

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 2.87

2018 NF PE RVU: 2.87

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

77409 Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 11-19 MeV **Global:** XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014

Tab 14

Specialty Developing Recommendation: ACRO, ASTRO

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 3.02

2018 NF PE RVU: 3.02

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

77411 Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 20 MeV or greater **Global:** XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014

Tab 14

Specialty Developing Recommendation: ACRO, ASTRO

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 3.01

2018 NF PE RVU: 3.01

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77412 Radiation treatment delivery, >=1 MeV; complex **Global:** XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent **Tab** 14 **Specialty Developing** ACRO, **First** **2017 Est.**
RUC Meeting: January 2014 **Recommendation:** ASTRO **Identified:** October 2012 **Medicare**
Utilization:

RUC Recommendation: PE Only, revised introductory guidelines

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: 0.00 **2018 Work RVU:** 0.00
2007 NF PE RVU: 3.46 **2018 NF PE RVU:** 3.46
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: PE Only

77413 Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 MeV **Global:** XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent **Tab** 14 **Specialty Developing** ACRO, **First** **2017 Est.**
RUC Meeting: January 2014 **Recommendation:** ASTRO **Identified:** October 2012 **Medicare**
Utilization:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: 0.00 **2018 Work RVU:**
2007 NF PE RVU: 3.46 **2018 NF PE RVU:** 3.46
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Deleted from CPT

77414 Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 MeV **Global:** XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent **Tab** 14 **Specialty Developing** ACRO, **First** **2017 Est.**
RUC Meeting: January 2014 **Recommendation:** ASTRO **Identified:** October 2012 **Medicare**
Utilization:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

2007 Work RVU: 0.00 **2018 Work RVU:**
2007 NF PE RVU: 3.68 **2018 NF PE RVU:** 3.68
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

77416 Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 MeV or greater **Global:** XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014

Tab 14

Specialty Developing Recommendation: ACRO, ASTRO

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 3.68

2018 NF PE RVU: 3.68

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

77418 Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session

Global: XXX

Issue: Radiation Treatment Delivery - PE Only

Screen: CMS Fastest Growing / Services with Stand-Alone PE Procedure Time / Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: January 2014

Tab 14

Specialty Developing Recommendation: ACRO, ASTRO

First Identified: October 2008

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 16.8

2018 NF PE RVU: 16.8

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2013

Referred to CPT Asst ☒ **Published in CPT Asst:** Nov 2009 and Q&A - Mar 2010

77421 Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy

Global: XXX

Issue: Radiation Treatment Delivery - PE Only

Screen: Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 / High Volume Growth2

Complete? Yes

Most Recent RUC Meeting: January 2014

Tab 14

Specialty Developing Recommendation: ACRO, ASTRO

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 0.39

2018 Work RVU:

2007 NF PE RVU: 3.11

2018 NF PE RVU: 3.11

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77422 High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking **Global:** XXX **Issue:** High Energy Neutron Radiation Treatment **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015

Tab 35

Specialty Developing Recommendation: AAOS, ASPS, ASSH

First Identified: November 2014

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 4.58

2018 NF PE RVU: 4.58

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: Contractor Price

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

77423 High energy neutron radiation treatment delivery, 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s) **Global:** XXX **Issue:** High Energy Neutron Radiation Treatment **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015

Tab 35

Specialty Developing Recommendation: AAOS, ASPS, ASSH

First Identified: November 2014

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: 3.84

2018 NF PE RVU: 3.84

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: Contractor Price

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

77427 Radiation treatment management, 5 treatments **Global:** XXX **Issue:** Radiation Treatment Management **Screen:** Site of Service Anomaly / High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 54

Specialty Developing Recommendation: ASTRO

First Identified: September 2007

2017 Est. Medicare Utilization: 1,053,135

2007 Work RVU: 3.70

2018 Work RVU: 3.37

2007 NF PE RVU: 1.15

2018 NF PE RVU: 1.15

2007 Fac PE RVU 1.15

2018 Fac PE RVU:1.15

Result: Decrease

RUC Recommendation: 3.45. Remove from high E/M screen.

Referred to CPT June 2009

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

77435 Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent
RUC Meeting: January 2017

Tab 30 **Specialty Developing**
Recommendation:

First
Identified: October 2016

2017 Est.
Medicare
Utilization: 30,567

2007 Work RVU: 13.00 **2018 Work RVU:** 11.87
2007 NF PE RVU: 4.63 **2018 NF PE RVU:** 4.63
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Remove from screen

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77470 Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation) **Global:** XXX **Issue:** Special Radiation Treatment **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent
RUC Meeting: January 2016

Tab 41 **Specialty Developing** ASTRO
Recommendation:

First
Identified: July 2015

2017 Est.
Medicare
Utilization: 91,985

2007 Work RVU: 2.09 **2018 Work RVU:** 2.03
2007 NF PE RVU: 9.35 **2018 NF PE RVU:** 9.35
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Decrease

RUC Recommendation: 2.03

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77522 Proton treatment delivery; simple, with compensation **Global:** XXX **Issue:** Proton Beam Treatment Delivery **Screen:** Contractor Priced High Volume **Complete?** No

Most Recent
RUC Meeting: April 2018

Tab 33 **Specialty Developing**
Recommendation:

First
Identified: January 2018

2017 Est.
Medicare
Utilization: 22,627

2007 Work RVU: 0.00 **2018 Work RVU:** 0.00
2007 NF PE RVU: 0 **2018 NF PE RVU:** 0
2007 Fac PE RVU 0 **2018 Fac PE RVU:**0
Result:

RUC Recommendation: Survey for PE

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77523 Proton treatment delivery; intermediate

Global: XXX

Issue: Proton Beam Treatment
Delivery

Screen: High Volume Growth4 /
Contractor Priced High
Volume

Complete? No

Most Recent
RUC Meeting: April 2018

Tab 33

Specialty Developing
Recommendation:

First
Identified: October 2016

2017 Est.
Medicare
Utilization: 48,753

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Survey for PE

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result:

77525 Proton treatment delivery; complex

Global: XXX

Issue: Proton Beam Treatment
Delivery

Screen: Contractor Priced High
Volume

Complete? No

Most Recent
RUC Meeting: October 2018

Tab 27

Specialty Developing
Recommendation:

First
Identified: October 2018

2017 Est.
Medicare
Utilization: 9,737

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Survey for PE

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result:

77600 Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)

Global: XXX

Issue: Hyperthermia - PE Only

Screen: Services with Stand-
Alone PE Procedure
Time

Complete? Yes

Most Recent
RUC Meeting: April 2013

Tab 30

Specialty Developing
Recommendation:

First
Identified: October 2012

2017 Est.
Medicare
Utilization: 4,341

2007 Work RVU: 1.56

2018 Work RVU: 1.31

2007 NF PE RVU: 5.09

2018 NF PE RVU: 5.09

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: New PE Inputs

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

77767 Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter up to 2.0 cm or 1 channel **Global:** XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015

Tab 16

Specialty Developing Recommendation: ASTRO, ACRO

First Identified: October 2014

2017 Est. Medicare Utilization: 4,364

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 1.05
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.05

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

77768 Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions **Global:** XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015

Tab 16

Specialty Developing Recommendation: ASTRO, ACRO

First Identified: October 2014

2017 Est. Medicare Utilization: 7,271

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 1.40
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.40

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

77770 Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel **Global:** XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015

Tab 16

Specialty Developing Recommendation: ASTRO, ACRO

First Identified: October 2014

2017 Est. Medicare Utilization: 16,788

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 1.95
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.95

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77771 Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels **Global:** XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015

Tab 16

Specialty Developing Recommendation: ASTRO, ACRO

First Identified: October 2014

2017 Est. Medicare Utilization: 22,451

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 3.80
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 3.80

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

77772 Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels **Global:** XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015

Tab 16

Specialty Developing Recommendation: ASTRO, ACRO

First Identified: October 2014

2017 Est. Medicare Utilization: 4,070

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 5.40
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 5.40

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

77776 Interstitial radiation source application; simple **Global:** 090 **Issue:** Interstitial Radiation Source Codes **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015

Tab 17

Specialty Developing Recommendation: ACR, ASTRO

First Identified: February 2015

2017 Est. Medicare Utilization:

2007 Work RVU: 4.67
2007 NF PE RVU: 4.23
2007 Fac PE RVU 4.23
Result: Deleted from CPT

2018 Work RVU:
2018 NF PE RVU: 4.23
2018 Fac PE RVU: 4.23

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77777 Interstitial radiation source application; intermediate

Global: 090

Issue: Interstitial Radiation Source Codes

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: April 2015

Tab 17

Specialty Developing Recommendation: ACR, ASTRO

First Identified: February 2015

2017 Est. Medicare Utilization:

2007 Work RVU: 7.49

2018 Work RVU:

2007 NF PE RVU: 6.92

2018 NF PE RVU: 6.92

2007 Fac PE RVU 6.92

2018 Fac PE RVU:6.92

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

77778 Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed

Global: 000

Issue: Interstitial Radiation Source Codes

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 21

Specialty Developing Recommendation: ACR, ASTRO

First Identified: October 2012

2017 Est. Medicare Utilization: 4,840

2007 Work RVU: 11.23

2018 Work RVU: 8.78

2007 NF PE RVU: 9.38

2018 NF PE RVU: 9.38

2007 Fac PE RVU 9.38

2018 Fac PE RVU:9.38

Result: Decrease

RUC Recommendation: 8.78

Referred to CPT February 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

77781 Deleted from CPT

Global: XXX

Issue: Brachytherapy

Screen: CMS Fastest Growing

Complete? Yes

Most Recent RUC Meeting: October 2008

Tab 26

Specialty Developing Recommendation: ASTRO

First Identified: October 2008

2017 Est. Medicare Utilization:

2007 Work RVU: 1.21

2018 Work RVU:

2007 NF PE RVU: 16.73

2018 NF PE RVU: 16.73

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2008

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77782 Deleted from CPT

Global: XXX **Issue:** Brachytherapy

Screen: High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ASTRO

First Identified: February 2008 **2017 Est. Medicare Utilization:**

2007 Work RVU: 2.04 **2018 Work RVU:**
2007 NF PE RVU: 18.94 **2018 NF PE RVU:** 18.94
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2008
Referred to CPT Asst ☐ **Published in CPT Asst:**

77784 Deleted from CPT

Global: XXX **Issue:** Brachytherapy

Screen: CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** S **Specialty Developing Recommendation:** ASTRO

First Identified: February 2008 **2017 Est. Medicare Utilization:**

2007 Work RVU: 5.15 **2018 Work RVU:**
2007 NF PE RVU: 28.04 **2018 NF PE RVU:** 28.04
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2008
Referred to CPT Asst ☐ **Published in CPT Asst:**

77785 Remote afterloading high dose rate radionuclide brachytherapy; 1 channel

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy

Screen: High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab** 16 **Specialty Developing Recommendation:** ASTRO

First Identified: **2017 Est. Medicare Utilization:**

2007 Work RVU: **2018 Work RVU:**
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU **2018 Fac PE RVU:**
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77786 Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels **Global:** XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2015

Tab 16 **Specialty Developing Recommendation:** ASTRO

First Identified:

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

77787 Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy

Screen: High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure Time / Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: January 2015

Tab 16 **Specialty Developing Recommendation:** ASTRO

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

77790 Supervision, handling, loading of radiation source

Global: XXX **Issue:** Interstitial Radiation Source Codes

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 21 **Specialty Developing Recommendation:** ACR, ASTRO, SIR

First Identified: October 2012

2017 Est. Medicare Utilization: 228

2007 Work RVU: 1.05

2018 Work RVU: 0.00

2007 NF PE RVU: 1

2018 NF PE RVU: 1

2007 Fac PE RVU NA

2018 Fac PE RVU: NA

RUC Recommendation: 0.00

Referred to CPT February 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

77X49

Global:

Issue: Breast MRI with Computer-Aided Detection

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent
RUC Meeting: October 2017

Tab 06

Specialty Developing
Recommendation: ACR

First
Identified: June 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 1.45

Referred to CPT June 2017

Referred to CPT Asst ☐ Published in CPT Asst:

77X50

Global:

Issue: Breast MRI with Computer-Aided Detection

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent
RUC Meeting: October 2017

Tab 06

Specialty Developing
Recommendation: ACR

First
Identified: June 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 1.60

Referred to CPT June 2017

Referred to CPT Asst ☐ Published in CPT Asst:

77X51

Global:

Issue: Breast MRI with Computer-Aided Detection

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent
RUC Meeting: October 2017

Tab 06

Specialty Developing
Recommendation: ACR

First
Identified: June 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 2.10

Referred to CPT June 2017

Referred to CPT Asst ☐ Published in CPT Asst:

77X52

Global:

Issue: Breast MRI with Computer-Aided Detection

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent
RUC Meeting: October 2017

Tab 06

Specialty Developing
Recommendation: ACR

First
Identified: June 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 2.30

Referred to CPT June 2017

Referred to CPT Asst ☐ Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

78000 Thyroid uptake; single determination

Global: XXX

Issue: Thyroid Uptake/Imaging

Screen: Harvard Valued -
Utilization over 30,000

Complete? Yes

Most Recent
RUC Meeting: April 2012

Tab 22

Specialty Developing
Recommendation:

ACR, ACNM,
SNM

First
Identified:

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.19

2018 Work RVU:

2007 NF PE RVU: 1.21

2018 NF PE RVU: 1.21

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012

Referred to CPT Asst ☐ Published in CPT Asst:

Result: Deleted from CPT

78001 Thyroid uptake; multiple determinations

Global: XXX

Issue: Thyroid Uptake/Imaging

Screen: Harvard Valued -
Utilization over 30,000

Complete? Yes

Most Recent
RUC Meeting: April 2012

Tab 22

Specialty Developing
Recommendation:

ACR, ACNM,
SNM

First
Identified:

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.26

2018 Work RVU:

2007 NF PE RVU: 1.59

2018 NF PE RVU: 1.59

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012

Referred to CPT Asst ☐ Published in CPT Asst:

Result: Deleted from CPT

78003 Thyroid uptake; stimulation, suppression or discharge (not including initial uptake studies)

Global: XXX

Issue: Thyroid Uptake/Imaging

Screen: Harvard Valued -
Utilization over 30,000

Complete? Yes

Most Recent
RUC Meeting: April 2012

Tab 22

Specialty Developing
Recommendation:

ACR, ACNM,
SNM

First
Identified:

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.33

2018 Work RVU:

2007 NF PE RVU: 1.26

2018 NF PE RVU: 1.26

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012

Referred to CPT Asst ☐ Published in CPT Asst:

Result: Deleted from CPT

78006 Thyroid imaging, with uptake; single determination

Global: XXX

Issue: Thyroid Uptake/Imaging

Screen: Harvard Valued -
Utilization over 30,000

Complete? Yes

Most Recent
RUC Meeting: April 2012

Tab 22

Specialty Developing
Recommendation:

ACR, ACNM,
SNM

First
Identified:

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.49

2018 Work RVU:

2007 NF PE RVU: 3.38

2018 NF PE RVU: 3.38

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012

Referred to CPT Asst ☐ Published in CPT Asst:

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

78007 Thyroid imaging, with uptake; multiple determinations **Global:** XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 0.50 **2018 Work RVU:** **2007 NF PE RVU:** 2.76 **2018 NF PE RVU:** 2.76 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

78010 Thyroid imaging; only **Global:** XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2017 Est. Medicare Utilization:** **2007 Work RVU:** 0.39 **2018 Work RVU:** **2007 NF PE RVU:** 2.45 **2018 NF PE RVU:** 2.45 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

78011 Thyroid imaging; with vascular flow **Global:** XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2017 Est. Medicare Utilization:** **2007 Work RVU:** 0.45 **2018 Work RVU:** **2007 NF PE RVU:** 2.99 **2018 NF PE RVU:** 2.99 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

78012 Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed) **Global:** XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2017 Est. Medicare Utilization:** 2,595 **2007 Work RVU:** **2018 Work RVU:** 0.19 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 0.19 **Referred to CPT** February 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78013 Thyroid imaging (including vascular flow, when performed); **Global:** XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2017 Est. Medicare Utilization:** 2,324 **2007 Work RVU:** **2018 Work RVU:** 0.37 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 0.37 **Referred to CPT** February 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

78014 Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed) **Global:** XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2017 Est. Medicare Utilization:** 23,973 **2007 Work RVU:** **2018 Work RVU:** 0.50 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 0.50 **Referred to CPT** February 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

78070 Parathyroid planar imaging (including subtraction, when performed); **Global:** XXX **Issue:** Parathyroid Imaging **Screen:** Harvard Valued - Utilization over 30,000 / CPT 2013 Utilization Review **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 54 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2017 Est. Medicare Utilization:** 13,848 **2007 Work RVU:** 0.82 **2018 Work RVU:** 0.80 **2007 NF PE RVU:** 4.21 **2018 NF PE RVU:** 4.21 **2007 Fac PE RVU** NA **2018 Fac PE RVU:** NA **Result:** Maintain

RUC Recommendation: 0.80 **Referred to CPT** **Referred to CPT Asst** ☒ **Published in CPT Asst:** Dec 2016

Status Report: CMS Requests and Relativity Assessment Issues

78071 Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT) **Global:** XXX **Issue:** Parathyroid Imaging **Screen:** Harvard Valued - Utilization over 30,000 / CPT 2013 Utilization Review **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 54

Specialty Developing Recommendation:

ACR, ACNM, SNM

First Identified: April 2011

2017 Est. Medicare Utilization: 8,467

2007 Work RVU:

2018 Work RVU: 1.20

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: 1.20

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Dec 2016

78072 Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization

Global: XXX

Issue: Parathyroid Imaging

Screen: Harvard Valued - Utilization over 30,000 / CPT 2013 Utilization Review

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab 54

Specialty Developing Recommendation:

ACR, ACNM, SNM

First Identified: April 2011

2017 Est. Medicare Utilization: 8,710

2007 Work RVU:

2018 Work RVU: 1.60

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: 1.60

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Dec 2016

78223 Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function

Global: XXX

Issue: Hepatobiliary Ductal System Imaging

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: February 2011

Tab 12

Specialty Developing Recommendation:

ACR, SNM

First Identified: October 2009

2017 Est. Medicare Utilization:

2007 Work RVU: 0.84

2018 Work RVU:

2007 NF PE RVU: 4.95

2018 NF PE RVU: 4.95

2007 Fac PE RVU NA

2018 Fac PE RVU: NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

78226 Hepatobiliary system imaging, including gallbladder when present; **Global:** XXX **Issue:** Hepatobiliary System Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 12 **Specialty Developing Recommendation:** ACR, SNM, ACNM **First Identified:** **2017 Est. Medicare Utilization:** 66,546 **2007 Work RVU:** **2018 Work RVU:** 0.74 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 0.74 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

78227 Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed **Global:** XXX **Issue:** Hepatobiliary System Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab** 12 **Specialty Developing Recommendation:** ACR, SNM, ACNM **First Identified:** **2017 Est. Medicare Utilization:** 73,208 **2007 Work RVU:** **2018 Work RVU:** 0.90 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 0.90 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

78265 Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit **Global:** XXX **Issue:** Colon Transit Imaging **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 18 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** April 2015 **2017 Est. Medicare Utilization:** 1,637 **2007 Work RVU:** **2018 Work RVU:** 0.98 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU** **2018 Fac PE RVU:** **Result:** Not Part of RAW

RUC Recommendation: CPT Assistant article published **Referred to CPT** **Referred to CPT Asst** ☒ **Published in CPT Asst:** Dec 2015

78266 Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days **Global:** XXX **Issue:** Colon Transit Imaging **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 18 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** April 2015 **2017 Est. Medicare Utilization:** 227 **2007 Work RVU:** **2018 Work RVU:** 1.08 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU** **2018 Fac PE RVU:** **Result:** Not Part of RAW

RUC Recommendation: CPT Assistant article published **Referred to CPT** **Referred to CPT Asst** ☒ **Published in CPT Asst:** Dec 2015

Status Report: CMS Requests and Relativity Assessment Issues

78278 Acute gastrointestinal blood loss imaging

Global: XXX

Issue: Acute GI Blood Loss Imaging

Screen: Harvard Valued - Utilization over 30,000

Complete? Yes

Most Recent
RUC Meeting: September 2011

Tab 34

Specialty Developing
Recommendation: ACR, SNM, ACNM

First
Identified: April 2011

2017 Est.
Medicare
Utilization: 31,673

2007 Work RVU: 0.99

2018 Work RVU: 0.99

2007 NF PE RVU: 5.92

2018 NF PE RVU: 5.92

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.99

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

78300 Bone and/or joint imaging; limited area

Global: XXX

Issue: Bone Imaging

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent
RUC Meeting: April 2016

Tab 38

Specialty Developing
Recommendation: ACNM, ACR, SNMMI

First
Identified: July 2015

2017 Est.
Medicare
Utilization: 9,439

2007 Work RVU: 0.62

2018 Work RVU: 0.62

2007 NF PE RVU: 3

2018 NF PE RVU: 3

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.62

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

78305 Bone and/or joint imaging; multiple areas

Global: XXX

Issue: Bone Imaging

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent
RUC Meeting: April 2016

Tab 38

Specialty Developing
Recommendation: ACNM, ACR, SNMMI

First
Identified: July 2015

2017 Est.
Medicare
Utilization: 1,748

2007 Work RVU: 0.83

2018 Work RVU: 0.83

2007 NF PE RVU: 4.24

2018 NF PE RVU: 4.24

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.83

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

78306 Bone and/or joint imaging; whole body

Global: XXX

Issue: Bone Imaging

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent
RUC Meeting: April 2016

Tab 38

Specialty Developing
Recommendation: ACNM, ACR, SNMMI

First
Identified: July 2015

2017 Est.
Medicare
Utilization: 279,557

2007 Work RVU: 0.86

2018 Work RVU: 0.86

2007 NF PE RVU: 4.84

2018 NF PE RVU: 4.84

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.86

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

78451 Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic) **Global:** XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2017 Est. Medicare Utilization:** 40,412 **2007 Work RVU:** **2018 Work RVU:** 1.38 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Increase **2018 Fac PE RVU:**

RUC Recommendation: 1.40

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78452 Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection **Global:** XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2017 Est. Medicare Utilization:** 1,947,641 **2007 Work RVU:** **2018 Work RVU:** 1.62 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Decrease **2018 Fac PE RVU:**

RUC Recommendation: 1.75

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

78453 Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic) **Global:** XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2017 Est. Medicare Utilization:** 1,611 **2007 Work RVU:** **2018 Work RVU:** 1.00 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Decrease **2018 Fac PE RVU:**

RUC Recommendation: 1.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78454 Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection **Global:** XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2017 Est. Medicare Utilization:** 11,306 **2007 Work RVU:** **2018 Work RVU:** 1.34 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Decrease **2018 Fac PE RVU:**

RUC Recommendation: 1.34 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

78459 Myocardial imaging, positron emission tomography (PET), metabolic evaluation **Global:** XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab** 12 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2017 Est. Medicare Utilization:** 2,543 **2007 Work RVU:** 0.00 **2018 Work RVU:** 0.00 **2007 NF PE RVU:** 0 **2018 NF PE RVU:** 0 **2007 Fac PE RVU** 0 **2018 Fac PE RVU:**0 **Result:**

RUC Recommendation: Resurvey for January 2019 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

78460 Deleted from CPT **Global:** XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2017 Est. Medicare Utilization:** **2007 Work RVU:** 0.86 **2018 Work RVU:** **2007 NF PE RVU:** 3.1 **2018 NF PE RVU:** 3.1 **2007 Fac PE RVU** NA **2018 Fac PE RVU:**NA **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78461 Deleted from CPT

Global: XXX

Issue: Myocardial Perfusion Imaging

Screen: Codes Reported Together 95% or More

Complete? Yes

Most Recent RUC Meeting: February 2009

Tab 16

Specialty Developing Recommendation: SNM, ACR, ASNC, ACC

First Identified:

2017 Est. Medicare Utilization:

2007 Work RVU: 1.23

2018 Work RVU:

2007 NF PE RVU: 4.81

2018 NF PE RVU: 4.81

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT October 2008

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

78464 Deleted from CPT

Global: XXX

Issue: Myocardial Perfusion Imaging

Screen: Codes Reported Together 95% or More

Complete? Yes

Most Recent RUC Meeting: February 2009

Tab 16

Specialty Developing Recommendation: SNM, ACR, ASNC, ACC

First Identified:

2017 Est. Medicare Utilization:

2007 Work RVU: 1.09

2018 Work RVU:

2007 NF PE RVU: 7.03

2018 NF PE RVU: 7.03

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT October 2008

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

78465 Deleted from CPT

Global: XXX

Issue: Myocardial Perfusion Imaging

Screen: Codes Reported Together 95% or More

Complete? Yes

Most Recent RUC Meeting: February 2009

Tab 16

Specialty Developing Recommendation: SNM, ACR, ASNC, ACC

First Identified: February 2008

2017 Est. Medicare Utilization:

2007 Work RVU: 1.46

2018 Work RVU:

2007 NF PE RVU: 12.08

2018 NF PE RVU: 12.08

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT October 2008

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

78472	Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing	Global: XXX	Issue: Cardiac Blood Pool Imaging	Screen: Harvard Valued - Utilization over 30,000	Complete? Yes
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Most Recent RUC Meeting: September 2011

Tab 35

Specialty Developing Recommendation: ACC, ACR, SNM, ACNM

First Identified: April 2011

2017 Est. Medicare Utilization: 23,671

2007 Work RVU: 0.98

2018 Work RVU: 0.98

2007 NF PE RVU: 5.87

2018 NF PE RVU: 5.87

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.98

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

78478 Deleted from CPT

Global: XXX

Issue: Myocardial Perfusion Imaging

Screen: Codes Reported Together 95% or More

Complete? Yes

Most Recent RUC Meeting: February 2009

Tab 16

Specialty Developing Recommendation: SNM, ACR, ASNC, ACC

First Identified: February 2008

2017 Est. Medicare Utilization:

2007 Work RVU: 0.50

2018 Work RVU:

2007 NF PE RVU: 1.54

2018 NF PE RVU: 1.54

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2008

Referred to CPT Asst ☐

Published in CPT Asst:

78480 Deleted from CPT

Global: XXX

Issue: Myocardial Perfusion Imaging

Screen: Codes Reported Together 95% or More

Complete? Yes

Most Recent RUC Meeting: February 2009

Tab 16

Specialty Developing Recommendation: SNM, ACR, ASNC, ACC

First Identified: February 2008

2017 Est. Medicare Utilization:

2007 Work RVU: 0.30

2018 Work RVU:

2007 NF PE RVU: 1.51

2018 NF PE RVU: 1.51

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2008

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

78491	Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress	Global: XXX	Issue: Myocardial PET	Screen: High Volume Growth4	Complete? No
Most Recent RUC Meeting: October 2018	Tab 12	Specialty Developing Recommendation: ACC, ACR, ACNM, SNMMI	First Identified: May 2018	2017 Est. Medicare Utilization: 1,166	2007 Work RVU: 0.00 2007 NF PE RVU: 0 2007 Fac PE RVU 0 2018 Work RVU: 0.00 2018 NF PE RVU: 0 2018 Fac PE RVU: 0
RUC Recommendation: Resurvey for January 2019	Referred to CPT Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:				

78492	Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress	Global: XXX	Issue: Myocardial PET	Screen: High Volume Growth4	Complete? No
Most Recent RUC Meeting: October 2018	Tab 12	Specialty Developing Recommendation: ACC, ACR, ACNM, SNMMI	First Identified: October 2016	2017 Est. Medicare Utilization: 135,774	2007 Work RVU: 0.00 2007 NF PE RVU: 0 2007 Fac PE RVU 0 2018 Work RVU: 0.00 2018 NF PE RVU: 0 2018 Fac PE RVU: 0
RUC Recommendation: Resurvey for January 2019	Referred to CPT May 2018 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:				

78579	Pulmonary ventilation imaging (eg, aerosol or gas)	Global: XXX	Issue: Pulmonary Imaging	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: February 2011	Tab 13	Specialty Developing Recommendation: ACR, SNM	First Identified: February 2010	2017 Est. Medicare Utilization: 812	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU 2018 Work RVU: 0.49 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.49	Referred to CPT October 2010 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:				

78580	Pulmonary perfusion imaging (eg, particulate)	Global: XXX	Issue: Pulmonary Imaging	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: February 2011	Tab 13	Specialty Developing Recommendation: SNM, ACR	First Identified: February 2010	2017 Est. Medicare Utilization: 12,650	2007 Work RVU: 0.74 2007 NF PE RVU: 3.97 2007 Fac PE RVU NA 2018 Work RVU: 0.74 2018 NF PE RVU: 3.97 2018 Fac PE RVU: NA
RUC Recommendation: 0.74	Referred to CPT October 2010 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:				

Status Report: CMS Requests and Relativity Assessment Issues

78582 Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging **Global:** XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011	Tab 13	Specialty Developing Recommendation:	ACR, SNM	First Identified: February 2010	2017 Est. Medicare Utilization: 203,306	2007 Work RVU:	2018 Work RVU: 1.07
						2007 NF PE RVU:	2018 NF PE RVU:
						2007 Fac PE RVU	2018 Fac PE RVU:
RUC Recommendation: 1.07				Referred to CPT October 2010		Result: Decrease	
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

78584 Pulmonary perfusion imaging, particulate, with ventilation; single breath **Global:** XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010	Tab 31	Specialty Developing Recommendation:	SNM, ACR	First Identified: February 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 0.99	2018 Work RVU:
						2007 NF PE RVU: 3.34	2018 NF PE RVU: 3.34
						2007 Fac PE RVU NA	2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT				Referred to CPT October 2010		Result: Deleted from CPT	
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

78585 Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath **Global:** XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010	Tab 31	Specialty Developing Recommendation:	SNM, ACR	First Identified: October 2009	2017 Est. Medicare Utilization:	2007 Work RVU: 1.09	2018 Work RVU:
						2007 NF PE RVU: 6.53	2018 NF PE RVU: 6.53
						2007 Fac PE RVU NA	2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT				Referred to CPT October 2010		Result: Deleted from CPT	
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

78586 Pulmonary ventilation imaging, aerosol; single projection **Global:** XXX **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010	Tab 31	Specialty Developing Recommendation:	SNM, ACR	First Identified: February 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 0.40	2018 Work RVU:
						2007 NF PE RVU: 3.02	2018 NF PE RVU: 3.02
						2007 Fac PE RVU NA	2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT				Referred to CPT October 2010		Result: Deleted from CPT	
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

78587 Deleted from CPT

Global: XXX

Issue: Pulmonary Perfusion Imaging

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: February 2010

Tab 31

Specialty Developing Recommendation: SNM, ACR

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 0.49

2018 Work RVU:

2007 NF PE RVU: 3.51

2018 NF PE RVU: 3.51

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

78588 Deleted from CPT

Global: XXX

Issue: Pulmonary Perfusion Imaging

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: February 2010

Tab 31

Specialty Developing Recommendation: SNM, ACR

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 1.09

2018 Work RVU:

2007 NF PE RVU: 4.7

2018 NF PE RVU: 4.7

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

78591 Deleted from CPT

Global: XXX

Issue: Pulmonary Perfusion Imaging

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: February 2010

Tab 31

Specialty Developing Recommendation: SNM, ACR

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 0.40

2018 Work RVU:

2007 NF PE RVU: 3.21

2018 NF PE RVU: 3.21

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

78593 Deleted from CPT

Global: XXX

Issue: Pulmonary Perfusion Imaging

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: February 2010

Tab 31

Specialty Developing Recommendation: SNM, ACR

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 0.49

2018 Work RVU:

2007 NF PE RVU: 3.84

2018 NF PE RVU: 3.84

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78594 Deleted from CPT

Global: XXX

Issue: Pulmonary Perfusion Imaging

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: February 2010

Tab 31

Specialty Developing Recommendation: SNM, ACR

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 0.53

2018 Work RVU:

2007 NF PE RVU: 5.12

2018 NF PE RVU: 5.12

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

78596 Deleted from CPT

Global: XXX

Issue: Pulmonary Perfusion Imaging

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: February 2010

Tab 31

Specialty Developing Recommendation: SNM, ACR

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 1.27

2018 Work RVU:

2007 NF PE RVU: 7.7

2018 NF PE RVU: 7.7

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

78597 Quantitative differential pulmonary perfusion, including imaging when performed

Global: XXX

Issue: Pulmonary Imaging

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: February 2011

Tab 13

Specialty Developing Recommendation: ACR, SNM

First Identified: February 2010

2017 Est. Medicare Utilization: 1,550

2007 Work RVU:

2018 Work RVU: 0.75

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 0.75

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

78598 Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed

Global: XXX

Issue: Pulmonary Imaging

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: February 2011

Tab 13

Specialty Developing Recommendation: ACR, SNM

First Identified: February 2010

2017 Est. Medicare Utilization: 3,718

2007 Work RVU:

2018 Work RVU: 0.85

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 0.85

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78803	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SPECT)	Global: XXX	Issue: RAW	Screen: CPT 2013 Utilization Review	Complete? No
Most Recent RUC Meeting: January 2016	Tab 54	Specialty Developing Recommendation: ACR, ACNM, SNM	First Identified: January 2016	2017 Est. Medicare Utilization: 9,563	2007 Work RVU: 1.09 2007 NF PE RVU: 8.73 2007 Fac PE RVU NA 2018 Work RVU: 1.09 2018 NF PE RVU: 8.73 2018 Fac PE RVU: NA
RUC Recommendation:			Referred to CPT	Published in CPT Asst: Dec 2016	
			Referred to CPT Asst <input checked="" type="checkbox"/>		

78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	Global: XXX	Issue:	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: February 2011	Tab 41	Specialty Developing Recommendation: ACR, SNM	First Identified: October 2010	2017 Est. Medicare Utilization: 563,363	2007 Work RVU: 0.00 2007 NF PE RVU: 0 2007 Fac PE RVU 0 2018 Work RVU: 0.00 2018 NF PE RVU: 0 2018 Fac PE RVU: 0
RUC Recommendation: Reaffirmed RUC recommendation			Referred to CPT	Published in CPT Asst:	
			Referred to CPT Asst <input type="checkbox"/>		

78X29		Global:	Issue: Myocardial PET	Screen: High Volume Growth4	Complete? No
Most Recent RUC Meeting: October 2018	Tab 12	Specialty Developing Recommendation: ACC, ACR, ACNM, SNMMI	First Identified: May 2018	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU 2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: Resurvey for January 2019			Referred to CPT	Published in CPT Asst:	
			Referred to CPT Asst <input type="checkbox"/>		

78X31		Global:	Issue: Myocardial PET	Screen: High Volume Growth4	Complete? No
Most Recent RUC Meeting: October 2018	Tab 12	Specialty Developing Recommendation: ACC, ACR, ACNM, SNMMI	First Identified: May 2018	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU 2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: Resurvey for January 2019			Referred to CPT	Published in CPT Asst:	
			Referred to CPT Asst <input type="checkbox"/>		

Status Report: CMS Requests and Relativity Assessment Issues

78X32				Global:	Issue: Myocardial PET	Screen: High Volume Growth4	Complete? No
Most Recent RUC Meeting: October 2018	Tab 12	Specialty Developing Recommendation:	ACC, ACR, ACNM, SNMMI	First Identified: May 2018	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: Resurvey for January 2019				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

78X33				Global:	Issue: Myocardial PET	Screen: High Volume Growth4	Complete? No
Most Recent RUC Meeting: October 2018	Tab 12	Specialty Developing Recommendation:	ACC, ACR, ACNM, SNMMI	First Identified: May 2018	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: Resurvey for January 2019				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

78X34				Global:	Issue: Myocardial PET	Screen: High Volume Growth4	Complete? No
Most Recent RUC Meeting: October 2018	Tab 12	Specialty Developing Recommendation:	ACC, ACR, ACNM, SNMMI	First Identified: May 2018	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: Resurvey for January 2019				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

78X35				Global:	Issue: Myocardial PET	Screen: High Volume Growth4	Complete? No
Most Recent RUC Meeting: October 2018	Tab 12	Specialty Developing Recommendation:	ACC, ACR, ACNM, SNMMI	First Identified: May 2018	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: Resurvey for January 2019				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

79101 Radiopharmaceutical therapy, by intravenous administration **Global:** XXX **Issue:** Radiopharmaceutical Therapy **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab 31 Specialty Developing Recommendation:** SNM, ACR **First Identified:** October 2009 **2017 Est. Medicare Utilization:** 10,776 **2007 Work RVU:** 1.96 **2018 Work RVU:** 1.96 **2007 NF PE RVU:** 2.98 **2018 NF PE RVU:** 2.98 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Maintain

RUC Recommendation: Article published Feb 2012 **Referred to CPT** **Referred to CPT Asst** ☒ **Published in CPT Asst:** Feb 2012

85060 Blood smear, peripheral, interpretation by physician with written report **Global:** XXX **Issue:** Blood Smear Interpretation **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab 30 Specialty Developing Recommendation:** CAP **First Identified:** April 2016 **2017 Est. Medicare Utilization:** 175,445 **2007 Work RVU:** 0.45 **2018 Work RVU:** 0.45 **2007 NF PE RVU:** 0.17 **2018 NF PE RVU:** 0.17 **2007 Fac PE RVU:** 0.17 **2018 Fac PE RVU:** 0.17 **Result:** Maintain

RUC Recommendation: 0.45 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

85097 Bone marrow, smear interpretation **Global:** XXX **Issue:** Bone Marrow Interpretation **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab 31 Specialty Developing Recommendation:** CAP **First Identified:** April 2016 **2017 Est. Medicare Utilization:** 139,140 **2007 Work RVU:** 0.94 **2018 Work RVU:** 0.94 **2007 NF PE RVU:** 1.76 **2018 NF PE RVU:** 1.76 **2007 Fac PE RVU:** 0.38 **2018 Fac PE RVU:** 0.38 **Result:** Increase

RUC Recommendation: 1.00 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

85390 Fibrinolytics or coagulopathy screen, interpretation and report **Global:** XXX **Issue:** Fibrinolytics Screen **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab 26 Specialty Developing Recommendation:** **First Identified:** April 2017 **2017 Est. Medicare Utilization:** 34,752 **2007 Work RVU:** 0.00 **2018 Work RVU:** 0.00 **2007 NF PE RVU:** 0 **2018 NF PE RVU:** 0 **2007 Fac PE RVU:** 0 **2018 Fac PE RVU:** 0 **Result:** Increase

RUC Recommendation: 0.75 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88104	Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation	Global: XXX	Issue: Cytopathology	Screen: Harvard Valued - Utilization over 100,000 / Final Rule for 2015	Complete? Yes
Most Recent RUC Meeting: April 2015	Tab 36	Specialty Developing Recommendation: AUR, ASC, CAP	First Identified: October 2009	2017 Est. Medicare Utilization: 76,119	2007 Work RVU: 0.56 2007 NF PE RVU: 0.93 2007 Fac PE RVU NA Result: Maintain
RUC Recommendation: New PE Inputs. 0.56			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.56 2018 NF PE RVU: 0.93 2018 Fac PE RVU: NA
<hr/>					
88106	Cytopathology, fluids, washings or brushings, except cervical or vaginal; simple filter method with interpretation	Global: XXX	Issue: Cytopathology	Screen: Harvard Valued - Utilization over 100,000 / Final Rule for 2015	Complete? Yes
Most Recent RUC Meeting: April 2015	Tab 36	Specialty Developing Recommendation: AUR, ASC, CAP	First Identified: February 2010	2017 Est. Medicare Utilization: 6,204	2007 Work RVU: 0.56 2007 NF PE RVU: 1.39 2007 Fac PE RVU NA Result: Maintain
RUC Recommendation: New PE Inputs. 0.56			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.37 2018 NF PE RVU: 1.39 2018 Fac PE RVU: NA
<hr/>					
88107	Deleted from CPT	Global: XXX	Issue: Cytopathology	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 17	Specialty Developing Recommendation: AUR, ASC, CAP	First Identified: February 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 0.76 2007 NF PE RVU: 1.66 2007 Fac PE RVU NA Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT October 2010 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: 1.66 2018 Fac PE RVU: NA

Status Report: CMS Requests and Relativity Assessment Issues

88108	Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)			Global: XXX	Issue: Cytopathology Concentration Technique- PE Only	Screen: Harvard Valued - Utilization over 100,000 / Final Rule for 2015	Complete?	Yes				
Most Recent RUC Meeting:	April 2015	Tab 36	Specialty Developing Recommendation:	ACR, CAP	First Identified:	February 2010	2017 Est. Medicare Utilization:	256,341	2007 Work RVU:	0.56	2018 Work RVU:	0.44
									2007 NF PE RVU:	1.27	2018 NF PE RVU:	1.27
									2007 Fac PE RVU	NA	2018 Fac PE RVU:	NA
RUC Recommendation:	New PE Inputs. 0.56				Referred to CPT		Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	Result:	Maintain	
<hr/>												
88112	Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal			Global: XXX	Issue: Cytopathology Concentration Technique- PE Only	Screen: CMS High Expenditure Procedural Codes1 / Final Rule for 2015	Complete?	Yes				
Most Recent RUC Meeting:	April 2015	Tab 36	Specialty Developing Recommendation:	ACR, CAP	First Identified:	September 2011	2017 Est. Medicare Utilization:	939,483	2007 Work RVU:	1.18	2018 Work RVU:	0.56
									2007 NF PE RVU:	1.85	2018 NF PE RVU:	1.85
									2007 Fac PE RVU	NA	2018 Fac PE RVU:	NA
RUC Recommendation:	New PE Inputs. 0.56				Referred to CPT		Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	Result:	Decrease	
<hr/>												
88120	Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual			Global: XXX	Issue: RAW review	Screen: CMS Request - Final Rule for 2013	Complete?	Yes				
Most Recent RUC Meeting:	October 2017	Tab 19	Specialty Developing Recommendation:		First Identified:	November 2012	2017 Est. Medicare Utilization:	57,402	2007 Work RVU:		2018 Work RVU:	1.20
									2007 NF PE RVU:		2018 NF PE RVU:	
									2007 Fac PE RVU		2018 Fac PE RVU:	
RUC Recommendation:	Utilization shift is appropriate.				Referred to CPT		Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	Result:	Maintain	

Status Report: CMS Requests and Relativity Assessment Issues

88121 Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology **Global:** XXX **Issue:** RAW review **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab** 19 **Specialty Developing Recommendation:** **First Identified:** November 2012 **2017 Est. Medicare Utilization:** 33,947 **2007 Work RVU:** **2018 Work RVU:** 1.00 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Maintain **2018 Fac PE RVU:**

RUC Recommendation: Utilization shift is appropriate. **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

88141 Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician **Global:** XXX **Issue:** Cytopathology Cervical/Vaginal **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 26 **Specialty Developing Recommendation:** CAP **First Identified:** October 2017 **2017 Est. Medicare Utilization:** 67,071 **2007 Work RVU:** 0.42 **2018 Work RVU:** 0.42 **2007 NF PE RVU:** 0.21 **2018 NF PE RVU:** 0.21 **2007 Fac PE RVU Result:** Maintain **2018 Fac PE RVU:** 0.21

RUC Recommendation: 0.42 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

88160 Cytopathology, smears, any other source; screening and interpretation **Global:** XXX **Issue:** Cytopathology Concentration Technique - PE Only **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 36 **Specialty Developing Recommendation:** **First Identified:** April 2015 **2017 Est. Medicare Utilization:** 8,129 **2007 Work RVU:** 0.50 **2018 Work RVU:** 0.50 **2007 NF PE RVU:** 0.85 **2018 NF PE RVU:** 0.85 **2007 Fac PE RVU Result:** PE Only **2018 Fac PE RVU:** NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88161 Cytopathology, smears, any other source; preparation, screening and interpretation **Global:** XXX **Issue:** Cytopathology Concentration Technique - PE Only **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 36 **Specialty Developing Recommendation:** **First Identified:** April 2015 **2017 Est. Medicare Utilization:** 4,298 **2007 Work RVU:** 0.50 **2018 Work RVU:** 0.50 **2007 NF PE RVU:** 0.99 **2018 NF PE RVU:** 0.99 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** PE Only

RUC Recommendation: New PE Inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

88162 Cytopathology, smears, any other source; extended study involving over 5 slides and/or multiple stains **Global:** XXX **Issue:** Cytopathology Concentration Technique - PE Only **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab** 36 **Specialty Developing Recommendation:** **First Identified:** April 2015 **2017 Est. Medicare Utilization:** 2,699 **2007 Work RVU:** 0.76 **2018 Work RVU:** 0.76 **2007 NF PE RVU:** 1.05 **2018 NF PE RVU:** 1.05 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** PE Only

RUC Recommendation: New PE Inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

88184 Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker **Global:** XXX **Issue:** Flow Cytometry **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** **Specialty Developing Recommendation:** CAP **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 96,375 **2007 Work RVU:** 0.00 **2018 Work RVU:** 0.00 **2007 NF PE RVU:** 1.6 **2018 NF PE RVU:** 1.6 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** PE Only

RUC Recommendation: New PE Inputs. Removed from FR 2018 as misvalued.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88185 Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (List separately in addition to code for first marker) **Global:** ZZZ **Issue:** Flow Cytometry **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab

Specialty Developing Recommendation: CAP

First Identified: July 2015

2017 Est. Medicare Utilization: 1,832,288

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: 0.85

2018 NF PE RVU: 0.85

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: PE Only

RUC Recommendation: New PE Inputs. Removed from FR 2018 as misvalued.

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

88187 Flow cytometry, interpretation; 2 to 8 markers

Global: XXX

Issue: Flow Cytometry Interpretation

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab 42

Specialty Developing Recommendation: CAP

First Identified: July 2015

2017 Est. Medicare Utilization: 39,880

2007 Work RVU: 1.36

2018 Work RVU: 0.74

2007 NF PE RVU: 0.44

2018 NF PE RVU: 0.44

2007 Fac PE RVU 0.44

2018 Fac PE RVU:0.44

Result: Decrease

RUC Recommendation: 0.74

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

88188 Flow cytometry, interpretation; 9 to 15 markers

Global: XXX

Issue: Flow Cytometry Interpretation

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab 42

Specialty Developing Recommendation: CAP

First Identified: July 2015

2017 Est. Medicare Utilization: 33,346

2007 Work RVU: 1.69

2018 Work RVU: 1.20

2007 NF PE RVU: 0.54

2018 NF PE RVU: 0.54

2007 Fac PE RVU 0.54

2018 Fac PE RVU:0.54

Result: Decrease

RUC Recommendation: 1.40

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88189 Flow cytometry, interpretation; 16 or more markers				Global: XXX	Issue: Flow Cytometry Interpretation	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 42	Specialty Developing Recommendation:	CAP	First Identified: July 2015	2017 Est. Medicare Utilization: 207,125	2007 Work RVU: 2.23 2007 NF PE RVU: 0.68 2007 Fac PE RVU 0.68	2018 Work RVU: 1.70 2018 NF PE RVU: 0.68 2018 Fac PE RVU:0.68
RUC Recommendation: 1.70				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease	

88300	Level I - Surgical pathology, gross examination only			Global: XXX	Issue: Pathology Consultations	Screen: Havard Valued - Utilization over 1 Million / Low Value-Billed in Multiple Units / CMS Request - Final Rule for 2012	Complete? Yes
Most Recent RUC Meeting:	January 2012	Tab 24	Specialty Developing Recommendation:	AAD, AGA, CAP, ASGE	First Identified: February 2009	2017 Est. Medicare Utilization: 216,315	2007 Work RVU: 0.08 2007 NF PE RVU: 0.49 2007 Fac PE RVU NA 2018 Work RVU: 0.08 2018 NF PE RVU: 0.49 2018 Fac PE RVU:NA
RUC Recommendation:	0.08 and new PE inputs				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain

88302	Level II - Surgical pathology, gross and microscopic examination Appendix, incidental Fallopian tube, sterilization Fingers/toes, amputation, traumatic Foreskin, newborn Hernia sac, any location Hydrocele sac Nerve Skin, plastic repair Sympathetic ganglion Testis, castration Vaginal mucosa, incidental Vas deferens, sterilization				Global: XXX	Issue: Pathology Consultations	Screen: Havard Valued - Utilization over 1 Million / CMS Request - Final Rule for 2012	Complete? Yes
	Most Recent RUC Meeting: January 2012	Tab 24	Specialty Developing Recommendation:	AAD, AGA, CAP, ASGE	First Identified: February 2009	2017 Est. Medicare Utilization: 84,101	2007 Work RVU: 0.13 2007 NF PE RVU: 1.1 2007 Fac PE RVU NA	2018 Work RVU: 0.13 2018 NF PE RVU: 1.1 2018 Fac PE RVU:NA
	RUC Recommendation: 0.13 and new PE inputs				Referred to CPT		Result: Maintain	
					Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

88304	Level III - Surgical pathology, gross and microscopic examination Abortion, induced Abscess Aneurysm - arterial/ventricular Anus, tag Appendix, other than incidental Artery, atheromatous plaque Bartholin's gland cyst Bone fragment(s), other than pathologic fracture Bursa/synovial cyst Carpal tunnel tissue Cartilage, shavings Cholesteatoma Colon, colostomy stoma Conjunctiva - biopsy/pterygium Cornea Diverticulum - esophagus/small intestine Dupuytren's contracture tissue Femoral head, other than fracture Fissure/fistula Foreskin, other than newborn Gallbladder Ganglion cyst Hematoma Hemorrhoids Hydatid of Morgagni Intervertebral disc Joint, loose body Meniscus Mucocele, salivary Neuroma - Morton's/traumatic Pilonidal cyst/sinus Polyps, inflammatory - nasal/sinusoidal Skin - cyst/tag/debridement Soft tissue, debridement Soft tissue, lipoma Spermatocoele Tendon/tendon sheath Testicular appendage Thrombus or embolus Tonsil and/or adenoids Varicocele Vas deferens, other than sterilization Vein, varicosity			Global: XXX	Issue: Pathology Consultations	Screen: Havard Valued - Utilization over 1 Million / Low Value-High Volume / CMS Request - Final Rule for 2012	Complete? Yes
	Most Recent RUC Meeting: January 2012	Tab 24	Specialty Developing Recommendation:	AAD, AGA, CAP, ASGE	First Identified: October 2008	2017 Est. Medicare Utilization: 992,616	2007 Work RVU: 0.22 2007 NF PE RVU: 1.37 2007 Fac PE RVU NA Result: Maintain
RUC Recommendation: 0.22 and new PE inputs				Referred to CPT	Published in CPT Asst:		
				Referred to CPT Asst		<input type="checkbox"/>	

Status Report: CMS Requests and Relativity Assessment Issues

88305	Level IV - Surgical pathology, gross and microscopic examination Abortion - spontaneous/missed Artery, biopsy Bone marrow, biopsy Bone exostosis Brain/meninges, other than for tumor resection Breast, biopsy, not requiring microscopic evaluation of surgical margins Breast, reduction mammoplasty Bronchus, biopsy Cell block, any source Cervix, biopsy Colon, biopsy Duodenum, biopsy Endocervix, curettings/biopsy Endometrium, curettings/biopsy Esophagus, biopsy Extremity, amputation, traumatic Fallopian tube, biopsy Fallopian tube, ectopic pregnancy Femoral head, fracture Fingers/toes, amputation, non-traumatic Gingiva/oral mucosa, biopsy Heart valve Joint, resection Kidney, biopsy Larynx, biopsy Leiomyoma(s), uterine myomectomy - without uterus Lip, biopsy/wedge resection Lung, transbronchial biopsy Lymph node, biopsy Muscle, biopsy Nasal mucosa, biopsy Nasopharynx/oropharynx, biopsy Nerve, biopsy Odontogenic/dental cyst Omentum, biopsy Ovary with or without tube, non-neoplastic Ovary, biopsy/wedge resection Parathyroid gland Peritoneum, biopsy Pituitary tumor Placenta, other than third trimester Pleura/pericardium - biopsy/tissue Polyp, cervical/endometrial Polyp, colorectal Polyp, stomach/small intestine Prostate, needle biopsy Prostate, TUR Salivary gland, biopsy Sinus, paranasal biopsy Skin, other than cyst/tag/debridement/plastic repair Small intestine, biopsy Soft tissue, other than tumor/mass/lipoma/debridement Spleen Stomach, biopsy Synovium Testis, other than tumor/biopsy/castration Thyroglossal duct/brachial cleft cyst Tongue, biopsy Tonsil, biopsy Trachea, biopsy Ureter, biopsy Urethra, biopsy Urinary bladder, biopsy Uterus, with or without tubes and ovaries, for prolapse Vagina, biopsy Vulva/labia, biopsy				Global: XXX	Issue: Pathology Consultations	Screen: Havard Valued - Utilization over 1 Million / CMS Request - Final Rule for 2012	Complete? Yes
Most Recent RUC Meeting: January 2012		Tab 24	Specialty Developing Recommendation:	AAD, AGA, CAP, ASGE	First Identified: October 2008	2017 Est. Medicare Utilization: 17,292,392	2007 Work RVU: 0.75 2007 NF PE RVU: 1.97 2007 Fac PE RVU: NA Result: Maintain	2018 Work RVU: 0.75 2018 NF PE RVU: 1.97 2018 Fac PE RVU: NA
RUC Recommendation: 0.75 and new PE inputs					Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

88307 Level V - Surgical pathology, gross and microscopic examination Adrenal, resection Bone - biopsy/curettings Bone fragment(s), pathologic fracture Brain, biopsy Brain/meninges, tumor resection Breast, excision of lesion, requiring microscopic evaluation of surgical margins Breast, mastectomy - partial/simple Cervix, conization Colon, segmental resection, other than for tumor Extremity, amputation, non-traumatic Eye, enucleation Kidney, partial/total nephrectomy Larynx, partial/total resection Liver, biopsy - needle/wedge Liver, partial resection Lung, wedge biopsy Lymph nodes, regional resection Mediastinum, mass Myocardium, biopsy Odontogenic tumor Ovary with or without tube, neoplastic Pancreas, biopsy Placenta, third trimester Prostate, except radical resection Salivary gland Sentinel lymph node Small intestine, resection, other than for tumor Soft tissue mass (except lipoma) - biopsy/simple excision Stomach - subtotal/total resection, other than for tumor Testis, biopsy Thymus, tumor Thyroid, total/lobe Ureter, resection Urinary bladder, TUR Uterus, with or without tubes and ovaries, other than neoplastic/prolapse

Global: XXX

Issue: Pathology Consultations

Screen: Havard Valued - Utilization over 1 Million / CMS Request- Final Rule for 2012

Complete? Yes

Most Recent
RUC Meeting: January 2012

Tab 24

Specialty Developing
Recommendation: AAD, AGA, CAP, ASGE

First
Identified: February 2009

2017 Est.
Medicare
Utilization: 968,656

2007 Work RVU: 1.59

2018 Work RVU: 1.59

2007 NF PE RVU: 3.48

2018 NF PE RVU: 3.48

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 1.59 and new PE inputs

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

88309 Level VI - Surgical pathology, gross and microscopic examination Bone resection Breast, mastectomy - with regional lymph nodes Colon, segmental resection for tumor Colon, total resection Esophagus, partial/total resection Extremity, disarticulation Fetus, with dissection Larynx, partial/total resection - with regional lymph nodes Lung - total/lobe/segment resection Pancreas, total/subtotal resection Prostate, radical resection Small intestine, resection for tumor Soft tissue tumor, extensive resection Stomach - subtotal/total resection for tumor Testis, tumor Tongue/tonsil -resection for tumor Urinary bladder, partial/total resection Uterus, with or without tubes and ovaries, neoplastic Vulva, total/subtotal resection

Global: XXX

Issue: Pathology Services

Screen: Havard Valued - Utilization over 1 Million / CMS Request- Final Rule for 2012

Complete? Yes

Most Recent
RUC Meeting: January 2012

Tab 24

Specialty Developing
Recommendation: AAD, AGA, CAP, ASGE

First
Identified: February 2009

2017 Est.
Medicare
Utilization: 152,571

2007 Work RVU: 2.80

2018 Work RVU: 2.80

2007 NF PE RVU: 4.86

2018 NF PE RVU: 4.86

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 2.80 and new PE inputs

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

88312 Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver) **Global:** XXX **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012

Tab 33 Specialty Developing Recommendation: CAP

First Identified: October 2008

2017 Est. Medicare Utilization: 1,383,645

2007 Work RVU: 0.54

2018 Work RVU: 0.54

2007 NF PE RVU: 1.76

2018 NF PE RVU: 1.76

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.54

Referred to CPT June 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

88313 Special stain including interpretation and report; Group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry

Global: XXX **Issue:** Special Stains

Screen: Havard Valued - Utilization over 1 Million / Low Value-High Volume

Complete? Yes

Most Recent RUC Meeting: February 2011

Tab 33 Specialty Developing Recommendation: CAP

First Identified: October 2008

2017 Est. Medicare Utilization: 1,390,871

2007 Work RVU: 0.24

2018 Work RVU: 0.24

2007 NF PE RVU: 1.42

2018 NF PE RVU: 1.42

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.24

Referred to CPT June 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

88314 Special stain including interpretation and report; histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)

Global: XXX **Issue:** Special Stains

Screen: Havard Valued - Utilization over 1 Million

Complete? Yes

Most Recent RUC Meeting: February 2011

Tab 33 Specialty Developing Recommendation: CAP

First Identified: February 2009

2017 Est. Medicare Utilization: 19,944

2007 Work RVU: 0.45

2018 Work RVU: 0.45

2007 NF PE RVU: 2.04

2018 NF PE RVU: 2.04

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.45

Referred to CPT June 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88318	Deleted from CPT			Global: XXX	Issue: Special Stains	Screen: Havard Valued - Utilization over 1 Million	Complete? Yes
Most Recent RUC Meeting:	February 2010	Tab 22	Specialty Developing Recommendation:	CAP, AAD	First Identified:	2017 Est. Medicare Utilization:	
RUC Recommendation:	Deleted from CPT				Referred to CPT	June 2010	
					Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:
						2007 Work RVU: 0.42	2018 Work RVU:
						2007 NF PE RVU: 1.98	2018 NF PE RVU: 1.98
						2007 Fac PE RVU NA	2018 Fac PE RVU: NA
						Result: Deleted from CPT	

88319	Special stain including interpretation and report; Group III, for enzyme constituents			Global: XXX	Issue: Special Stains	Screen: Havard Valued - Utilization over 1 Million	Complete? Yes
Most Recent RUC Meeting:	February 2011	Tab 33	Specialty Developing Recommendation:	CAP	First Identified:	2017 Est. Medicare Utilization:	
RUC Recommendation:	0.53				Referred to CPT	June 2010	
					Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:
						2007 Work RVU: 0.53	2018 Work RVU: 0.53
						2007 NF PE RVU: 3.36	2018 NF PE RVU: 3.36
						2007 Fac PE RVU NA	2018 Fac PE RVU: NA
						Result: Maintain	

88321	Consultation and report on referred slides prepared elsewhere			Global: XXX	Issue: Microslide Consultation	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting:	January 2016	Tab 43	Specialty Developing Recommendation:	CAP, ASC	First Identified:	July 2015	
RUC Recommendation:	1.63				Referred to CPT		
					Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:
						2017 Est. Medicare Utilization:	
						184,911	
						2007 Work RVU: 1.63	2018 Work RVU: 1.63
						2007 NF PE RVU: 0.78	2018 NF PE RVU: 0.78
						2007 Fac PE RVU 0.54	2018 Fac PE RVU: 0.54
						Result: Maintain	

88323	Consultation and report on referred material requiring preparation of slides			Global: XXX	Issue: Microslide Consultation	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting:	January 2016	Tab 43	Specialty Developing Recommendation:	CAP, ASC	First Identified:	July 2015	
RUC Recommendation:	1.83				Referred to CPT		
					Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:
						2017 Est. Medicare Utilization:	
						33,588	
						2007 Work RVU: 1.83	2018 Work RVU: 1.83
						2007 NF PE RVU: 1.88	2018 NF PE RVU: 1.88
						2007 Fac PE RVU NA	2018 Fac PE RVU: NA
						Result: Maintain	

Status Report: CMS Requests and Relativity Assessment Issues

88325 Consultation, comprehensive, with review of records and specimens, with report on referred material **Global:** XXX **Issue:** Microslide Consultation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 43 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 9,295 **2007 Work RVU:** 2.50 **2018 Work RVU:** 2.85 **2007 NF PE RVU:** 2.76 **2018 NF PE RVU:** 2.76 **2007 Fac PE RVU:** 0.87 **2018 Fac PE RVU:** 0.87

RUC Recommendation: 2.85

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

88329 Pathology consultation during surgery; **Global:** XXX **Issue:** Pathology Consultation During Surgery **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 18 **Specialty Developing Recommendation:** CAP **First Identified:** February 2010 **2017 Est. Medicare Utilization:** 30,466 **2007 Work RVU:** 0.67 **2018 Work RVU:** 0.67 **2007 NF PE RVU:** 0.66 **2018 NF PE RVU:** 0.66 **2007 Fac PE RVU:** 0.27 **2018 Fac PE RVU:** 0.27

RUC Recommendation: 0.67

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

88331 Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen **Global:** XXX **Issue:** Pathology Consultation During Surgery **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 18 **Specialty Developing Recommendation:** CAP **First Identified:** October 2009 **2017 Est. Medicare Utilization:** 494,832 **2007 Work RVU:** 1.19 **2018 Work RVU:** 1.19 **2007 NF PE RVU:** 1.14 **2018 NF PE RVU:** 1.14 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA

RUC Recommendation: 1.19

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

88332 Pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure) **Global:** XXX **Issue:** Pathology Consultation During Surgery **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 18 **Specialty Developing Recommendation:** CAP **First Identified:** October 2009 **2017 Est. Medicare Utilization:** 176,784 **2007 Work RVU:** 0.59 **2018 Work RVU:** 0.59 **2007 NF PE RVU:** 0.46 **2018 NF PE RVU:** 0.46 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA

RUC Recommendation: 0.59

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

88333 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site **Global:** XXX **Issue:** Pathology Consultation During Surgery **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016

Tab 39 Specialty Developing Recommendation: ASC, CAP

First Identified: July 2015

2017 Est. Medicare Utilization: 68,280

2007 Work RVU: 1.20

2018 Work RVU: 1.20

2007 NF PE RVU: 1.15

2018 NF PE RVU: 1.15

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Maintain

RUC Recommendation: 1.20

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

88334 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Pathology Consultation During Surgery **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016

Tab 39 Specialty Developing Recommendation: ASC, CAP

First Identified: July 2015

2017 Est. Medicare Utilization: 32,880

2007 Work RVU: 0.73

2018 Work RVU: 0.73

2007 NF PE RVU: 0.65

2018 NF PE RVU: 0.65

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Maintain

RUC Recommendation: 0.73

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

88341 Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 21 Specialty Developing Recommendation: CAP

First Identified: November 2013

2017 Est. Medicare Utilization: 2,780,046

2007 Work RVU:

2018 Work RVU: 0.56

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 0.65

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

88342	Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure	Global: XXX	Issue: Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s)	Screen: CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 21 Specialty Developing Recommendation: CAP	First Identified: April 2011	2017 Est. Medicare Utilization: 1,848,048	2007 Work RVU: 0.85 2007 NF PE RVU: 1.6 2007 Fac PE RVU: NA Result: Decrease	2018 Work RVU: 0.70 2018 NF PE RVU: 1.6 2018 Fac PE RVU: NA
RUC Recommendation: 0.70		Referred to CPT May 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
88343	Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; each additional separately identifiable antibody per slide (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s)	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 21 Specialty Developing Recommendation: CAP	First Identified: November 2013	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: Deleted from CPT		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
88344	Immunohistochemistry or immunocytochemistry, per specimen; each multiplex antibody stain procedure	Global: XXX	Issue: Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s)	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 21 Specialty Developing Recommendation: CAP	First Identified: November 2013	2017 Est. Medicare Utilization: 99,915	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Decrease	2018 Work RVU: 0.77 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.77		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

88346 Immunofluorescence, per specimen; initial single antibody stain procedure **Global:** XXX **Issue:** Immunofluorescent Studies **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015

Tab 17 **Specialty Developing Recommendation:** CAP, ASC

First Identified: April 2013

2017 Est. Medicare Utilization: 58,079

2007 Work RVU: 0.86

2018 Work RVU: 0.74

2007 NF PE RVU: 1.67

2018 NF PE RVU: 1.67

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 0.74

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

88347 Immunofluorescent study, each antibody; indirect method

Global: XXX **Issue:** Immunofluorescent Studies **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015

Tab 17 **Specialty Developing Recommendation:** CAP, ASC

First Identified: October 2013

2017 Est. Medicare Utilization:

2007 Work RVU: 0.86

2018 Work RVU:

2007 NF PE RVU: 1.28

2018 NF PE RVU: 1.28

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

88348 Electron microscopy, diagnostic

Global: XXX **Issue:** Electron Microscopy-PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: October 2013

Tab 14 **Specialty Developing Recommendation:** CAP

First Identified: October 2012

2017 Est. Medicare Utilization: 15,790

2007 Work RVU: 1.51

2018 Work RVU: 1.51

2007 NF PE RVU: 11.48

2018 NF PE RVU: 11.48

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: PE Only

RUC Recommendation: New PE Inputs

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88349 Electron microscopy; scanning

Global: XXX

Issue: Electron Microscopy-PE Only

Screen: Services with Stand-Alone PE Procedure Time

Complete? Yes

Most Recent RUC Meeting: October 2013

Tab 14

Specialty Developing Recommendation: CAP

First Identified: October 2012

2017 Est. Medicare Utilization:

2007 Work RVU: 0.76

2018 Work RVU:

2007 NF PE RVU: 4.88

2018 NF PE RVU: 4.88

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT Oct 2013

Referred to CPT Asst ☐ **Published in CPT Asst:**

88350 Immunofluorescence, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)

Global: ZZZ

Issue: Immunofluorescent Studies

Screen: CMS-Other - Utilization over 250,000

Complete? Yes

Most Recent RUC Meeting: January 2015

Tab 17

Specialty Developing Recommendation: CAP, ASC

First Identified: October 2014

2017 Est. Medicare Utilization: 235,286

2007 Work RVU:

2018 Work RVU: 0.59

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 0.70

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

88356 Morphometric analysis; nerve

Global: XXX

Issue: RAW

Screen: High Volume Growth2

Complete? Yes

Most Recent RUC Meeting: April 2014

Tab 37

Specialty Developing Recommendation: ASCP, CAP

First Identified: April 2013

2017 Est. Medicare Utilization: 14,853

2007 Work RVU: 3.02

2018 Work RVU: 2.80

2007 NF PE RVU: 4.79

2018 NF PE RVU: 4.79

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 2.80

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88360 Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; manual **Global:** XXX **Issue:** Tumor Immunohistochemistry **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016

Tab 40 Specialty Developing Recommendation: ASC, CAP

First Identified: July 2015

2017 Est. Medicare Utilization: 429,143

2007 Work RVU: 1.10

2018 Work RVU: 0.85

2007 NF PE RVU: 1.87

2018 NF PE RVU: 1.87

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 0.85

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

88361 Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; using computer-assisted technology **Global:** XXX **Issue:** Tumor Immunohistochemistry **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016

Tab 40 Specialty Developing Recommendation: ASC, CAP

First Identified: July 2015

2017 Est. Medicare Utilization: 168,651

2007 Work RVU: 1.18

2018 Work RVU: 0.95

2007 NF PE RVU: 2.94

2018 NF PE RVU: 2.94

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 0.95

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

88364 In situ hybridization (eg, FISH), per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 21 Specialty Developing Recommendation: CAP, ASCP, ASC

First Identified: November 2013

2017 Est. Medicare Utilization: 22,900

2007 Work RVU:

2018 Work RVU: 0.70

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 0.88

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88365	In situ hybridization (eg, FISH), per specimen; initial single probe stain procedure	Global: XXX	Issue: Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s)	Screen: CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 / CMS Request Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 21	Specialty Developing Recommendation: CAP	First Identified: September 2011	2017 Est. Medicare Utilization: 39,901	2007 Work RVU: 1.20 2007 NF PE RVU: 2.32 2007 Fac PE RVU NA 2018 Work RVU: 0.88 2018 NF PE RVU: 2.32 2018 Fac PE RVU: NA
RUC Recommendation: 0.88			Referred to CPT May 2013 Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Dec 2011 & May 2012	Result: Decrease
88366	In situ hybridization (eg, FISH), per specimen; each multiplex probe stain procedure	Global: XXX	Issue: Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s)	Screen: CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 21	Specialty Developing Recommendation: CAP, ASCP, ASC	First Identified: May 2013	2017 Est. Medicare Utilization: 1,637	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU 2018 Work RVU: 1.24 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.24			Referred to CPT May 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease
88367	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; initial single probe stain procedure	Global: XXX	Issue: Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s)	Screen: CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 / CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: September 2014	Tab 18	Specialty Developing Recommendation: CAP, ASCP, ASC	First Identified: September 2011	2017 Est. Medicare Utilization: 6,036	2007 Work RVU: 1.30 2007 NF PE RVU: 4.31 2007 Fac PE RVU NA 2018 Work RVU: 0.73 2018 NF PE RVU: 4.31 2018 Fac PE RVU: NA
RUC Recommendation: 0.86			Referred to CPT May 2013 Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Dec 2011 & May 2012	Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

88368 Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; initial single probe stain procedure **Global:** XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab** 18 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 23,090 **2007 Work RVU:** 1.40 **2018 Work RVU:** 0.88 **2007 NF PE RVU:** 2.96 **2018 NF PE RVU:** 2.96 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **RUC Recommendation:** 0.88 **Referred to CPT:** May 2013 **Referred to CPT Asst:** ☒ **Published in CPT Asst:** Dec 2011 & May 2012 **Result:** Decrease

88373 Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 21 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** November 2013 **2017 Est. Medicare Utilization:** 7,516 **2007 Work RVU:** **2018 Work RVU:** 0.58 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** 0.86 **Referred to CPT:** **Referred to CPT Asst:** ☐ **Published in CPT Asst:** **Result:** Decrease

88374 Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; each multiplex probe stain procedure **Global:** XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab** 21 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** **2017 Est. Medicare Utilization:** 97,621 **2007 Work RVU:** **2018 Work RVU:** 0.93 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** 1.04 **Referred to CPT:** **Referred to CPT Asst:** ☐ **Published in CPT Asst:** **Result:** Decrease

Status Report: CMS Requests and Relativity Assessment Issues

88377 Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; each multiplex probe stain procedure **Global:** XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 21

Specialty Developing Recommendation:

CAP, ASCP, ASC

First Identified: May 2013

2017 Est. Medicare Utilization: 148,019

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 1.40
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.40

Referred to CPT May 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

90465 Deleted from CPT

Global: XXX

Issue: Immunization Administration

Screen: CMS Request - Practice Expense Review

Complete? Yes

Most Recent RUC Meeting: February 2008

Tab R

Specialty Developing Recommendation:

AAP

First Identified: NA

2017 Est. Medicare Utilization:

2007 Work RVU: 0.17
2007 NF PE RVU: 0.35
2007 Fac PE RVU NA
Result: PE Only

2018 Work RVU:
2018 NF PE RVU: 0.35
2018 Fac PE RVU: NA

RUC Recommendation: New PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

90467 Deleted from CPT

Global: XXX

Issue: Immunization Administration

Screen: CMS Request - Practice Expense Review

Complete? Yes

Most Recent RUC Meeting: February 2008

Tab R

Specialty Developing Recommendation:

AAP

First Identified: NA

2017 Est. Medicare Utilization:

2007 Work RVU: 0.17
2007 NF PE RVU: 0.17
2007 Fac PE RVU 0.09
Result: PE Only

2018 Work RVU:
2018 NF PE RVU: 0.17
2018 Fac PE RVU: 0.09

RUC Recommendation: New PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid) **Global:** XXX **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review / CMS Fastest Growing **Complete?** Yes

Most Recent
RUC Meeting: February 2008

Tab R

Specialty Developing AAP
Recommendation:

First
Identified: February 2008

2017 Est.
Medicare
Utilization: 329,160

2007 Work RVU: 0.17

2018 Work RVU: 0.17

2007 NF PE RVU: 0.35

2018 NF PE RVU: 0.35

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: PE Only

RUC Recommendation: New PE inputs

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

90472 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

Global: ZZZ

Issue: Immunization Administration

Screen: CMS Request - Practice Expense Review

Complete? Yes

Most Recent
RUC Meeting: February 2008

Tab R

Specialty Developing AAP
Recommendation:

First
Identified: February 2008

2017 Est.
Medicare
Utilization: 26,046

2007 Work RVU: 0.15

2018 Work RVU: 0.15

2007 NF PE RVU: 0.13

2018 NF PE RVU: 0.13

2007 Fac PE RVU 0.11

2018 Fac PE RVU:0.11

Result: PE Only

RUC Recommendation: New PE inputs

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

90473 Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)

Global: XXX

Issue: Immunization Administration

Screen: CMS Request - Practice Expense Review

Complete? Yes

Most Recent
RUC Meeting: February 2008

Tab R

Specialty Developing AAP
Recommendation:

First
Identified: NA

2017 Est.
Medicare
Utilization: 1

2007 Work RVU: 0.17

2018 Work RVU: 0.17

2007 NF PE RVU: 0.18

2018 NF PE RVU: 0.18

2007 Fac PE RVU 0.06

2018 Fac PE RVU:0.06

Result: PE Only

RUC Recommendation: New PE inputs

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Immunization Administration	Screen: CMS Request - Practice Expense Review	Complete? Yes
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Most Recent RUC Meeting: February 2008	Tab R	Specialty Developing Recommendation: AAP	First Identified: NA	2017 Est. Medicare Utilization: 2	2007 Work RVU: 0.15	2018 Work RVU: 0.15
					2007 NF PE RVU: 0.09	2018 NF PE RVU: 0.09
					2007 Fac PE RVU 0.05	2018 Fac PE RVU: 0.05
RUC Recommendation: New PE inputs			Referred to CPT		Result: PE Only	
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

90785	Interactive complexity (List separately in addition to the code for primary procedure)	Global: ZZZ	Issue: Psychotherapy for Crisis and Interactive Complexity	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
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Most Recent RUC Meeting: April 2013	Tab 35	Specialty Developing Recommendation: APA, APA (HCPAC), NASW	First Identified: April 2013	2017 Est. Medicare Utilization: 435,675	2007 Work RVU:	2018 Work RVU: 0.33
					2007 NF PE RVU:	2018 NF PE RVU:
					2007 Fac PE RVU	2018 Fac PE RVU:
RUC Recommendation: 0.33			Referred to CPT February 2012		Result: Increase	
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

90791	Psychiatric diagnostic evaluation	Global: XXX	Issue: Psychotherapy	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
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Most Recent RUC Meeting: April 2012	Tab 26	Specialty Developing Recommendation: APA, APA (HCPAC), NASW	First Identified: April 2013	2017 Est. Medicare Utilization: 923,991	2007 Work RVU:	2018 Work RVU: 3.00
					2007 NF PE RVU:	2018 NF PE RVU:
					2007 Fac PE RVU	2018 Fac PE RVU:
RUC Recommendation: 3.00			Referred to CPT February 2012		Result: Increase	
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

90792 Psychiatric diagnostic evaluation with medical services

Global: XXX Issue: Psychotherapy

Screen: CMS High Expenditure
Procedural Codes1

Complete? Yes

Most Recent
RUC Meeting: April 2012

Tab 26

Specialty Developing
Recommendation: APA, APA
(HCPAC),
NASW

First
Identified: April 2013

2017 Est.
Medicare
Utilization: 569,037

2007 Work RVU:

2018 Work RVU: 3.25

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: 3.25

Referred to CPT February 2012

Referred to CPT Asst ☐ Published in CPT Asst:

Result: Increase

90801 Psychiatric diagnostic interview examination

Global: 000 Issue: RAW review

Screen: CMS High Expenditure
Procedural Codes1

Complete? Yes

Most Recent
RUC Meeting: January 2012

Tab 30

Specialty Developing
Recommendation:

First
Identified: September 2011

2017 Est.
Medicare
Utilization:

2007 Work RVU: 2.80

2018 Work RVU:

2007 NF PE RVU: 1.25

2018 NF PE RVU: 1.25

2007 Fac PE RVU 0.85

2018 Fac PE RVU:0.85

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012

Referred to CPT Asst ☐ Published in CPT Asst:

Result: Deleted from CPT

90805 Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services

Global: 000 Issue: RAW review

Screen: CMS High Expenditure
Procedural Codes1

Complete? Yes

Most Recent
RUC Meeting: January 2012

Tab 30

Specialty Developing
Recommendation:

First
Identified: September 2011

2017 Est.
Medicare
Utilization:

2007 Work RVU: 1.37

2018 Work RVU:

2007 NF PE RVU: 0.53

2018 NF PE RVU: 0.53

2007 Fac PE RVU 0.38

2018 Fac PE RVU:0.38

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012

Referred to CPT Asst ☐ Published in CPT Asst:

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;	Global: 000	Issue: RAW review	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
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Most Recent RUC Meeting: January 2012

Tab 30 **Specialty Developing Recommendation:**

First Identified: September 2011

2017 Est. Medicare Utilization:

2007 Work RVU: 1.86

2018 Work RVU:

2007 NF PE RVU: 0.66

2018 NF PE RVU: 0.66

2007 Fac PE RVU 0.53

2018 Fac PE RVU:0.53

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;	Global: XXX	Issue: RAW review	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
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Most Recent RUC Meeting: January 2012

Tab 30 **Specialty Developing Recommendation:**

First Identified: September 2011

2017 Est. Medicare Utilization:

2007 Work RVU: 2.79

2018 Work RVU:

2007 NF PE RVU: 0.94

2018 NF PE RVU: 0.94

2007 Fac PE RVU 0.8

2018 Fac PE RVU:0.8

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;	Global: XXX	Issue: RAW review	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
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Most Recent RUC Meeting: January 2012

Tab 30 **Specialty Developing Recommendation:**

First Identified: September 2011

2017 Est. Medicare Utilization:

2007 Work RVU: 1.89

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 0.63

2018 Fac PE RVU:0.63

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90832 Psychotherapy, 30 minutes with patient

Global: XXX

Issue: Psychotherapy

Screen: CMS High Expenditure
Procedural Codes1

Complete? Yes

Most Recent
RUC Meeting: April 2012

Tab 26

Specialty Developing
Recommendation:

APA, APA
(HCPAC),
NASW

First
Identified: April 2013

2017 Est.
Medicare
Utilization: 2,442,027

2007 Work RVU:

2018 Work RVU: 1.50

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 1.50

Referred to CPT February 2012

Referred to CPT Asst ☐ Published in CPT Asst:

90833 Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

Global: ZZZ

Issue: Psychotherapy

Screen: CMS High Expenditure
Procedural Codes1

Complete? Yes

Most Recent
RUC Meeting: April 2012

Tab 26

Specialty Developing
Recommendation:

APA, APA
(HCPAC),
NASW

First
Identified: April 2013

2017 Est.
Medicare
Utilization: 1,386,282

2007 Work RVU:

2018 Work RVU: 1.50

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 1.50

Referred to CPT February 2012

Referred to CPT Asst ☐ Published in CPT Asst:

90834 Psychotherapy, 45 minutes with patient

Global: XXX

Issue: Psychotherapy

Screen: CMS High Expenditure
Procedural Codes1

Complete? Yes

Most Recent
RUC Meeting: April 2012

Tab 26

Specialty Developing
Recommendation:

APA, APA
(HCPAC),
NASW

First
Identified: April 2013

2017 Est.
Medicare
Utilization: 5,252,053

2007 Work RVU:

2018 Work RVU: 2.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 2.00

Referred to CPT February 2012

Referred to CPT Asst ☐ Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

90836 Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure) **Global:** ZZZ **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012

Tab 26 Specialty Developing Recommendation: APA, APA (HCPAC), NASW

First Identified: April 2013

2017 Est. Medicare Utilization: 551,525

2007 Work RVU:

2018 Work RVU: 1.90

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 1.90

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

90837 Psychotherapy, 60 minutes with patient

Global: XXX **Issue:** Psychotherapy

Screen: CMS High Expenditure Procedural Codes1

Complete? Yes

Most Recent RUC Meeting: April 2012

Tab 26 Specialty Developing Recommendation: APA, APA (HCPAC), NASW

First Identified: April 2013

2017 Est. Medicare Utilization: 5,699,272

2007 Work RVU:

2018 Work RVU: 3.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 3.00

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

90838 Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure) **Global:** ZZZ **Issue:** Psychotherapy

Screen: CMS High Expenditure Procedural Codes1

Complete? Yes

Most Recent RUC Meeting: April 2012

Tab 26 Specialty Developing Recommendation: APA, APA (HCPAC), NASW

First Identified: April 2013

2017 Est. Medicare Utilization: 102,023

2007 Work RVU:

2018 Work RVU: 2.50

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 2.50

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90839 Psychotherapy for crisis; first 60 minutes

Global: XXX

Issue: Psychotherapy for Crisis and Interactive Complexity

Screen: CMS High Expenditure Procedural Codes¹

Complete? Yes

Most Recent
RUC Meeting: April 2013

Tab 35

Specialty Developing
Recommendation: APA, APA (HCPAC), NASW

First
Identified: April 2013

2017 Est.
Medicare
Utilization: 22,668

2007 Work RVU:

2018 Work RVU: 3.13

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 3.13

Referred to CPT February 2012

Referred to CPT Asst ☐ Published in CPT Asst:

90840 Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)

Global: ZZZ

Issue: Psychotherapy for Crisis and Interactive Complexity

Screen: CMS High Expenditure Procedural Codes¹

Complete? Yes

Most Recent
RUC Meeting: April 2013

Tab 35

Specialty Developing
Recommendation: APA, APA (HCPAC), NASW

First
Identified: April 2013

2017 Est.
Medicare
Utilization: 6,481

2007 Work RVU:

2018 Work RVU: 1.50

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 1.50

Referred to CPT February 2012

Referred to CPT Asst ☐ Published in CPT Asst:

90845 Psychoanalysis

Global: XXX

Issue: Psychotherapy

Screen: CMS High Expenditure Procedural Codes¹

Complete? Yes

Most Recent
RUC Meeting: October 2011

Tab

Specialty Developing
Recommendation:

First
Identified: April 2013

2017 Est.
Medicare
Utilization: 5,222

2007 Work RVU: 1.79

2018 Work RVU: 2.10

2007 NF PE RVU: 0.53

2018 NF PE RVU: 0.53

2007 Fac PE RVU 0.49

2018 Fac PE RVU: 0.49

Result: Increase

RUC Recommendation: 2.10

Referred to CPT

Referred to CPT Asst ☐ Published in CPT Asst:

90846 Family psychotherapy (without the patient present), 50 minutes

Global: XXX

Issue: Psychotherapy

Screen: CMS High Expenditure Procedural Codes¹

Complete? Yes

Most Recent
RUC Meeting: April 2012

Tab 26

Specialty Developing
Recommendation: APA, APA (HCPAC), NASW

First
Identified: April 2013

2017 Est.
Medicare
Utilization: 22,737

2007 Work RVU: 1.83

2018 Work RVU: 2.40

2007 NF PE RVU: 0.62

2018 NF PE RVU: 0.62

2007 Fac PE RVU 0.6

2018 Fac PE RVU: 0.6

Result: Increase

RUC Recommendation: 2.40

Referred to CPT February 2012

Referred to CPT Asst ☐ Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes		Global: XXX	Issue: Psychotherapy	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 26	Specialty Developing Recommendation: APA, APA (HCPAC), NASW	First Identified: April 2013	2017 Est. Medicare Utilization: 183,080	2007 Work RVU: 2.21 2007 NF PE RVU: 0.8 2007 Fac PE RVU: 0.69 Result: Increase	2018 Work RVU: 2.50 2018 NF PE RVU: 0.8 2018 Fac PE RVU: 0.69
RUC Recommendation: 2.50			Referred to CPT February 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>						
90853	Group psychotherapy (other than of a multiple-family group)		Global: XXX	Issue: Psychotherapy	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 26	Specialty Developing Recommendation: APA, APA (HCPAC), NASW	First Identified: April 2013	2017 Est. Medicare Utilization: 1,038,538	2007 Work RVU: 0.59 2007 NF PE RVU: 0.26 2007 Fac PE RVU: 0.22 Result: Maintain	2018 Work RVU: 0.59 2018 NF PE RVU: 0.26 2018 Fac PE RVU: 0.22
RUC Recommendation: 0.59			Referred to CPT February 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>						
90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy		Global: XXX	Issue: RAW review	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: January 2012	Tab 30	Specialty Developing Recommendation:	First Identified: September 2011	2017 Est. Medicare Utilization:	2007 Work RVU: 0.95 2007 NF PE RVU: 0.46 2007 Fac PE RVU: 0.31 Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 0.46 2018 Fac PE RVU: 0.31
RUC Recommendation: Deleted from CPT			Referred to CPT February 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
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Status Report: CMS Requests and Relativity Assessment Issues

90863 Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure) **Global:** XXX **Issue:** Pharmacologic Management with Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab** 40 **Specialty Developing Recommendation:** APA (HCPAC) **First Identified:** April 2013 **2017 Est. Medicare Utilization:** **2007 Work RVU:** **2018 Work RVU:** 0.48 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Increase **2018 Fac PE RVU:**

RUC Recommendation: 0.48 **Referred to CPT** February 2012 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

90868 Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session **Global:** 000 **Issue:** **Screen:** Contractor Priced High Volume **Complete?** No

Most Recent RUC Meeting: April 2018 **Tab** 33 **Specialty Developing Recommendation:** **First Identified:** January 2018 **2017 Est. Medicare Utilization:** 119,822 **2007 Work RVU:** **2018 Work RVU:** 0.00 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** **2018 Fac PE RVU:**

RUC Recommendation: Review in 2 years (Oct 2020) **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

90870 Electroconvulsive therapy (includes necessary monitoring) **Global:** 000 **Issue:** Electroconvulsive Therapy **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 41 **Specialty Developing Recommendation:** APA **First Identified:** October 2009 **2017 Est. Medicare Utilization:** 136,881 **2007 Work RVU:** 1.88 **2018 Work RVU:** 2.50 **2007 NF PE RVU:** 1.93 **2018 NF PE RVU:** 1.93 **2007 Fac PE RVU Result:** Increase **2018 Fac PE RVU:** 0.54

RUC Recommendation: 2.50 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

908XX **Global:** **Issue:** Biofeedback Training **Screen:** Negative IWPUT **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2018 **2017 Est. Medicare Utilization:** **2007 Work RVU:** **2018 Work RVU:** **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** **2018 Fac PE RVU:**

RUC Recommendation: **Referred to CPT** September 2018 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90911	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry	Global: 000	Issue: Biofeedback Training	Screen: Negative IWPUT	Complete? No
Most Recent RUC Meeting: April 2018	Tab 27 Specialty Developing Recommendation: ACOG, AUA	First Identified: April 2017	2017 Est. Medicare Utilization: 26,133	2007 Work RVU: 0.89 2007 NF PE RVU: 1.51 2007 Fac PE RVU: 0.31	2018 Work RVU: 0.89 2018 NF PE RVU: 1.51 2018 Fac PE RVU: 0.31
RUC Recommendation: Refer to CPT		Referred to CPT September 2018 Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

90935	Hemodialysis procedure with single evaluation by a physician or other qualified health care professional	Global: 000	Issue: Hemodialysis-Dialysis Services	Screen: Havard Valued - Utilization over 1 Million	Complete? Yes
Most Recent RUC Meeting: October 2009	Tab 30 Specialty Developing Recommendation: RPA	First Identified: October 2008	2017 Est. Medicare Utilization: 1,148,499	2007 Work RVU: 1.22 2007 NF PE RVU: NA 2007 Fac PE RVU: 0.64	2018 Work RVU: 1.48 2018 NF PE RVU: NA 2018 Fac PE RVU: 0.64
RUC Recommendation: 1.48		Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

90937	Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription	Global: 000	Issue: Hemodialysis-Dialysis Services	Screen: Havard Valued - Utilization over 1 Million	Complete? Yes
Most Recent RUC Meeting: October 2009	Tab 30 Specialty Developing Recommendation: RPA	First Identified: February 2009	2017 Est. Medicare Utilization: 54,853	2007 Work RVU: 2.11 2007 NF PE RVU: NA 2007 Fac PE RVU: 0.93	2018 Work RVU: 2.11 2018 NF PE RVU: NA 2018 Fac PE RVU: 0.93
RUC Recommendation: 2.11		Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

90945 Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional **Global:** 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 30 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2017 Est. Medicare Utilization:** 157,045 **2007 Work RVU:** 1.28 **2018 Work RVU:** 1.56 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 0.66 **2018 Fac PE RVU:** 0.66 **RUC Recommendation:** 1.56 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Increase

90947 Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated evaluations by a physician or other qualified health care professional, with or without substantial revision of dialysis prescription **Global:** 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab** 30 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2017 Est. Medicare Utilization:** 13,085 **2007 Work RVU:** 2.16 **2018 Work RVU:** 2.52 **2007 NF PE RVU:** NA **2018 NF PE RVU:** NA **2007 Fac PE RVU:** 0.94 **2018 Fac PE RVU:** 0.94 **RUC Recommendation:** 2.52 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Increase

90951 End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2017 Est. Medicare Utilization:** 43 **2007 Work RVU:** **2018 Work RVU:** 18.46 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** RUC Recommended revised clinical staff time **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** PE Only

Status Report: CMS Requests and Relativity Assessment Issues

90952 End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent
RUC Meeting: April 2009

Tab 29 **Specialty Developing** RPA
Recommendation:

First
Identified: February 2009

2017 Est.
Medicare
Utilization: 3

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU: 0.00
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: RUC Recommended revised clinical staff time

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

90953 End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent
RUC Meeting: April 2009

Tab 29 **Specialty Developing** RPA
Recommendation:

First
Identified: February 2009

2017 Est.
Medicare
Utilization: 14

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU: 0.00
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: RUC Recommended revised clinical staff time

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

90954 End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent
RUC Meeting: April 2009

Tab 29 **Specialty Developing** RPA
Recommendation:

First
Identified: February 2009

2017 Est.
Medicare
Utilization: 531

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU: 15.98
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: RUC Recommended revised clinical staff time

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90955 End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent
RUC Meeting: April 2009

Tab 29 **Specialty Developing** RPA
Recommendation:

First
Identified: February 2009

2017 Est.
Medicare
Utilization: 95

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU: 8.79
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: RUC Recommended revised clinical staff time

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

90956 End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent
RUC Meeting: April 2009

Tab 29 **Specialty Developing** RPA
Recommendation:

First
Identified: February 2009

2017 Est.
Medicare
Utilization: 132

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU: 5.95
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: RUC Recommended revised clinical staff time

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

90957 End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent
RUC Meeting: April 2009

Tab 29 **Specialty Developing** RPA
Recommendation:

First
Identified: February 2009

2017 Est.
Medicare
Utilization: 1,804

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU: 12.52
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: RUC Recommended revised clinical staff time

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90958 End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent
RUC Meeting: April 2009

Tab 29 **Specialty Developing** RPA
Recommendation:

First
Identified: February 2009

2017 Est.
Medicare
Utilization: 401

2007 Work RVU:

2018 Work RVU: 8.34

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: PE Only

RUC Recommendation: RUC Recommended revised clinical staff time

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

90959 End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent
RUC Meeting: April 2009

Tab 29 **Specialty Developing** RPA
Recommendation:

First
Identified: February 2009

2017 Est.
Medicare
Utilization: 399

2007 Work RVU:

2018 Work RVU: 5.50

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: PE Only

RUC Recommendation: RUC Recommended revised clinical staff time

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

90960 End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent
RUC Meeting: April 2009

Tab 29 **Specialty Developing** RPA
Recommendation:

First
Identified: February 2009

2017 Est.
Medicare
Utilization: 2,268,319

2007 Work RVU:

2018 Work RVU: 5.18

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: PE Only

RUC Recommendation: RUC Recommended revised physician and clinical staff time

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

90961 End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent
RUC Meeting: April 2009 **Tab** 29 **Specialty Developing** RPA
Recommendation:

First
Identified: February 2009

2017 Est.
Medicare
Utilization: 719,000

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU: 4.26
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: RUC Recommended revised physician and clinical staff time

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent
RUC Meeting: April 2009 **Tab** 29 **Specialty Developing** RPA
Recommendation:

First
Identified: February 2009

2017 Est.
Medicare
Utilization: 205,671

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU: 3.15
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: RUC Recommended revised clinical staff time

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90963 End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent
RUC Meeting: April 2009 **Tab** 29 **Specialty Developing** RPA
Recommendation:

First
Identified: February 2009

2017 Est.
Medicare
Utilization: 221

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU: 10.56
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: RUC Recommended revised clinical staff time

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90964 End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent
RUC Meeting: April 2009 **Tab** 29 **Specialty Developing** RPA
Recommendation:

First
Identified: February 2009

2017 Est.
Medicare
Utilization: 806

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU: 9.14
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: RUC Recommended revised clinical staff time

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

90965 End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent
RUC Meeting: April 2009 **Tab** 29 **Specialty Developing** RPA
Recommendation:

First
Identified: February 2009

2017 Est.
Medicare
Utilization: 1,085

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU: 8.69
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: RUC Recommended revised clinical staff time

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

90966 End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older **Global:** XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent
RUC Meeting: April 2009 **Tab** 29 **Specialty Developing** RPA
Recommendation:

First
Identified: February 2009

2017 Est.
Medicare
Utilization: 339,627

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU: 4.26
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: RUC Recommended revised clinical staff time

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

909XX				Global:	Issue: Biofeedback Training	Screen: Negative IWPUT	Complete? No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:		First Identified: September 2018	2017 Est. Medicare Utilization:	2007 Work RVU:	2018 Work RVU:
						2007 NF PE RVU:	2018 NF PE RVU:
						2007 Fac PE RVU Result:	2018 Fac PE RVU:
RUC Recommendation:				Referred to CPT September 2018			
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>							
91038	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)			Global: 000	Issue: Gastroenterological Tests	Screen: CMS Request - Practice Expense Review	Complete? Yes
Most Recent RUC Meeting:	Tab 23	Specialty Developing Recommendation:	AGA, ASGE	First Identified: February 2010	2017 Est. Medicare Utilization: 4,318	2007 Work RVU: 1.10	2018 Work RVU: 1.10
	February 2010					2007 NF PE RVU: 2.36	2018 NF PE RVU: 2.36
						2007 Fac PE RVU 2.36	2018 Fac PE RVU: 2.36
RUC Recommendation:	New PE Inputs			Referred to CPT		Result: PE Only	
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>							
91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report			Global: XXX	Issue: Gastrointestinal Tract Imaging	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting:	Tab 44	Specialty Developing Recommendation:	ACG, AGA, ASGE	First Identified: July 2015	2017 Est. Medicare Utilization: 52,143	2007 Work RVU: 3.64	2018 Work RVU: 2.49
	January 2016					2007 NF PE RVU: 21.77	2018 NF PE RVU: 21.77
						2007 Fac PE RVU NA	2018 Fac PE RVU: NA
RUC Recommendation:	2.49			Referred to CPT		Result: Decrease	
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>							
91111	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report			Global: XXX	Issue: Gastrointestinal Tract Imaging	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting:	Tab 44	Specialty Developing Recommendation:	ACG, AGA, ASGE	First Identified: July 2015	2017 Est. Medicare Utilization: 101	2007 Work RVU: 1.00	2018 Work RVU: 1.00
	January 2016					2007 NF PE RVU: 18.65	2018 NF PE RVU: 18.65
						2007 Fac PE RVU NA	2018 Fac PE RVU: NA
RUC Recommendation:	1.00			Referred to CPT		Result: Maintain	
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

91132 Electrogastrography, diagnostic, transcutaneous;

Global: XXX

Issue: Electrogastrography

Screen: CMS Request - Practice Expense Review

Complete? Yes

Most Recent RUC Meeting: February 2010

Tab 24

Specialty Developing Recommendation: AGA, ACG, ASGE

First Identified:

2017 Est. Medicare Utilization: 120

2007 Work RVU: 0.00

2018 Work RVU: 0.52

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU: 0

2018 Fac PE RVU: 0

Result: PE Only

RUC Recommendation: New PE Inputs

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

91133 Electrogastrography, diagnostic, transcutaneous; with provocative testing

Global: XXX

Issue: Electrogastrography

Screen: CMS Request - Practice Expense Review

Complete? Yes

Most Recent RUC Meeting: February 2010

Tab 24

Specialty Developing Recommendation: AGA, ACG, ASGE

First Identified:

2017 Est. Medicare Utilization: 73

2007 Work RVU: 0.00

2018 Work RVU: 0.66

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU: 0

2018 Fac PE RVU: 0

Result: PE Only

RUC Recommendation: New PE Inputs

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

92081 Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)

Global: XXX

Issue: Visual Field Examination

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: April 2010

Tab 42

Specialty Developing Recommendation: AAO, AOA (optometric)

First Identified: October 2009

2017 Est. Medicare Utilization: 95,594

2007 Work RVU: 0.36

2018 Work RVU: 0.30

2007 NF PE RVU: 0.95

2018 NF PE RVU: 0.95

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Decrease

RUC Recommendation: 0.30

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

92082	Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)			Global: XXX	Issue: Visual Field Examination	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes					
Most Recent RUC Meeting:	April 2010	Tab 42	Specialty Developing Recommendation:	AAO, AOA (optometric)	First Identified:	October 2009	2017 Est. Medicare Utilization:	131,135	2007 Work RVU:	0.44	2018 Work RVU:	0.40
									2007 NF PE RVU:	1.26	2018 NF PE RVU:	1.26
									2007 Fac PE RVU	NA	2018 Fac PE RVU:	NA
RUC Recommendation:	0.40				Referred to CPT				Result:	Decrease		
					Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:					
92083	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)			Global: XXX	Issue: Visual Field Examination	Screen: MPC List / CMS High Expenditure Procedural Codes1	Complete? Yes					
Most Recent RUC Meeting:	April 2012	Tab 46	Specialty Developing Recommendation:	AAO, AOA (optometric)	First Identified:	October 2010	2017 Est. Medicare Utilization:	2,943,051	2007 Work RVU:	0.50	2018 Work RVU:	0.50
									2007 NF PE RVU:	1.46	2018 NF PE RVU:	1.46
									2007 Fac PE RVU	NA	2018 Fac PE RVU:	NA
RUC Recommendation:	0.50				Referred to CPT				Result:	Maintain		
					Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:					
92100	Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)			Global: XXX	Issue: Serial Tonometry	Screen: Harvard Valued - Utilization over 30,000	Complete? Yes					
Most Recent RUC Meeting:	September 2011	Tab 36	Specialty Developing Recommendation:	AAO, AOA (optometric)	First Identified:	April 2011	2017 Est. Medicare Utilization:	34,476	2007 Work RVU:	0.92	2018 Work RVU:	0.61
									2007 NF PE RVU:	1.33	2018 NF PE RVU:	1.33
									2007 Fac PE RVU	0.35	2018 Fac PE RVU:	0.35
RUC Recommendation:	0.61				Referred to CPT				Result:	Decrease		
					Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:					

Status Report: CMS Requests and Relativity Assessment Issues

92133 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve **Global:** XXX **Issue:** Computerized Scanning Ophthalmology Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 23

Specialty Developing Recommendation: AAO, AOA (eye)

First Identified: October 2009

2017 Est. Medicare Utilization: 2,714,139

2007 Work RVU:

2018 Work RVU: 0.40

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 0.50

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

92134 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina **Global:** XXX **Issue:** Computerized Scanning Ophthalmology Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 23

Specialty Developing Recommendation: AAO, AOA (eye)

First Identified: October 2008

2017 Est. Medicare Utilization: 6,952,911

2007 Work RVU:

2018 Work RVU: 0.45

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 0.50

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

92135 Deleted from CPT **Global:** XXX **Issue:** Ophthalmic Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009

Tab 31

Specialty Developing Recommendation: AAO, AOA

First Identified: October 2008

2017 Est. Medicare Utilization:

2007 Work RVU: 0.35

2018 Work RVU:

2007 NF PE RVU: 0.79

2018 NF PE RVU: 0.79

2007 Fac PE RVU NA

2018 Fac PE RVU: NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92136 Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation **Global:** XXX **Issue:** Ophthalmic Biometry **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 36 **Specialty Developing Recommendation:** AAO **First Identified:** October 2008 **2017 Est. Medicare Utilization:** 1,629,745 **2007 Work RVU:** 0.54 **2018 Work RVU:** 0.54 **2007 NF PE RVU:** 1.6 **2018 NF PE RVU:** 1.6 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **RUC Recommendation:** 0.54 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

92140 Provocative tests for glaucoma, with interpretation and report, without tonography **Global:** XXX **Issue:** Glaucoma Provocative Tests **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 41 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** October 2015 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 0.50 **2018 Work RVU:** **2007 NF PE RVU:** 0.97 **2018 NF PE RVU:** 0.97 **2007 Fac PE RVU:** 0.2 **2018 Fac PE RVU:** 0.2 **RUC Recommendation:** Deleted from CPT **Referred to CPT** May 2016 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

92225 Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial **Global:** XXX **Issue:** Ophthalmoscopy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 05 **Specialty Developing Recommendation:** AAO, AOA (Optometry), ASRS **First Identified:** April 2017 **2017 Est. Medicare Utilization:** 1,006,238 **2007 Work RVU:** 0.38 **2018 Work RVU:** 0.38 **2007 NF PE RVU:** 0.23 **2018 NF PE RVU:** 0.23 **2007 Fac PE RVU:** 0.15 **2018 Fac PE RVU:** 0.15 **RUC Recommendation:** Deleted from CPT **Referred to CPT** February 2018 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92226 Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; subsequent **Global:** XXX **Issue:** Ophthalmoscopy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018

Tab 05

Specialty Developing Recommendation: AAO, AOA (Optometry), ASRS

First Identified: February 2018

2017 Est. Medicare Utilization: 2,628,654

2007 Work RVU: 0.33

2018 Work RVU: 0.33

2007 NF PE RVU: 0.22

2018 NF PE RVU: 0.22

2007 Fac PE RVU 0.14

2018 Fac PE RVU:0.14

RUC Recommendation: Deleted from CPT

Referred to CPT February 2018

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

92235 Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral

Global: XXX

Issue: Ophthalmoscopic Angiography

Screen: Harvard Valued - Utilization over 30,000 / CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part3

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab 21

Specialty Developing Recommendation: AAO, ASRS

First Identified: April 2011

2017 Est. Medicare Utilization: 496,141

2007 Work RVU: 0.81

2018 Work RVU: 0.75

2007 NF PE RVU: 2.54

2018 NF PE RVU: 2.54

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: 0.75

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

92240 Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral

Global: XXX

Issue: Ophthalmoscopic Angiography

Screen: Codes Reported Together 75% or More-Part3 / CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab 21

Specialty Developing Recommendation: AAO, ASRS

First Identified: January 2015

2017 Est. Medicare Utilization: 9,258

2007 Work RVU: 1.10

2018 Work RVU: 0.80

2007 NF PE RVU: 5.7

2018 NF PE RVU: 5.7

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: 0.80

Referred to CPT October 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

92242	Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral	Global: XXX	Issue: Ophthalmoscopic Angiography	Screen: Codes Reported Together 75% or More-Part3	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 21	Specialty Developing Recommendation: AAO, ASRS	First Identified: October 2015	2017 Est. Medicare Utilization: 46,452	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease
RUC Recommendation: 0.95			Referred to CPT October 2015 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.95 2018 NF PE RVU: 2018 Fac PE RVU:
<hr/>					
92250	Fundus photography with interpretation and report	Global: XXX	Issue: Fundus Photography	Screen: MPC List / CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 45	Specialty Developing Recommendation: AAO, ASRS, AOA (optometry)	First Identified: October 2010	2017 Est. Medicare Utilization: 3,196,249	2007 Work RVU: 0.44 2007 NF PE RVU: 1.48 2007 Fac PE RVU NA Result: Decrease
RUC Recommendation: 0.40			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.40 2018 NF PE RVU: 1.48 2018 Fac PE RVU: NA
<hr/>					
92270	Electro-oculography with interpretation and report	Global: XXX	Issue: Electro-oculography	Screen: High Volume Growth1 / High Volume Growth 3	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 19	Specialty Developing Recommendation: AAO-HNS	First Identified: February 2008	2017 Est. Medicare Utilization: 1,883	2007 Work RVU: 0.81 2007 NF PE RVU: 1.5 2007 Fac PE RVU NA Result: Maintain
RUC Recommendation: CPT Assistant article published.			Referred to CPT February 2014 Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Aug 2008 and Q&A Jun 2009	2018 Work RVU: 0.81 2018 NF PE RVU: 1.5 2018 Fac PE RVU: NA

Status Report: CMS Requests and Relativity Assessment Issues

92275	Electroretinography with interpretation and report	Global: XXX	Issue: Electroretinography	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2018	Tab 17	Specialty Developing Recommendation: AAO, ASRS, AOA (optometry)	First Identified: July 2015	2017 Est. Medicare Utilization: 135,807	2007 Work RVU: 1.01 2007 NF PE RVU: 2.08 2007 Fac PE RVU: NA Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT June 2017	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
92285	External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, gonioscopy, stereo-photography)	Global: XXX	Issue: Ocular Photography	Screen: CMS Fastest Growing, Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: October 2009	Tab 32	Specialty Developing Recommendation: AAO, AOA	First Identified: October 2008	2017 Est. Medicare Utilization: 369,248	2007 Work RVU: 0.20 2007 NF PE RVU: 0.95 2007 Fac PE RVU: NA Result: Decrease
RUC Recommendation: 0.05 and new PE inputs			Referred to CPT February 2010	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
92286	Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis	Global: XXX	Issue: Anterior Segment Imaging	Screen: Harvard Valued - Utilization over 30,000 / Harvard-Valued Annual Allowed Charges Greater than \$10 million	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 28	Specialty Developing Recommendation: AAO, AOA (optometric)	First Identified: April 2011	2017 Est. Medicare Utilization: 119,011	2007 Work RVU: 0.66 2007 NF PE RVU: 2.83 2007 Fac PE RVU: NA Result: Decrease
RUC Recommendation: 0.40			Referred to CPT October 2011	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

92287	Anterior segment imaging with interpretation and report; with fluorescein angiography	Global: XXX	Issue: Anterior Segment Imaging	Screen: Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis 2018	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 28	Specialty Developing Recommendation: AAO, AOA (optometric)	First Identified:	2017 Est. Medicare Utilization: 5,116	2007 Work RVU: 0.81 2007 NF PE RVU: 2.28 2007 Fac PE RVU: 0.31 2018 Work RVU: 0.81 2018 NF PE RVU: 2.28 2018 Fac PE RVU: 0.31
RUC Recommendation: CPT Assistant article published			Referred to CPT October 2011	Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Mar 2013
<hr/>					
92504	Binocular microscopy (separate diagnostic procedure)	Global: XXX	Issue: Binocular Microscopy	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 43	Specialty Developing Recommendation: AAO-HNS	First Identified: October 2009	2017 Est. Medicare Utilization: 233,384	2007 Work RVU: 0.18 2007 NF PE RVU: 0.51 2007 Fac PE RVU: 0.08 2018 Work RVU: 0.18 2018 NF PE RVU: 0.51 2018 Fac PE RVU: 0.08
RUC Recommendation: 0.18			Referred to CPT	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
<hr/>					
92506	Evaluation of speech, language, voice, communication, and/or auditory processing	Global: XXX	Issue: Speech Language Pathology Services	Screen: CMS Request/Speech Language Pathology Request	Complete? Yes
Most Recent RUC Meeting: February 2010	Tab 28	Specialty Developing Recommendation: ASHA	First Identified:	2017 Est. Medicare Utilization:	2007 Work RVU: 0.86 2007 NF PE RVU: 2.76 2007 Fac PE RVU: 0.36 2018 Work RVU: 2018 NF PE RVU: 2.76 2018 Fac PE RVU: 0.36
RUC Recommendation: Deleted from CPT.			Referred to CPT October 2012	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	Global: XXX	Issue: Speech Language Pathology Services	Screen: CMS Request/Speech Language Pathology Request / High Volume Growth 3	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 54 Specialty Developing Recommendation: ASHA	First Identified: October 2015	2017 Est. Medicare Utilization: 241,336	2007 Work RVU: 0.52 2007 NF PE RVU: 1.13 2007 Fac PE RVU: 0.21 Result: Decrease	2018 Work RVU: 1.30 2018 NF PE RVU: 1.13 2018 Fac PE RVU: 0.21
RUC Recommendation: 1.30 work RVU and clinical staff time removed. Remove from High Volume screen.		Referred to CPT			
		Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	Global: XXX	Issue: Speech Language Pathology Services	Screen: CMS Request/Speech Language Pathology Request	Complete? Yes
Most Recent RUC Meeting: February 2010	Tab 28 Specialty Developing Recommendation: ASHA	First Identified:	2017 Est. Medicare Utilization: 4,800	2007 Work RVU: 0.26 2007 NF PE RVU: 0.51 2007 Fac PE RVU: 0.11 Result: Decrease	2018 Work RVU: 0.33 2018 NF PE RVU: 0.51 2018 Fac PE RVU: 0.11
RUC Recommendation: 0.43 work RVU and clinical staff time removed		Referred to CPT			
		Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	Global: XXX	Issue: Speech Evaluation	Screen: CMS Request/Speech Language Pathology Request	Complete? Yes
Most Recent RUC Meeting: January 2013	Tab 32 Specialty Developing Recommendation: ASHA	First Identified:	2017 Est. Medicare Utilization: 134	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Increase	2018 Work RVU: 1.75 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.75		Referred to CPT October 2012			
		Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

92522 Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); **Global:** XXX **Issue:** Speech Evaluation **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: January 2013

Tab 32 Specialty Developing Recommendation: ASHA

First Identified:

2017 Est. Medicare Utilization: 2,936

2007 Work RVU:

2018 Work RVU: 1.50

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 1.50

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

92523 Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language) **Global:** XXX **Issue:** Speech Evaluation

Screen: CMS Request/Speech Language Pathology Request

Complete? Yes

Most Recent RUC Meeting: January 2013

Tab 32 Specialty Developing Recommendation: ASHA

First Identified:

2017 Est. Medicare Utilization: 11,705

2007 Work RVU:

2018 Work RVU: 3.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 3.36

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

92524 Behavioral and qualitative analysis of voice and resonance

Global: XXX

Issue: Speech Evaluation

Screen: CMS Request/Speech Language Pathology Request

Complete? Yes

Most Recent RUC Meeting: January 2013

Tab 32 Specialty Developing Recommendation: ASHA

First Identified:

2017 Est. Medicare Utilization: 13,803

2007 Work RVU:

2018 Work RVU: 1.50

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 1.75

Referred to CPT October 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92526	Treatment of swallowing dysfunction and/or oral function for feeding	Global: XXX	Issue: Speech Language Pathology Services (HCPAC)	Screen: CMS Request/Speech Language Pathology Request / High Volume Growth2	Complete? No
Most Recent RUC Meeting: October 2017	Tab 19	Specialty Developing Recommendation: ASHA, AAO-HNS	First Identified: NA	2017 Est. Medicare Utilization: 88,418	2007 Work RVU: 0.55 2007 NF PE RVU: 1.65 2007 Fac PE RVU: 0.19 2018 Work RVU: 1.34 2018 NF PE RVU: 1.65 2018 Fac PE RVU: 0.19
RUC Recommendation: Review utilization			Referred to CPT	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
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92537	Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations)	Global: XXX	Issue: Vestibular Caloric Irrigation	Screen: CMS-Other - Utilization over 250,000	Complete? Yes
Most Recent RUC Meeting: January 2015	Tab 18	Specialty Developing Recommendation: AAA, AAN, AAO-HNS, ASHA	First Identified: October 2014	2017 Est. Medicare Utilization: 75,603	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: 2018 Work RVU: 0.60 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.80			Referred to CPT October 2014	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
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92538	Caloric vestibular test with recording, bilateral; monothermal (ie, one irrigation in each ear for a total of two irrigations)	Global: XXX	Issue: Vestibular Caloric Irrigation	Screen: CMS-Other - Utilization over 250,000	Complete? Yes
Most Recent RUC Meeting: January 2015	Tab 18	Specialty Developing Recommendation: AAA, AAN, AAO-HNS, ASHA	First Identified: October 2014	2017 Est. Medicare Utilization: 6,648	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: 2018 Work RVU: 0.30 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.55			Referred to CPT October 2014	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

92540	Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording	Global: XXX	Issue: EOG VNG	Screen: Codes Reported Together 95% or More	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 24	Specialty Developing Recommendation: AAN, ASHA, AAO-HNS, AAA	First Identified:	2017 Est. Medicare Utilization: 94,332	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease 2018 Work RVU: 1.50 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.50			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	Global: XXX	Issue: EOG VNG	Screen: Codes Reported Together 95% or More / Harvard Valued - Utilization over 100,000 / CMS-Other Source – Utilization over 250,000	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 24	Specialty Developing Recommendation: AAN, ASHA, AAO-HNS, AAA	First Identified: February 2008	2017 Est. Medicare Utilization: 12,601	2007 Work RVU: 0.40 2007 NF PE RVU: 1.05 2007 Fac PE RVU NA Result: Maintain 2018 Work RVU: 0.40 2018 NF PE RVU: 1.05 2018 Fac PE RVU: NA
RUC Recommendation: 0.40			Referred to CPT February 2009 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
92542	Positional nystagmus test, minimum of 4 positions, with recording	Global: XXX	Issue: EOG VNG	Screen: Codes Reported Together 95% or More / CMS-Other Source – Utilization over 250,000	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 24	Specialty Developing Recommendation: AAN, ASHA, AAO-HNS, AAA	First Identified: February 2008	2017 Est. Medicare Utilization: 22,340	2007 Work RVU: 0.33 2007 NF PE RVU: 1.16 2007 Fac PE RVU NA Result: Increase 2018 Work RVU: 0.48 2018 NF PE RVU: 1.16 2018 Fac PE RVU: NA
RUC Recommendation: 0.48			Referred to CPT February 2009 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

92543 Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording **Global:** XXX **Issue:** Vestibular Caloric Irrigation **Screen:** Codes Reported Together 95% or More / Low Value-High Volume / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015

Tab 18

Specialty Developing Recommendation: AAA, AAN, AAO-HNS, ASHA

First Identified: February 2008

2017 Est. Medicare Utilization:

2007 Work RVU: 0.10

2018 Work RVU:

2007 NF PE RVU: 0.59

2018 NF PE RVU: 0.59

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

92544 Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording **Global:** XXX **Issue:** EOG VNG

Screen: Codes Reported Together 95% or More / CMS-Other Source – Utilization over 250,000

Complete? Yes

Most Recent RUC Meeting: April 2014

Tab 24

Specialty Developing Recommendation: AAN, ASHA, AAO-HNS, AAA

First Identified: February 2008

2017 Est. Medicare Utilization: 2,869

2007 Work RVU: 0.26

2018 Work RVU: 0.27

2007 NF PE RVU: 0.93

2018 NF PE RVU: 0.93

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Increase

RUC Recommendation: 0.27

Referred to CPT February 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

92545 Oscillating tracking test, with recording

Global: XXX **Issue:** EOG VNG

Screen: Codes Reported Together 95% or More / CMS-Other Source – Utilization over 250,000

Complete? Yes

Most Recent RUC Meeting: April 2014

Tab 24

Specialty Developing Recommendation: AAN, ASHA, AAO-HNS, AAA

First Identified: February 2008

2017 Est. Medicare Utilization: 4,134

2007 Work RVU: 0.23

2018 Work RVU: 0.25

2007 NF PE RVU: 0.85

2018 NF PE RVU: 0.85

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Increase

RUC Recommendation: 0.25

Referred to CPT February 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92546 Sinusoidal vertical axis rotational testing

Global: XXX Issue: EOG VNG

Screen: CMS-Other - Utilization over 250,000

Complete? Yes

Most Recent
RUC Meeting: April 2014

Tab 24

Specialty Developing
Recommendation:

First
Identified: February 2014

2017 Est.
Medicare
Utilization: 46,107

2007 Work RVU: 0.29

2018 Work RVU: 0.29

2007 NF PE RVU: 1.94

2018 NF PE RVU: 1.94

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: Editorial change only

Referred to CPT February 2014

Referred to CPT Asst ☐ Published in CPT Asst:

92547 Use of vertical electrodes (List separately in addition to code for primary procedure)

Global: ZZZ Issue: EOG VNG

Screen: CMS-Other - Utilization over 250,000

Complete? Yes

Most Recent
RUC Meeting: April 2014

Tab 24

Specialty Developing
Recommendation:

First
Identified: February 2014

2017 Est.
Medicare
Utilization: 30,810

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: 0.09

2018 NF PE RVU: 0.09

2007 Fac PE RVU 0.09

2018 Fac PE RVU:0.09

Result: Maintain

RUC Recommendation: Editorial change only

Referred to CPT February 2014

Referred to CPT Asst ☐ Published in CPT Asst:

92548 Computerized dynamic posturography

Global: XXX Issue: Computerized Dynamic Posturography

Screen: CMS-Other - Utilization over 250,000 / Negative IWPUT / Different Performing Specialty from Survey

Complete? No

Most Recent
RUC Meeting: October 2017

Tab 19

Specialty Developing
Recommendation: AAA, AAN, ASHA

First
Identified: February 2014

2017 Est.
Medicare
Utilization: 43,768

2007 Work RVU: 0.50

2018 Work RVU: 0.50

2007 NF PE RVU: 2.1

2018 NF PE RVU: 2.1

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: Refer to CPT

Referred to CPT September 2018 / February 2014

Referred to CPT Asst ☐ Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

92550 Tympanometry and reflex threshold measurements **Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAA **First Identified:** **2017 Est. Medicare Utilization:** 251,402 **2007 Work RVU:** **2018 Work RVU:** 0.35 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 0.35 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

92557 Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined) **Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2017 Est. Medicare Utilization:** 1,228,485 **2007 Work RVU:** 0.00 **2018 Work RVU:** 0.60 **2007 NF PE RVU:** 1.21 **2018 NF PE RVU:** 1.21 **2007 Fac PE RVU** NA **2018 Fac PE RVU:** NA **Result:** Decrease

RUC Recommendation: 0.60 work RVU and clinical staff time removed **Referred to CPT** February 2009 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

92558 Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis **Global:** XXX **Issue:** Otoacoustic Emissions Measurement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** February 2011 **2017 Est. Medicare Utilization:** **2007 Work RVU:** **2018 Work RVU:** 0.17 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU** **2018 Fac PE RVU:** **Result:** Increase

RUC Recommendation: 0.17 **Referred to CPT** February 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92567 Tympanometry (impedance testing)

Global: XXX

Issue: Bundled Audiology Tests

Screen: Codes Reported
Together 95% or More /
Low Value-High Volume

Complete? Yes

Most Recent
RUC Meeting: April 2009

Tab 22

Specialty Developing
Recommendation:

ASHA, AAO-
HNS, AAN

First
Identified: February 2008

2017 Est.
Medicare
Utilization: 856,575

2007 Work RVU: 0.00

2018 Work RVU: 0.20

2007 NF PE RVU: 0.51

2018 NF PE RVU: 0.51

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 0.20 work RVU and clinical staff time removed

Referred to CPT February 2009

Referred to CPT Asst ☐ Published in CPT Asst:

92568 Acoustic reflex testing, threshold

Global: XXX

Issue: Bundled Audiology Tests

Screen: Codes Reported
Together 95% or More

Complete? Yes

Most Recent
RUC Meeting: April 2009

Tab 22

Specialty Developing
Recommendation:

ASHA, AAO-
HNS, AAN

First
Identified: February 2008

2017 Est.
Medicare
Utilization: 6,626

2007 Work RVU: 0.00

2018 Work RVU: 0.29

2007 NF PE RVU: 0.32

2018 NF PE RVU: 0.32

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 0.29 work RVU and clinical staff time removed

Referred to CPT February 2009

Referred to CPT Asst ☐ Published in CPT Asst:

92569 Deleted from CPT

Global: XXX

Issue: Bundled Audiology Tests

Screen: Codes Reported
Together 95% or More

Complete? Yes

Most Recent
RUC Meeting: April 2009

Tab 22

Specialty Developing
Recommendation:

ASHA, AAO-
HNS, AAN

First
Identified: February 2008

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0.35

2018 NF PE RVU: 0.35

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2009

Referred to CPT Asst ☐ Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

92570 Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing **Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: October 2015

Tab 21

Specialty Developing Recommendation: ASHA, AAO-HNS, AAA

First Identified:

2017 Est. Medicare Utilization: 43,275

2007 Work RVU:

2018 Work RVU: 0.55

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 0.55

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

92585 Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive

Global: XXX

Issue:

Screen: CMS-Other - Utilization over 30,000

Complete? No

Most Recent RUC Meeting: January 2018

Tab 31

Specialty Developing Recommendation: AAA, AANEM, ACNS, ASHA

First Identified: October 2017

2017 Est. Medicare Utilization: 37,974

2007 Work RVU: 0.50

2018 Work RVU: 0.50

2007 NF PE RVU: 2.02

2018 NF PE RVU: 2.02

2007 Fac PE RVU NA

2018 Fac PE RVU: NA

Result:

RUC Recommendation: Refer to CPT

Referred to CPT February 2019

Referred to CPT Asst ☐

Published in CPT Asst:

92587 Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report

Global: XXX

Issue: Otoacoustic Emissions Measurement

Screen: CMS Fastest Growing

Complete? Yes

Most Recent RUC Meeting: April 2011

Tab 35

Specialty Developing Recommendation: ASHA

First Identified: October 2008

2017 Est. Medicare Utilization: 69,720

2007 Work RVU: 0.13

2018 Work RVU: 0.35

2007 NF PE RVU: 1.19

2018 NF PE RVU: 1.19

2007 Fac PE RVU NA

2018 Fac PE RVU: NA

Result: Increase

RUC Recommendation: 0.45

Referred to CPT October 2010

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

92588 Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report **Global:** XXX **Issue:** Otoacoustic Emissions Measurement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2011

Tab 35 **Specialty Developing Recommendation:** ASHA

First Identified:

2017 Est. Medicare Utilization: 85,792

2007 Work RVU: 0.36

2018 Work RVU: 0.55

2007 NF PE RVU: 1.48

2018 NF PE RVU: 1.48

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Increase

RUC Recommendation: 0.60

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

92597 Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech **Global:** XXX **Issue:** Speech Language Pathology Services (RUC) **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2009

Tab 30 **Specialty Developing Recommendation:** ASHA

First Identified: NA

2017 Est. Medicare Utilization: 2,903

2007 Work RVU: 0.86

2018 Work RVU: 1.26

2007 NF PE RVU: 1.69

2018 NF PE RVU: 1.69

2007 Fac PE RVU 0.4

2018 Fac PE RVU:0.4

Result: Decrease

RUC Recommendation: 1.48 work RVU and clinical staff time removed

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92605 Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour **Global:** XXX **Issue:** Eval of Rx for Non-Speech Generating Device **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2011

Tab 35 **Specialty Developing Recommendation:** ASHA

First Identified:

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU: 1.75

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU 0

2018 Fac PE RVU:0

Result: Increase

RUC Recommendation: 1.75

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification	Global: XXX	Issue: Speech Language Pathology Services	Screen: CMS Request/Speech Language Pathology Request	Complete? Yes
Most Recent RUC Meeting: February 2010	Tab 28 Specialty Developing Recommendation: ASHA	First Identified:	2017 Est. Medicare Utilization:	2007 Work RVU: 0.00 2007 NF PE RVU: 0 2007 Fac PE RVU 0 Result: Decrease	2018 Work RVU: 1.40 2018 NF PE RVU: 0 2018 Fac PE RVU: 0
RUC Recommendation: 1.40 work RVU and clinical staff time removed		Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	Global: XXX	Issue: Speech Language Pathology Services	Screen: CMS Request/Speech Language Pathology Request	Complete? Yes
Most Recent RUC Meeting: February 2010	Tab 28 Specialty Developing Recommendation: ASHA	First Identified:	2017 Est. Medicare Utilization: 294	2007 Work RVU: 0.00 2007 NF PE RVU: 3.38 2007 Fac PE RVU NA Result: Decrease	2018 Work RVU: 1.85 2018 NF PE RVU: 3.38 2018 Fac PE RVU: NA
RUC Recommendation: 1.85 work RVU and clinical staff time removed		Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Speech Language Pathology Services	Screen: CMS Request/Speech Language Pathology Request	Complete? Yes
Most Recent RUC Meeting: February 2010	Tab 28 Specialty Developing Recommendation: ASHA	First Identified:	2017 Est. Medicare Utilization: 97	2007 Work RVU: 0.00 2007 NF PE RVU: 0.63 2007 Fac PE RVU NA Result: Decrease	2018 Work RVU: 0.70 2018 NF PE RVU: 0.63 2018 Fac PE RVU: NA
RUC Recommendation: 0.70 work RVU and clinical staff time removed		Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

92609 Therapeutic services for the use of speech-generating device, including programming and modification **Global:** XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 28 **Specialty Developing Recommendation:** ASHA

First Identified: **2017 Est. Medicare Utilization:** 12,903

2007 Work RVU: 0.00 **2018 Work RVU:** 1.50
2007 NF PE RVU: 1.77 **2018 NF PE RVU:** 1.77
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Decrease

RUC Recommendation: 1.50 work RVU and clinical staff time removed

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92610 Evaluation of oral and pharyngeal swallowing function

Global: XXX **Issue:** Speech Language Pathology Services (RUC) **Screen:** CMS Request/Speech Language Pathology Request / High Volume Growth2 **Complete?** No

Most Recent RUC Meeting: October 2017 **Tab** 19 **Specialty Developing Recommendation:** ASHA, AAO-HNS

First Identified: NA **2017 Est. Medicare Utilization:** 16,278

2007 Work RVU: 0.00 **2018 Work RVU:** 1.30
2007 NF PE RVU: 2.98 **2018 NF PE RVU:** 2.98
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Decrease

RUC Recommendation: Review utilization

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92611 Motion fluoroscopic evaluation of swallowing function by cine or video recording

Global: XXX **Issue:** Speech Language Pathology Services (HCPAC) **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab** 39 **Specialty Developing Recommendation:** ASHA

First Identified: NA **2017 Est. Medicare Utilization:** 8,612

2007 Work RVU: 0.00 **2018 Work RVU:** 1.34
2007 NF PE RVU: 3.04 **2018 NF PE RVU:** 3.04
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Decrease

RUC Recommendation: 1.34 work RVU and clinical staff time removed

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92618 Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Eval of Rx for Non-Speech Generating Device **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2011

Tab 35 **Specialty Developing Recommendation:** ASHA

First Identified:

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU: 0.65

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 0.65

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

92620 Evaluation of central auditory function, with report; initial 60 minutes **Global:** XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008

Tab 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS

First Identified: NA

2017 Est. Medicare Utilization: 2,911

2007 Work RVU: 0.00

2018 Work RVU: 1.50

2007 NF PE RVU: 1.32

2018 NF PE RVU: 1.32

2007 Fac PE RVU NA

2018 Fac PE RVU: NA

Result: Decrease

RUC Recommendation: 1.50

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92621 Evaluation of central auditory function, with report; each additional 15 minutes (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008

Tab 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS

First Identified: NA

2017 Est. Medicare Utilization: 69

2007 Work RVU: 0.00

2018 Work RVU: 0.35

2007 NF PE RVU: 0.29

2018 NF PE RVU: 0.29

2007 Fac PE RVU NA

2018 Fac PE RVU: NA

Result: Decrease

RUC Recommendation: 0.35

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92625 Assessment of tinnitus (includes pitch, loudness matching, and masking) **Global:** XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008

Tab 17

Specialty Developing Recommendation:

ASHA, AAO-HNS

First Identified: NA

2017 Est. Medicare Utilization: 7,143

2007 Work RVU: 0.00

2018 Work RVU: 1.15

2007 NF PE RVU: 1.3

2018 NF PE RVU: 1.3

2007 Fac PE RVU 1.3

2018 Fac PE RVU:1.3

Result: Decrease

RUC Recommendation: 1.15

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

92626 Evaluation of auditory rehabilitation status; first hour

Global: XXX

Issue: Audiology Services

Screen: CMS Request - Audiology Services / High Volume Growth2

Complete? Yes

Most Recent RUC Meeting: October 2018

Tab 30

Specialty Developing Recommendation:

AAA, ASHA

First Identified: NA

2017 Est. Medicare Utilization: 25,537

2007 Work RVU: 0.00

2018 Work RVU: 1.40

2007 NF PE RVU: 2.11

2018 NF PE RVU: 2.11

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 1.40

Referred to CPT May 2018

Referred to CPT Asst ☒

Published in CPT Asst: July 2014

92627 Evaluation of auditory rehabilitation status; each additional 15 minutes (List separately in addition to code for primary procedure)

Global: ZZZ

Issue: Audiology Services

Screen: CMS Request - Audiology Services

Complete? Yes

Most Recent RUC Meeting: October 2018

Tab 30

Specialty Developing Recommendation:

ASHA, AAO-HNS

First Identified: NA

2017 Est. Medicare Utilization: 9,671

2007 Work RVU: 0.00

2018 Work RVU: 0.33

2007 NF PE RVU: 0.52

2018 NF PE RVU: 0.52

2007 Fac PE RVU 0.52

2018 Fac PE RVU:0.52

Result: Decrease

RUC Recommendation: 0.33

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

92640 Diagnostic analysis with programming of auditory brainstem implant, per hour **Global:** XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2017 Est. Medicare Utilization:** 12 **2007 Work RVU:** 0.00 **2018 Work RVU:** 1.76 **2007 NF PE RVU:** 1.4 **2018 NF PE RVU:** 1.4 **2007 Fac PE RVU:** 1.4 **2018 Fac PE RVU:** 1.4 **Result:** Decrease

RUC Recommendation: 1.76 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

92920 Percutaneous transluminal coronary angioplasty; single major coronary artery or branch **Global:** 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2017 Est. Medicare Utilization:** 25,210 **2007 Work RVU:** **2018 Work RVU:** 9.85 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 9.00 **Referred to CPT** October 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

92921 Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2017 Est. Medicare Utilization:** **2007 Work RVU:** **2018 Work RVU:** 0.00 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 4.00 **Referred to CPT** October 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

92924 Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch **Global:** 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2017 Est. Medicare Utilization:** 2,052 **2007 Work RVU:** **2018 Work RVU:** 11.74 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 11.00 **Referred to CPT** October 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92925 Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012

Tab 10 Specialty Developing Recommendation: ACC

First Identified: October 2010

2017 Est. Medicare Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 0.00
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 5.00

Referred to CPT October 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

92928 Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch **Global:** 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012

Tab 10 Specialty Developing Recommendation: ACC

First Identified: October 2010

2017 Est. Medicare Utilization: 258,003

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 10.96
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 10.49

Referred to CPT October 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

92929 Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012

Tab 10 Specialty Developing Recommendation: ACC

First Identified: October 2010

2017 Est. Medicare Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 0.00
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.44

Referred to CPT October 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	Global: 000	Issue: Percutaneous Coronary Intervention	Screen: MPC List	Complete? Yes
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Most Recent RUC Meeting: January 2012	Tab 10	Specialty Developing Recommendation: ACC	First Identified: October 2010	2017 Est. Medicare Utilization: 15,277	2007 Work RVU:	2018 Work RVU: 12.29
					2007 NF PE RVU:	2018 NF PE RVU:
RUC Recommendation: 12.32			Referred to CPT October 2011		2007 Fac PE RVU	2018 Fac PE RVU:
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease	

92934	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Percutaneous Coronary Intervention	Screen: MPC List	Complete? Yes
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Most Recent RUC Meeting: January 2012	Tab 10	Specialty Developing Recommendation: ACC	First Identified: October 2010	2017 Est. Medicare Utilization:	2007 Work RVU:	2018 Work RVU: 0.00
					2007 NF PE RVU:	2018 NF PE RVU:
RUC Recommendation: 5.50			Referred to CPT October 2011		2007 Fac PE RVU	2018 Fac PE RVU:
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease	

92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	Global: 000	Issue: Percutaneous Coronary Intervention	Screen: MPC List	Complete? Yes
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Most Recent RUC Meeting: January 2012	Tab 10	Specialty Developing Recommendation: ACC	First Identified: October 2010	2017 Est. Medicare Utilization: 20,635	2007 Work RVU:	2018 Work RVU: 10.95
					2007 NF PE RVU:	2018 NF PE RVU:
RUC Recommendation: 10.49			Referred to CPT October 2011		2007 Fac PE RVU	2018 Fac PE RVU:
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease	

Status Report: CMS Requests and Relativity Assessment Issues

92938	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Percutaneous Coronary Intervention	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2012	Tab 10 Specialty Developing Recommendation: ACC	First Identified: October 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 0.00 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 6.00		Referred to CPT October 2011 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
92941	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel	Global: 000	Issue: Percutaneous Coronary Intervention	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2012	Tab 10 Specialty Developing Recommendation: ACC	First Identified: October 2010	2017 Est. Medicare Utilization: 44,165	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 12.31 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 12.32		Referred to CPT October 2011 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel	Global: 000	Issue: Percutaneous Coronary Intervention	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2012	Tab 10 Specialty Developing Recommendation: ACC	First Identified: October 2010	2017 Est. Medicare Utilization: 8,850	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 12.31 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 12.32		Referred to CPT October 2011 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			

Status Report: CMS Requests and Relativity Assessment Issues

92944	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Percutaneous Coronary Intervention	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2012	Tab 10 Specialty Developing Recommendation: ACC	First Identified: October 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 0.00 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 6.00		Referred to CPT October 2011 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
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92960	Cardioversion, elective, electrical conversion of arrhythmia; external	Global: 000	Issue: Cardioversion	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: October 2010	Tab 19 Specialty Developing Recommendation: ACC	First Identified: October 2009	2017 Est. Medicare Utilization: 184,646	2007 Work RVU: 2.25 2007 NF PE RVU: 5.83 2007 Fac PE RVU Result: Maintain	2018 Work RVU: 2.00 2018 NF PE RVU: 5.83 2018 Fac PE RVU: 1.25
RUC Recommendation: 2.25		Referred to CPT Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
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92973	Percutaneous transluminal coronary thrombectomy mechanical (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: RAW	Screen: High Volume Growth2	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 19 Specialty Developing Recommendation:	First Identified: April 2013	2017 Est. Medicare Utilization: 1,918	2007 Work RVU: 3.28 2007 NF PE RVU: NA 2007 Fac PE RVU Result: Maintain	2018 Work RVU: 3.28 2018 NF PE RVU: NA 2018 Fac PE RVU: 1.42
RUC Recommendation: Remove from screen		Referred to CPT Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:			
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Status Report: CMS Requests and Relativity Assessment Issues

92980	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel	Global: 000	Issue: Percutaneous Coronary Intervention	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2012	Tab 10 Specialty Developing Recommendation: ACC	First Identified: October 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 14.82 2007 NF PE RVU: NA 2007 Fac PE RVU: 6.65 Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 6.65
RUC Recommendation: Deleted from CPT		Referred to CPT October 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
92981	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Percutaneous Coronary Intervention	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2012	Tab 10 Specialty Developing Recommendation: ACC	First Identified: October 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 4.16 2007 NF PE RVU: NA 2007 Fac PE RVU: 1.8 Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 1.8
RUC Recommendation: Deleted from CPT		Referred to CPT October 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
92982	Percutaneous transluminal coronary balloon angioplasty; single vessel	Global: 000	Issue: Percutaneous Coronary Intervention	Screen: MPC List / Harvard-Valued Annual Allowed Charges Greater than \$10 million	Complete? Yes
Most Recent RUC Meeting: January 2012	Tab 10 Specialty Developing Recommendation: ACC	First Identified: October 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 10.96 2007 NF PE RVU: NA 2007 Fac PE RVU: 4.97 Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 4.97
RUC Recommendation: Deleted from CPT		Referred to CPT October 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

92984	Percutaneous transluminal coronary balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Percutaneous Coronary Intervention	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2012	Tab 10 Specialty Developing Recommendation: ACC	First Identified: October 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 2.97 2007 NF PE RVU: NA 2007 Fac PE RVU: 1.28 Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: NA 2018 Fac PE RVU: 1.28
RUC Recommendation: Deleted from CPT		Referred to CPT October 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
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92986	Percutaneous balloon valvuloplasty; aortic valve	Global: 090	Issue: Valvuloplasty	Screen: CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: October 2008	Tab 26 Specialty Developing Recommendation: ACC	First Identified: October 2008	2017 Est. Medicare Utilization: 3,173	2007 Work RVU: 22.70 2007 NF PE RVU: NA 2007 Fac PE RVU: 12.84 Result: Remove from Screen	2018 Work RVU: 22.60 2018 NF PE RVU: NA 2018 Fac PE RVU: 12.84
RUC Recommendation: Deleted from CPT		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
92992	Atrial septectomy or septostomy; transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization)	Global: 090	Issue: Septostomy	Screen: CMS Request - NPRM for 2019	Complete? No
Most Recent RUC Meeting: October 2018	Tab 27 Specialty Developing Recommendation:	First Identified: October 2018	2017 Est. Medicare Utilization: 29	2007 Work RVU: 0.00 2007 NF PE RVU: 0 2007 Fac PE RVU: 0 Result:	2018 Work RVU: 0.00 2018 NF PE RVU: 0 2018 Fac PE RVU: 0
RUC Recommendation: Survey		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
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92993	Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization)	Global: 090	Issue: Septostomy	Screen: CMS Request - NPRM for 2019	Complete? No
Most Recent RUC Meeting: October 2018	Tab 27 Specialty Developing Recommendation:	First Identified: October 2018	2017 Est. Medicare Utilization: 2	2007 Work RVU: 0.00 2007 NF PE RVU: 0 2007 Fac PE RVU: 0 Result:	2018 Work RVU: 0.00 2018 NF PE RVU: 0 2018 Fac PE RVU: 0
RUC Recommendation: Survey		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

92995 Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel **Global:** 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent **Tab** 10 **Specialty Developing** ACC
RUC Meeting: January 2012 **Recommendation:**

First Identified: October 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 12.07
2007 NF PE RVU: NA
2007 Fac PE RVU 5.45
Result: Deleted from CPT

2018 Work RVU:
2018 NF PE RVU: NA
2018 Fac PE RVU:5.45

RUC Recommendation: Deleted from CPT

Referred to CPT October 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

92996 Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)

Global: ZZZ

Issue: Percutaneous Coronary Intervention

Screen: MPC List

Complete? Yes

Most Recent **Tab** 10 **Specialty Developing** ACC
RUC Meeting: January 2012 **Recommendation:**

First Identified: October 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 3.26
2007 NF PE RVU: NA
2007 Fac PE RVU 1.41
Result: Deleted from CPT

2018 Work RVU:
2018 NF PE RVU: NA
2018 Fac PE RVU:1.41

RUC Recommendation: Deleted from CPT

Referred to CPT October 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

92X18

Global:

Issue: Ophthalmoscopy

Screen: Negative IWPUT

Complete? Yes

Most Recent **Tab** 05 **Specialty Developing** AAO, AOA (Optometry), ASRS
RUC Meeting: April 2018 **Recommendation:**

First Identified: February 2018

2017 Est. Medicare Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.40

Referred to CPT February 2018

Referred to CPT Asst ☐ **Published in CPT Asst:**

92X19

Global:

Issue: Ophthalmoscopy

Screen: Negative IWPUT

Complete? Yes

Most Recent **Tab** 05 **Specialty Developing** AAO, AOA (Optometry), ASRS
RUC Meeting: April 2018 **Recommendation:**

First Identified: February 2018

2017 Est. Medicare Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.26

Referred to CPT February 2018

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92X71

Global:

Issue: Electroretinography

Screen: CMS High Expenditure
Procedural Codes2

Complete? Yes

Most Recent
RUC Meeting: January 2018

Tab 17

Specialty Developing
Recommendation:

First
Identified: September 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 0.80

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

92X73

Global:

Issue: Electroretinography

Screen: CMS High Expenditure
Procedural Codes2

Complete? Yes

Most Recent
RUC Meeting: January 2018

Tab 17

Specialty Developing
Recommendation:

First
Identified: September 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 0.72

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

92XX0

Global:

Issue: Computerized Dynamic
Posturography

Screen: CMS-Other - Utilization
over 250,000 / Negative
IWPUT / Different
Performing Specialty
from Survey

Complete? No

Most Recent
RUC Meeting:

Tab

Specialty Developing
Recommendation:

First
Identified:

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result:

RUC Recommendation:

Referred to CPT September 2018

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	Global: XXX	Issue: Electrocardiogram	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: October 2012	Tab 20	Specialty Developing Recommendation: AAFP, ACC, ACP	First Identified: September 2011	2017 Est. Medicare Utilization: 12,137,145	2007 Work RVU: 0.17 2007 NF PE RVU: 0.47 2007 Fac PE RVU NA Result: Maintain
RUC Recommendation: 0.17			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.17 2018 NF PE RVU: 0.47 2018 Fac PE RVU: NA
93005	Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report	Global: XXX	Issue: Electrocardiogram	Screen: High Volume Growth1 / CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: October 2012	Tab 20	Specialty Developing Recommendation: AAFP, ACC, ACP	First Identified: February 2008	2017 Est. Medicare Utilization: 461,623	2007 Work RVU: 0.00 2007 NF PE RVU: 0.41 2007 Fac PE RVU NA Result: PE Only
RUC Recommendation: 0.00			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.00 2018 NF PE RVU: 0.41 2018 Fac PE RVU: NA
93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only	Global: XXX	Issue: Electrocardiogram	Screen: MPC List / CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: October 2012	Tab 20	Specialty Developing Recommendation: AAFP, ACC, ACP	First Identified: October 2010	2017 Est. Medicare Utilization: 19,163,816	2007 Work RVU: 0.17 2007 NF PE RVU: 0.06 2007 Fac PE RVU 0.06 Result: Maintain
RUC Recommendation: 0.17			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.17 2018 NF PE RVU: 0.06 2018 Fac PE RVU: 0.06

Status Report: CMS Requests and Relativity Assessment Issues

93012 Deleted from CPT

Global: XXX

Issue: External Cardiovascular Device Monitoring

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: April 2010

Tab 25

Specialty Developing Recommendation: ACC

First Identified: October 2009

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 5.55

2018 NF PE RVU: 5.55

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93014 Deleted from CPT

Global: XXX

Issue: External Cardiovascular Device Monitoring

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: April 2010

Tab 25

Specialty Developing Recommendation: ACC

First Identified: October 2009

2017 Est. Medicare Utilization:

2007 Work RVU: 0.52

2018 Work RVU:

2007 NF PE RVU: 0.2

2018 NF PE RVU: 0.2

2007 Fac PE RVU 0.2

2018 Fac PE RVU:0.2

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93015 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report

Global: XXX

Issue: Cardiovascular Stress Tests

Screen: Codes Reported Together 75% or More- Part1 / CMS High Expenditure Procedural Codes1

Complete? Yes

Most Recent RUC Meeting: April 2012

Tab 47

Specialty Developing Recommendation: ACC

First Identified: February 2010

2017 Est. Medicare Utilization: 1,062,623

2007 Work RVU: 0.75

2018 Work RVU: 0.75

2007 NF PE RVU: 1.95

2018 NF PE RVU: 1.95

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: 0.75. CPT Assistant published.

Referred to CPT October 2010

Referred to CPT Asst ☒ **Published in CPT Asst:** Jan 2010

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

93016	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report	Global: XXX	Issue: Cardiovascular Stress Tests	Screen: Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 47 Specialty Developing Recommendation: ACC	First Identified: February 2010	2017 Est. Medicare Utilization: 1,125,108	2007 Work RVU: 0.45 2007 NF PE RVU: 0.19 2007 Fac PE RVU: 0.19 Result: Maintain	2018 Work RVU: 0.45 2018 NF PE RVU: 0.19 2018 Fac PE RVU: 0.19
RUC Recommendation: 0.45		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93017	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report	Global: XXX	Issue: Cardiovascular Stress Tests	Screen: High Volume Growth1 / CMS Request - Practice Expense Review / Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 45 Specialty Developing Recommendation: ACC	First Identified: February 2008	2017 Est. Medicare Utilization: 97,470	2007 Work RVU: 0.00 2007 NF PE RVU: 1.64 2007 Fac PE RVU: NA Result: PE Only	2018 Work RVU: 0.00 2018 NF PE RVU: 1.64 2018 Fac PE RVU: NA
RUC Recommendation: New PE inputs		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93018	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only	Global: XXX	Issue: Cardiovascular Stress Tests and Echocardiography	Screen: Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 47 Specialty Developing Recommendation: ACC	First Identified: February 2010	2017 Est. Medicare Utilization: 1,312,016	2007 Work RVU: 0.30 2007 NF PE RVU: 0.12 2007 Fac PE RVU: 0.12 Result: Maintain	2018 Work RVU: 0.30 2018 NF PE RVU: 0.12 2018 Fac PE RVU: 0.12
RUC Recommendation: 0.30		Referred to CPT October 2010 Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Jan 2010		

Status Report: CMS Requests and Relativity Assessment Issues

93025 Microvolt T-wave alternans for assessment of ventricular arrhythmias

Global: XXX

Issue: Microvolt T-Wave Assessment

Screen: CMS Request - Practice Expense Review

Complete? Yes

Most Recent RUC Meeting: October 2008

Tab 18

Specialty Developing Recommendation: ACC

First Identified: NA

2017 Est. Medicare Utilization: 278

2007 Work RVU: 0.75

2018 Work RVU: 0.75

2007 NF PE RVU: 6.67

2018 NF PE RVU: 6.67

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: PE Only

RUC Recommendation: New PE Inputs

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

93040 Rhythm ECG, 1-3 leads; with interpretation and report

Global: XXX

Issue: Rhythm EKG

Screen: Havard Valued - Utilization over 1 Million

Complete? Yes

Most Recent RUC Meeting: October 2009

Tab 34

Specialty Developing Recommendation: ACC

First Identified: February 2009

2017 Est. Medicare Utilization: 119,735

2007 Work RVU: 0.16

2018 Work RVU: 0.15

2007 NF PE RVU: 0.2

2018 NF PE RVU: 0.2

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Decrease

RUC Recommendation: 0.15

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

93041 Rhythm ECG, 1-3 leads; tracing only without interpretation and report

Global: XXX

Issue: Rhythm EKG

Screen: Havard Valued - Utilization over 1 Million

Complete? Yes

Most Recent RUC Meeting: October 2009

Tab 34

Specialty Developing Recommendation: ACC

First Identified: February 2009

2017 Est. Medicare Utilization: 13,345

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: 0.15

2018 NF PE RVU: 0.15

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Maintain

RUC Recommendation: 0.00 (PE only)

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

93042 Rhythm ECG, 1-3 leads; interpretation and report only

Global: XXX

Issue: Rhythm EKG

Screen: Havard Valued - Utilization over 1 Million

Complete? Yes

Most Recent RUC Meeting: October 2009

Tab 34

Specialty Developing Recommendation: ACC, ACEP

First Identified: October 2008

2017 Est. Medicare Utilization: 372,803

2007 Work RVU: 0.16

2018 Work RVU: 0.15

2007 NF PE RVU: 0.05

2018 NF PE RVU: 0.05

2007 Fac PE RVU: 0.05

2018 Fac PE RVU: 0.05

Result: Decrease

RUC Recommendation: 0.15

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

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 **Global:** XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent
RUC Meeting: April 2010 **Tab** 25 **Specialty Developing** ACC
Recommendation:

First
Identified: October 2009

2017 Est.
Medicare
Utilization: 347,714

2007 Work RVU: 0.52 **2018 Work RVU:** 0.52
2007 NF PE RVU: 3.29 **2018 NF PE RVU:** 3.29
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: 0.52

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

93225 External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; recording (includes connection, recording, and disconnection) **Global:** XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent
RUC Meeting: April 2010 **Tab** 25 **Specialty Developing** ACC
Recommendation:

First
Identified: October 2009

2017 Est.
Medicare
Utilization: 126,389

2007 Work RVU: 0.00 **2018 Work RVU:** 0.00
2007 NF PE RVU: 1.2 **2018 NF PE RVU:** 1.2
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: N/A no physician work

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

93226 External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; scanning analysis with report **Global:** XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent
RUC Meeting: April 2010 **Tab** 25 **Specialty Developing** ACC
Recommendation:

First
Identified: October 2009

2017 Est.
Medicare
Utilization: 175,340

2007 Work RVU: 0.00 **2018 Work RVU:** 0.00
2007 NF PE RVU: 1.88 **2018 NF PE RVU:** 1.88
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Maintain

RUC Recommendation: N/A no physician work

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93227 External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; review and interpretation by a physician or other qualified health care professional **Global:** XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent
RUC Meeting: April 2010 **Tab** 25 **Specialty Developing** ACC
Recommendation:

First
Identified: October 2009

2017 Est.
Medicare
Utilization: 390,987

2007 Work RVU: 0.52
2007 NF PE RVU: 0.21
2007 Fac PE RVU 0.21
2018 Work RVU: 0.52
2018 NF PE RVU: 0.21
2018 Fac PE RVU: 0.21
Result: Maintain

RUC Recommendation: 0.52

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

93228 External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional **Global:** XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent
RUC Meeting: April 2010 **Tab** 25 **Specialty Developing** ACC
Recommendation:

First
Identified: October 2009

2017 Est.
Medicare
Utilization: 127,103

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
2018 Work RVU: 0.52
2018 NF PE RVU:
2018 Fac PE RVU:
Result: Maintain

RUC Recommendation: 0.52

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93229 External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional **Global:** XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent
RUC Meeting: April 2010 **Tab** 25 **Specialty Developing** ACC
Recommendation:

First
Identified: October 2009

2017 Est.
Medicare
Utilization: 214,336

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
2018 Work RVU: 0.00
2018 NF PE RVU:
2018 Fac PE RVU:
Result: Maintain

RUC Recommendation: Contractor Priced

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93230 Deleted from CPT

Global: XXX

Issue: Cardiac Device Monitoring

Screen: CMS Request - 2009
Final Rule, Harvard
Valued - Utilization over
100,000

Complete? Yes

**Most Recent
RUC Meeting:** April 2009

Tab 31

**Specialty Developing
Recommendation:** ACC

**First
Identified:** NA

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.52

2018 Work RVU:

2007 NF PE RVU: 3.49

2018 NF PE RVU: 3.49

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

93231 Deleted from CPT

Global: XXX

Issue: External Cardiovascular
Device Monitoring

Screen: Harvard Valued -
Utilization over 100,000

Complete? Yes

**Most Recent
RUC Meeting:** April 2010

Tab 25

**Specialty Developing
Recommendation:**

**First
Identified:** October 2009

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 1.37

2018 NF PE RVU: 1.37

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

93232 Deleted from CPT

Global: XXX

Issue: External Cardiovascular
Device Monitoring

Screen: Harvard Valued -
Utilization over 100,000

Complete? Yes

**Most Recent
RUC Meeting:** April 2010

Tab 25

**Specialty Developing
Recommendation:**

**First
Identified:** October 2009

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 1.92

2018 NF PE RVU: 1.92

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93233 Deleted from CPT

Global: XXX

Issue: Cardiac Device Monitoring

Screen: CMS Request - 2009
Final Rule, Harvard
Valued - Utilization over
100,000

Complete? Yes

**Most Recent
RUC Meeting:** April 2009

Tab 31

**Specialty Developing
Recommendation:** ACC

**First
Identified:** NA

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.52

2018 Work RVU:

2007 NF PE RVU: 0.2

2018 NF PE RVU: 0.2

2007 Fac PE RVU 0.2

2018 Fac PE RVU:0.2

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

93235 Deleted from CPT

Global: XXX

Issue: External Cardiovascular
Device Monitoring

Screen: Harvard Valued -
Utilization over 100,000

Complete? Yes

**Most Recent
RUC Meeting:** April 2010

Tab 25

**Specialty Developing
Recommendation:**

**First
Identified:** October 2009

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

93236 Deleted from CPT

Global: XXX

Issue: Cardiovascular Stress Test

Screen: Harvard Valued -
Utilization over 100,000

Complete? Yes

**Most Recent
RUC Meeting:** April 2009

Tab 38

**Specialty Developing
Recommendation:** ACC

**First
Identified:** February 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93237 Deleted from CPT **Global:** XXX **Issue:** Wearable Cardiac Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab** 31 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 0.45 **2018 Work RVU:** **2007 NF PE RVU:** 0.18 **2018 NF PE RVU:** 0.18 **2007 Fac PE RVU:** 0.18 **2018 Fac PE RVU:** 0.18 **RUC Recommendation:** Deleted from CPT **Referred to CPT** February 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

93268 External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional **Global:** XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2017 Est. Medicare Utilization:** 14,522 **2007 Work RVU:** 0.52 **2018 Work RVU:** 0.52 **2007 NF PE RVU:** 7.02 **2018 NF PE RVU:** 7.02 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **RUC Recommendation:** 0.52 **Referred to CPT** February 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

93270 External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording, and disconnection) **Global:** XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2017 Est. Medicare Utilization:** 46,564 **2007 Work RVU:** 0.00 **2018 Work RVU:** 0.00 **2007 NF PE RVU:** 1 **2018 NF PE RVU:** 1 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **RUC Recommendation:** New PE inputs **Referred to CPT** February 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** PE Only

Status Report: CMS Requests and Relativity Assessment Issues

93271	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; transmission and analysis	Global: XXX	Issue: External Cardiovascular Device Monitoring	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes							
Most Recent RUC Meeting:	April 2010	Tab 25	Specialty Developing Recommendation:	ACC	First Identified:	October 2009	2017 Est. Medicare Utilization:	72,695	2007 Work RVU:	0.00	2018 Work RVU:	0.00
									2007 NF PE RVU:	5.82	2018 NF PE RVU:	5.82
									2007 Fac PE RVU	NA	2018 Fac PE RVU:	NA
RUC Recommendation:	New PE inputs				Referred to CPT	February 2010	Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	Result:	PE Only	
<hr/>												
93272	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; review and interpretation by a physician or other qualified health care professional	Global: XXX	Issue: External Cardiovascular Device Monitoring	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes							
Most Recent RUC Meeting:	April 2010	Tab 25	Specialty Developing Recommendation:	ACC	First Identified:	October 2009	2017 Est. Medicare Utilization:	110,377	2007 Work RVU:	0.52	2018 Work RVU:	0.52
									2007 NF PE RVU:	0.2	2018 NF PE RVU:	0.2
									2007 Fac PE RVU	0.2	2018 Fac PE RVU:	0.2
RUC Recommendation:	0.52				Referred to CPT	February 2010	Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	Result:	Maintain	
<hr/>												
93279	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system	Global: XXX	Issue: Cardiac Electrophysiology Device Monitoring Services	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes							
Most Recent RUC Meeting:	October 2016	Tab 25	Specialty Developing Recommendation:	ACC, HRS	First Identified:	July 2015	2017 Est. Medicare Utilization:	177,756	2007 Work RVU:		2018 Work RVU:	0.65
									2007 NF PE RVU:		2018 NF PE RVU:	
									2007 Fac PE RVU		2018 Fac PE RVU:	
RUC Recommendation:	0.65				Referred to CPT	February 2017	Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	Result:	Maintain	

Status Report: CMS Requests and Relativity Assessment Issues

93280	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead pacemaker system	Global: XXX	Issue: Cardiac Electrophysiology Device Monitoring Services	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 25 Specialty Developing Recommendation: ACC, HRS	First Identified: July 2015	2017 Est. Medicare Utilization: 1,054,421	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain	2018 Work RVU: 0.77 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.77		Referred to CPT February 2017 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93281	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system	Global: XXX	Issue: Cardiac Electrophysiology Device Monitoring Services	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 25 Specialty Developing Recommendation: ACC, HRS	First Identified: July 2015	2017 Est. Medicare Utilization: 65,336	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 0.85 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.85		Referred to CPT February 2017 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93282	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead transvenous implantable defibrillator system	Global: XXX	Issue: Cardiac Electrophysiology Device Monitoring Services	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 25 Specialty Developing Recommendation: ACC, HRS	First Identified: July 2015	2017 Est. Medicare Utilization: 133,788	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain	2018 Work RVU: 0.85 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.85		Referred to CPT February 2017 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

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93283	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead transvenous implantable defibrillator system	Global: XXX	Issue: Cardiac Electrophysiology Device Monitoring Services	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 25	Specialty Developing Recommendation: ACC, HRS	First Identified: July 2015	2017 Est. Medicare Utilization: 248,740	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain 2018 Work RVU: 1.15 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.15			Referred to CPT February 2017 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		
93284	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead transvenous implantable defibrillator system	Global: XXX	Issue: Cardiac Electrophysiology Device Monitoring Services	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 25	Specialty Developing Recommendation: ACC, HRS	First Identified: July 2015	2017 Est. Medicare Utilization: 268,979	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain 2018 Work RVU: 1.25 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.25			Referred to CPT February 2017 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		
93285	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; implantable loop recorder system	Global: XXX	Issue: Cardiac Electrophysiology Device Monitoring Services	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 25	Specialty Developing Recommendation: ACC, HRS	First Identified: July 2015	2017 Est. Medicare Utilization: 32,130	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain 2018 Work RVU: 0.52 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.52			Referred to CPT February 2017 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		

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93286	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system	Global: XXX	Issue: Cardiac Electrophysiology Device Monitoring Services	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes	
Most Recent RUC Meeting: October 2016	Tab 25	Specialty Developing Recommendation: ACC, HRS	First Identified: July 2015	2017 Est. Medicare Utilization: 14,196	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain	2018 Work RVU: 0.30 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.30			Referred to CPT February 2017 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93287	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system	Global: XXX	Issue: Cardiac Electrophysiology Device Monitoring Services	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes	
Most Recent RUC Meeting: October 2016	Tab 25	Specialty Developing Recommendation: ACC, HRS	First Identified: July 2015	2017 Est. Medicare Utilization: 10,223	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain	2018 Work RVU: 0.45 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.45			Referred to CPT February 2017 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93288	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system	Global: XXX	Issue: Cardiac Electrophysiology Device Monitoring Services	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes	
Most Recent RUC Meeting: October 2016	Tab 25	Specialty Developing Recommendation: ACC, HRS	First Identified: July 2015	2017 Est. Medicare Utilization: 295,146	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain	2018 Work RVU: 0.43 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.43			Referred to CPT February 2017 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

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93289 Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements **Global:** XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 121,132 **2007 Work RVU:** **2007 NF PE RVU:** **2007 Fac PE RVU Result:** Decrease **2018 Work RVU:** 0.75 **2018 NF PE RVU:** **2018 Fac PE RVU:**

RUC Recommendation: 0.75 **Referred to CPT** February 2017 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

93290 Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors **Global:** XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 128,851 **2007 Work RVU:** **2007 NF PE RVU:** **2007 Fac PE RVU Result:** Maintain **2018 Work RVU:** 0.43 **2018 NF PE RVU:** **2018 Fac PE RVU:**

RUC Recommendation: 0.43 **Referred to CPT** February 2017 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

93291 Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable loop recorder system, including heart rhythm derived data analysis **Global:** XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 58,150 **2007 Work RVU:** **2007 NF PE RVU:** **2007 Fac PE RVU Result:** Decrease **2018 Work RVU:** 0.37 **2018 NF PE RVU:** **2018 Fac PE RVU:**

RUC Recommendation: 0.37 **Referred to CPT** February 2017 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

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93292	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; wearable defibrillator system			Global: XXX	Issue: Cardiac Electrophysiology Device Monitoring Services	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes	
Most Recent RUC Meeting:	October 2016	Tab 25	Specialty Developing Recommendation:	ACC, HRS	First Identified: July 2015	2017 Est. Medicare Utilization: 1,309	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain	2018 Work RVU: 0.43 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation:	0.43				Referred to CPT February 2017 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days			Global: XXX	Issue: Cardiac Electrophysiology Device Monitoring Services	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes	
Most Recent RUC Meeting:	January 2017	Tab 23	Specialty Developing Recommendation:	ACC, HRS	First Identified: July 2015	2017 Est. Medicare Utilization: 117,827	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 0.31 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation:	0.31				Referred to CPT February 2017 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93294	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional			Global: XXX	Issue: Cardiac Electrophysiology Device Monitoring Services	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes	
Most Recent RUC Meeting:	January 2017	Tab 23	Specialty Developing Recommendation:	ACC, HRS	First Identified: July 2015	2017 Est. Medicare Utilization: 864,603	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 0.60 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation:	0.60				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

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93295 Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional **Global:** XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 23 Specialty Developing Recommendation: ACC, HRS

First Identified: July 2015

2017 Est. Medicare Utilization: 531,103

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 0.74
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.74

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93296 Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results **Global:** XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016

Tab 25 Specialty Developing Recommendation: ACC, HRS

First Identified: July 2015

2017 Est. Medicare Utilization: 1,024,464

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: PE Only

2018 Work RVU: 0.00
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: New PE inputs and Refer to CPT

Referred to CPT February 2017
Referred to CPT Asst ☐ **Published in CPT Asst:**

93297 Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional **Global:** XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 23 Specialty Developing Recommendation: ACC, HRS

First Identified: July 2015

2017 Est. Medicare Utilization: 334,878

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Maintain

2018 Work RVU: 0.52
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.52

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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93298	Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional	Global: XXX	Issue: Cardiac Electrophysiology Device Monitoring Services	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 23 Specialty Developing Recommendation: ACC, HRS	First Identified: July 2015	2017 Est. Medicare Utilization: 436,964	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain	2018 Work RVU: 0.52 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.52		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93299	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Global: XXX	Issue: Cardiac Electrophysiology Device Monitoring Services	Screen: CMS High Expenditure Procedural Codes2 / Contractor Priced High Volume	Complete? Yes
Most Recent RUC Meeting: October 2018	Tab 22 Specialty Developing Recommendation: ACC, HRS	First Identified: July 2015	2017 Est. Medicare Utilization: 468,596	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: PE Only	2018 Work RVU: 0.00 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: Refer to CPT for deletion. New PE inputs		Referred to CPT May 2019 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93306	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	Global: XXX	Issue: Transthoracic Echocardiography (TTE)	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 42 Specialty Developing Recommendation: ACC	First Identified: July 2015	2017 Est. Medicare Utilization: 7,319,930	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase	2018 Work RVU: 1.50 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.50		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

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93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography	Global: XXX	Issue: Transthoracic Echocardiography (TTE)	Screen: CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 42 Specialty Developing Recommendation: ACC	First Identified: NA	2017 Est. Medicare Utilization: 30,720	2007 Work RVU: 0.92 2007 NF PE RVU: 4.1 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 0.92 2018 NF PE RVU: 4.1 2018 Fac PE RVU: NA
RUC Recommendation: 0.92		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	Global: XXX	Issue: Transthoracic Echocardiography (TTE)	Screen: CMS Fastest Growing, Harvard Valued - Utilization over 100,000 / CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 42 Specialty Developing Recommendation: ACC	First Identified: October 2008	2017 Est. Medicare Utilization: 342,660	2007 Work RVU: 0.53 2007 NF PE RVU: 2.26 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 0.53 2018 NF PE RVU: 2.26 2018 Fac PE RVU: NA
RUC Recommendation: 0.53		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete	Global: ZZZ	Issue: Doppler Echocardiography	Screen: CMS Request - Practice Expense Review / CMS-Other - Utilization over 250,000	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 30 Specialty Developing Recommendation: ACC	First Identified: February 2009	2017 Est. Medicare Utilization: 349,759	2007 Work RVU: 0.38 2007 NF PE RVU: 1.82 2007 Fac PE RVU 1.82 Result: Maintain	2018 Work RVU: 0.38 2018 NF PE RVU: 1.82 2018 Fac PE RVU: 1.82
RUC Recommendation: 0.38		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

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93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging)	Global: ZZZ	Issue: Doppler Echocardiography	Screen: CMS-Other - Utilization over 250,000	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 30 Specialty Developing Recommendation: ACC	First Identified: October 2013	2017 Est. Medicare Utilization: 191,995	2007 Work RVU: 0.15 2007 NF PE RVU: 1.04 2007 Fac PE RVU: 1.04 Result: Maintain	2018 Work RVU: 0.15 2018 NF PE RVU: 1.04 2018 Fac PE RVU: 1.04
RUC Recommendation: 0.15		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)	Global: ZZZ	Issue: Doppler Echocardiography	Screen: CMS Request - Practice Expense Review / CMS-Other - Utilization over 250,000	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 30 Specialty Developing Recommendation: ACC	First Identified: February 2009	2017 Est. Medicare Utilization: 541,232	2007 Work RVU: 0.07 2007 NF PE RVU: 2.36 2007 Fac PE RVU: 2.36 Result: Maintain	2018 Work RVU: 0.07 2018 NF PE RVU: 2.36 2018 Fac PE RVU: 2.36
RUC Recommendation: 0.07		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
93350	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report;	Global: XXX	Issue: Stress Transthoracic Echocardiography (TTE) Complete	Screen: Other - Identified by RUC / Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 26 Specialty Developing Recommendation: ACC, ASE	First Identified: April 2008	2017 Est. Medicare Utilization: 106,012	2007 Work RVU: 1.48 2007 NF PE RVU: 3.03 2007 Fac PE RVU: NA Result: Decrease	2018 Work RVU: 1.46 2018 NF PE RVU: 3.03 2018 Fac PE RVU: NA
RUC Recommendation: 1.46; CPT Assistant article published		Referred to CPT October 2010 Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Jan 2010		

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93351	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional	Global: XXX	Issue: Stress Transthoracic Echocardiography (TTE) Complete	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes		
Most Recent RUC Meeting:	October 2016	Tab 26	Specialty Developing Recommendation: ACC, ASE	First Identified: July 2015	2017 Est. Medicare Utilization: 253,254	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain	2018 Work RVU: 1.75 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation:	1.75			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93451	Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed	Global: 000	Issue: Diagnostic Cardiac Catheterization	Screen: Codes Reported Together 95% or More / Modifier -51 Exempt	Complete? Yes		
Most Recent RUC Meeting:	April 2018	Tab 33	Specialty Developing Recommendation: ACC	First Identified:	2017 Est. Medicare Utilization: 41,867	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 2.47 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation:	Remove from Modifier -51 exempt list. 3.02			Referred to CPT October 2009 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93452	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	Global: 000	Issue: Diagnostic Cardiac Catheterization	Screen: Codes Reported Together 95% or More	Complete? Yes		
Most Recent RUC Meeting:	April 2011	Tab 28	Specialty Developing Recommendation: ACC	First Identified:	2017 Est. Medicare Utilization: 4,241	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 4.50 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation:	4.32			Referred to CPT October 2009 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

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93453 Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed **Global:** 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011

Tab 28 Specialty Developing Recommendation: ACC

First Identified:

2017 Est. Medicare Utilization: 3,058

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 5.99
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 5.98

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

93454 Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; **Global:** 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011

Tab 28 Specialty Developing Recommendation: ACC

First Identified:

2017 Est. Medicare Utilization: 117,035

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 4.54
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.95

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

93455 Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography **Global:** 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011

Tab 28 Specialty Developing Recommendation: ACC

First Identified:

2017 Est. Medicare Utilization: 28,452

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 5.29
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 6.15

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

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93456 Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization **Global:** 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018

Tab 33 Specialty Developing Recommendation: ACC

First Identified:

2017 Est. Medicare Utilization: 17,474

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 5.90
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: Remove from Modifier -51 Exempt List. 6.00

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

93457 Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization **Global:** 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011

Tab 28 Specialty Developing Recommendation: ACC

First Identified:

2017 Est. Medicare Utilization: 3,590

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 6.64
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 7.66

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

93458 Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed **Global:** 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011

Tab 28 Specialty Developing Recommendation: ACC

First Identified:

2017 Est. Medicare Utilization: 522,086

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 5.60
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 6.51

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

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93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	Global: 000	Issue: Diagnostic Cardiac Catheterization	Screen: Codes Reported Together 95% or More	Complete? Yes		
Most Recent RUC Meeting:	April 2011	Tab 28	Specialty Developing Recommendation: ACC	First Identified:	2017 Est. Medicare Utilization: 102,120	2007 Work RVU:	2018 Work RVU: 6.35
						2007 NF PE RVU:	2018 NF PE RVU:
						2007 Fac PE RVU	2018 Fac PE RVU:
RUC Recommendation:	7.34			Referred to CPT	October 2009	Result: Decrease	
				Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	

93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	Global: 000	Issue: Diagnostic Cardiac Catheterization	Screen: Codes Reported Together 95% or More	Complete? Yes		
Most Recent RUC Meeting:	April 2011	Tab 28	Specialty Developing Recommendation: ACC	First Identified:	2017 Est. Medicare Utilization: 90,213	2007 Work RVU:	2018 Work RVU: 7.10
						2007 NF PE RVU:	2018 NF PE RVU:
						2007 Fac PE RVU	2018 Fac PE RVU:
RUC Recommendation:	7.88			Referred to CPT	October 2009	Result: Decrease	
				Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	

93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	Global: 000	Issue: Diagnostic Cardiac Catheterization	Screen: Codes Reported Together 95% or More	Complete? Yes		
Most Recent RUC Meeting:	April 2011	Tab 28	Specialty Developing Recommendation: ACC	First Identified:	2017 Est. Medicare Utilization: 15,421	2007 Work RVU:	2018 Work RVU: 7.85
						2007 NF PE RVU:	2018 NF PE RVU:
						2007 Fac PE RVU	2018 Fac PE RVU:
RUC Recommendation:	9.00			Referred to CPT	October 2009	Result: Decrease	
				Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

93462 Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011

Tab 28 Specialty Developing Recommendation: ACC

First Identified:

2017 Est. Medicare Utilization: 5,197

2007 Work RVU:

2018 Work RVU: 3.73

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 3.73

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

93463 Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed (List separately in addition to code for primary procedure)

Global: ZZZ

Issue: Diagnostic Cardiac Catheterization

Screen: Codes Reported Together 95% or More

Complete? Yes

Most Recent RUC Meeting: April 2011

Tab 28 Specialty Developing Recommendation: ACC

First Identified:

2017 Est. Medicare Utilization: 6,407

2007 Work RVU:

2018 Work RVU: 2.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 2.00

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

93464 Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)

Global: ZZZ

Issue: Diagnostic Cardiac Catheterization

Screen: Codes Reported Together 95% or More

Complete? Yes

Most Recent RUC Meeting: April 2011

Tab 28 Specialty Developing Recommendation: ACC

First Identified:

2017 Est. Medicare Utilization: 853

2007 Work RVU:

2018 Work RVU: 1.80

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 1.80

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93501 Deleted from CPT

Global: 000

Issue: Cardiac Catheterization

Screen: Codes Reported
Together 95% or More

Complete? Yes

**Most Recent
RUC Meeting:** April 2010

Tab 26

**Specialty Developing
Recommendation:** ACC

**First
Identified:** February 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93503 Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes

Global: 000

Issue: Insertion of Catheter

Screen: CMS High Expenditure
Procedural Codes2 /
Codes Reported
Together 75%or More-
Part4 / Modifier -51
Exempt

Complete? Yes

**Most Recent
RUC Meeting:** April 2018

Tab 33

**Specialty Developing
Recommendation:** ACR, ASA

**First
Identified:** July 2015

**2017 Est.
Medicare
Utilization:** 82,408

2007 Work RVU: 0.00

2018 Work RVU: 2.00

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: 2.00

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

93508 Deleted from CPT

Global: 000

Issue: Cardiac Catheterization

Screen: Codes Reported
Together 95% or More

Complete? Yes

**Most Recent
RUC Meeting:** April 2010

Tab 26

**Specialty Developing
Recommendation:** ACC

**First
Identified:** February 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

93510 Deleted from CPT

Global: 000

Issue: Cardiac Catheterization

Screen: Codes Reported Together 95% or More/
CMS Request - Practice Expense Review, Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: February 2009

Tab 31

Specialty Developing Recommendation: ACC

First Identified: February 2008

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU: 0

2018 Fac PE RVU: 0

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

93511 Deleted from CPT

Global: 000

Issue: Cardiac Catheterization

Screen: Codes Reported Together 95% or More

Complete? Yes

Most Recent RUC Meeting: April 2010

Tab 26

Specialty Developing Recommendation: ACC

First Identified: February 2008

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 0

2018 Fac PE RVU: 0

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

93514 Deleted from CPT

Global: 000

Issue: Cardiac Catheterization

Screen: Codes Reported Together 95% or More

Complete? Yes

Most Recent RUC Meeting: April 2010

Tab 26

Specialty Developing Recommendation: ACC

First Identified: February 2008

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU: 0

2018 Fac PE RVU: 0

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93524 Deleted from CPT

Global: 000

Issue: Cardiac Catheterization

Screen: Codes Reported
Together 95% or More

Complete? Yes

**Most Recent
RUC Meeting:** April 2010

Tab 26

**Specialty Developing
Recommendation:** ACC

**First
Identified:** February 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93526 Deleted from CPT

Global: 000

Issue: Cardiac Catheterization

Screen: Codes Reported
Together 95% or More /
Harvard Valued -
Utilization over 100,000

Complete? Yes

**Most Recent
RUC Meeting:** February 2008

Tab S

**Specialty Developing
Recommendation:** ACC

**First
Identified:** February 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93527 Deleted from CPT

Global: 000

Issue: Cardiac Catheterization

Screen: Codes Reported
Together 95% or More

Complete? Yes

**Most Recent
RUC Meeting:** April 2010

Tab 26

**Specialty Developing
Recommendation:** ACC

**First
Identified:** February 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

93528 Deleted from CPT

Global: 000

Issue: Cardiac Catheterization

Screen: Codes Reported
Together 95% or More

Complete? Yes

**Most Recent
RUC Meeting:** April 2010

Tab 26

**Specialty Developing
Recommendation:** ACC

**First
Identified:** February 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93529 Deleted from CPT

Global: 000

Issue: Cardiac Catheterization

Screen: Codes Reported
Together 95% or More

Complete? Yes

**Most Recent
RUC Meeting:** April 2010

Tab 26

**Specialty Developing
Recommendation:** ACC

**First
Identified:** February 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93539 Deleted from CPT

Global: 000

Issue: Cardiac Catheterization

Screen: Codes Reported
Together 95% or More

Complete? Yes

**Most Recent
RUC Meeting:** February 2008

Tab S

**Specialty Developing
Recommendation:** ACC

**First
Identified:** February 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93540 Deleted from CPT

Global: 000

Issue: Cardiac Catheterization

Screen: Codes Reported
Together 95% or More

Complete? Yes

**Most Recent
RUC Meeting:** February 2008

Tab S

**Specialty Developing
Recommendation:** ACC

**First
Identified:** February 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

93541 Deleted from CPT

Global: 000

Issue: Cardiac Catheterization

Screen: Codes Reported
Together 95% or More

Complete? Yes

**Most Recent
RUC Meeting:** April 2010

Tab 26

**Specialty Developing
Recommendation:** ACC

**First
Identified:** February 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93542 Deleted from CPT

Global: 000

Issue: Cardiac Catheterization

Screen: Codes Reported
Together 95% or More

Complete? Yes

**Most Recent
RUC Meeting:** April 2010

Tab 26

**Specialty Developing
Recommendation:** ACC

**First
Identified:** February 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93543 Deleted from CPT

Global: 000

Issue: Cardiac Catheterization

Screen: Codes Reported
Together 95% or More /
CMS Request - Practice
Expense Review,
Harvard Valued -
Utilization over 100,000

Complete? Yes

**Most Recent
RUC Meeting:** February 2009

Tab 31

**Specialty Developing
Recommendation:** ACC

**First
Identified:** February 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

93544 Deleted from CPT

Global: 000

Issue: Cardiac Catheterization

Screen: Codes Reported
Together 95% or More

Complete? Yes

**Most Recent
RUC Meeting:** February 2008

Tab S

**Specialty Developing
Recommendation:** ACC

**First
Identified:** February 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93545 Deleted from CPT

Global: 000

Issue: Cardiac Catheterization

Screen: Codes Reported
Together 95% or More /
CMS Request - Practice
Expense Review

Complete? Yes

**Most Recent
RUC Meeting:** February 2009

Tab 31

**Specialty Developing
Recommendation:** ACC

**First
Identified:** February 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

93555 Deleted from CPT

Global: XXX

Issue: Cardiac Catheterization

Screen: Codes Reported
Together 95% or More /
CMS Request - Practice
Expense Review

Complete? Yes

**Most Recent
RUC Meeting:** February 2009

Tab 31

**Specialty Developing
Recommendation:** ACC

**First
Identified:** February 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

93556 Deleted from CPT

Global: XXX **Issue:** Cardiac Catheterization

Screen: Codes Reported Together 95% or More / CMS Request - Practice Expense Review

Complete? Yes

Most Recent
RUC Meeting: February 2009

Tab 31 **Specialty Developing** ACC
Recommendation:

First
Identified: February 2008

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

93561 Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)

Global: 000

Issue: Cardiac Output Measurement

Screen: Negative IWPUT

Complete? Yes

Most Recent
RUC Meeting: January 2018

Tab 27 **Specialty Developing**
Recommendation:

First
Identified: October 2017

2017 Est.
Medicare
Utilization: 30

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Increase

RUC Recommendation: 0.77

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93562 Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output

Global: 000

Issue: Cardiac Output Measurement

Screen: Negative IWPUT

Complete? Yes

Most Recent
RUC Meeting: January 2018

Tab 27 **Specialty Developing**
Recommendation:

First
Identified: October 2017

2017 Est.
Medicare
Utilization: 39

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Increase

RUC Recommendation: 0.95

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93563 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2017 Est. Medicare Utilization:** 171 **2007 Work RVU:** **2018 Work RVU:** 1.11 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 2.00 **Referred to CPT** October 2009 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

93564 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2017 Est. Medicare Utilization:** 9 **2007 Work RVU:** **2018 Work RVU:** 1.13 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 2.10 **Referred to CPT** October 2009 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

93565 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2017 Est. Medicare Utilization:** 106 **2007 Work RVU:** **2018 Work RVU:** 0.86 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 1.90 **Referred to CPT** October 2009 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93566	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Diagnostic Cardiac Catheterization	Screen: Codes Reported Together 95% or More	Complete? Yes
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Most Recent RUC Meeting: April 2011

Tab 28 Specialty Developing Recommendation: ACC

First Identified:

2017 Est. Medicare Utilization: 500

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 0.86
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.96

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

93567	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supraaortic aortography (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Diagnostic Cardiac Catheterization	Screen: Codes Reported Together 95% or More	Complete? Yes
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Most Recent RUC Meeting: April 2011

Tab 28 Specialty Developing Recommendation: ACC

First Identified:

2017 Est. Medicare Utilization: 34,266

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 0.97
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.97

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

93568	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Diagnostic Cardiac Catheterization	Screen: Codes Reported Together 95% or More	Complete? Yes
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Most Recent RUC Meeting: April 2011

Tab 28 Specialty Developing Recommendation: ACC

First Identified:

2017 Est. Medicare Utilization: 2,143

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 0.88
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.98

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93571 Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Coronary Flow Reserve Measurement **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017

Tab 13 Specialty Developing Recommendation: ACC, SCAI

First Identified: October 2016

2017 Est. Medicare Utilization: 63,676

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Decrease

RUC Recommendation: 1.50

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

93572 Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Coronary Flow Reserve Measurement **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017

Tab 13 Specialty Developing Recommendation: ACC, SCAI

First Identified: October 2017

2017 Est. Medicare Utilization: 10,713

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU: 0

2018 Fac PE RVU: 0

Result: Decrease

RUC Recommendation: 1.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

93613 Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Intracardiac 3D Mapping add-on **Screen:** CMS Fastest Growing / High Volume Growth2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 24 Specialty Developing Recommendation: ACC, HRS

First Identified: October 2008

2017 Est. Medicare Utilization: 65,821

2007 Work RVU: 6.99

2018 Work RVU: 5.23

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU: 3.03

2018 Fac PE RVU: 3.03

Result: Decrease

RUC Recommendation: 5.23

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

93620	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording	Global: 000	Issue: Intracardiac Catheter Ablation	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 45 Specialty Developing Recommendation: ACC	First Identified: February 2010	2017 Est. Medicare Utilization: 10,253	2007 Work RVU: 0.00 2007 NF PE RVU: 0 2007 Fac PE RVU: 0 Result: Maintain	2018 Work RVU: 0.00 2018 NF PE RVU: 0 2018 Fac PE RVU: 0
RUC Recommendation: 11.57		Referred to CPT October 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93623	Programmed stimulation and pacing after intravenous drug infusion (List separately in addition to code for primary procedure)	Global: ZZZ	Issue:	Screen: CMS-Other - Utilization over 30,000	Complete? No
Most Recent RUC Meeting: October 2018	Tab 27 Specialty Developing Recommendation:	First Identified: October 2018	2017 Est. Medicare Utilization: 34,890	2007 Work RVU: 0.00 2007 NF PE RVU: 0 2007 Fac PE RVU: 0 Result:	2018 Work RVU: 0.00 2018 NF PE RVU: 0 2018 Fac PE RVU: 0
RUC Recommendation: Review action plan		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93641	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement; with testing of single or dual chamber pacing cardioverter-defibrillator pulse generator	Global: 000	Issue: Insertion/Removal of Pacemaker or Pacing Cardioverter-Defibrillator	Screen: Codes Reported Together 75% or More-Part1 / Pre-Time Analysis	Complete? Yes
Most Recent RUC Meeting: September 2014	Tab 21 Specialty Developing Recommendation: ACC	First Identified: February 2010	2017 Est. Medicare Utilization: 22,830	2007 Work RVU: 0.00 2007 NF PE RVU: NA 2007 Fac PE RVU: NA Result: Maintain	2018 Work RVU: 0.00 2018 NF PE RVU: NA 2018 Fac PE RVU: NA
RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 2B.		Referred to CPT February 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

93651 Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination **Global:** 000 **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent **Tab** 11 **Specialty Developing** ACC, HRS
RUC Meeting: January 2012 **Recommendation:**

First Identified: February 2010 **2017 Est. Medicare Utilization:**

2007 Work RVU: 16.23 **2018 Work RVU:**
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 6.96 **2018 Fac PE RVU:**6.96
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

93652 Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia **Global:** 000 **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** CMS Fastest Growing/Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent **Tab** 11 **Specialty Developing** ACC, HRS
RUC Meeting: January 2012 **Recommendation:**

First Identified: October 2008 **2017 Est. Medicare Utilization:**

2007 Work RVU: 17.65 **2018 Work RVU:**
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU 7.58 **2018 Fac PE RVU:**7.58
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

93653 Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry **Global:** 000 **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent **Tab** 11 **Specialty Developing** ACC, HRS
RUC Meeting: January 2012 **Recommendation:**

First Identified: October 2011 **2017 Est. Medicare Utilization:** 31,544

2007 Work RVU: **2018 Work RVU:** 14.75
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU **2018 Fac PE RVU:**
Result: Decrease

RUC Recommendation: 15.00

Referred to CPT October 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93654 Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3D mapping, when performed, and left ventricular pacing and recording, when performed

Global: 000 **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab 11 Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2017 Est. Medicare Utilization:** 6,665 **2007 Work RVU:** **2018 Work RVU:** 19.75 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Decrease **2018 Fac PE RVU:**

RUC Recommendation: 20.00 **Referred to CPT** October 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

93655 Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (List separately in addition to code for primary procedure)

Global: ZZZ **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab 11 Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2017 Est. Medicare Utilization:** 22,269 **2007 Work RVU:** **2018 Work RVU:** 7.50 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Decrease **2018 Fac PE RVU:**

RUC Recommendation: 9.00 **Referred to CPT** October 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

93656 Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia including left or right atrial pacing/recording when necessary, right ventricular pacing/recording when necessary, and His bundle recording when necessary with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation

Global: 000 **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab 11 Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2017 Est. Medicare Utilization:** 40,222 **2007 Work RVU:** **2018 Work RVU:** 19.77 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Decrease **2018 Fac PE RVU:**

RUC Recommendation: 20.02 **Referred to CPT** October 2011 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93657 Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012

Tab 11 **Specialty Developing Recommendation:** ACC, HRS

First Identified: October 2011

2017 Est. Medicare Utilization: 16,089

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 7.50
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 10.00

Referred to CPT October 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

93662 Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Electrocardiography **Screen:** High Volume Growth1 / High Volume Growth5 **Complete?** No

Most Recent RUC Meeting: September 2014

Tab 21 **Specialty Developing Recommendation:** ACC

First Identified: February 2008

2017 Est. Medicare Utilization: 46,505

2007 Work RVU: 0.00
2007 NF PE RVU: 0
2007 Fac PE RVU 0
Result: Maintain

2018 Work RVU: 0.00
2018 NF PE RVU: 0
2018 Fac PE RVU:0

RUC Recommendation: Review action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93668 Peripheral arterial disease (PAD) rehabilitation, per session **Global:** XXX **Issue:** Peripheral Artery Disease (PAD) Rehabilitation (PE Only) **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2018

Tab 28 **Specialty Developing Recommendation:**

First Identified: July 2017

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00
2007 NF PE RVU: 0.4
2007 Fac PE RVU NA
Result: PE Only

2018 Work RVU: 0.00
2018 NF PE RVU: 0.4
2018 Fac PE RVU:NA

RUC Recommendation: New PE Inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93701 Bioimpedance-derived physiologic cardiovascular analysis

Global: XXX

Issue:

Screen: Low Value-High Volume

Complete? Yes

Most Recent
RUC Meeting: February 2011

Tab 41

Specialty Developing
Recommendation:

First
Identified: October 2010

2017 Est.
Medicare
Utilization: 29,900

2007 Work RVU: 0.17

2018 Work RVU: 0.00

2007 NF PE RVU: 0.91

2018 NF PE RVU: 0.91

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Remove from Screen

RUC Recommendation: Remove from screen

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

93731 Deleted from CPT

Global: XXX

Issue: Cardiology Services

Screen: CMS Fastest Growing

Complete? Yes

Most Recent
RUC Meeting: October 2008

Tab 26

Specialty Developing ACC
Recommendation:

First
Identified: October 2008

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.45

2018 Work RVU:

2007 NF PE RVU: 0.7

2018 NF PE RVU: 0.7

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

93732 Deleted from CPT

Global: XXX

Issue: Cardiology Services

Screen: CMS Fastest Growing

Complete? Yes

Most Recent
RUC Meeting: October 2008

Tab 26

Specialty Developing ACC
Recommendation:

First
Identified: October 2008

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.92

2018 Work RVU:

2007 NF PE RVU: 0.94

2018 NF PE RVU: 0.94

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

93733 Deleted from CPT

Global: XXX

Issue: Cardiology Services

Screen: CMS Fastest Growing

Complete? Yes

Most Recent
RUC Meeting: October 2008

Tab 26

Specialty Developing ACC
Recommendation:

First
Identified: October 2008

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.17

2018 Work RVU:

2007 NF PE RVU: 0.83

2018 NF PE RVU: 0.83

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

93743 Deleted from CPT

Global: XXX

Issue: Cardiology Services

Screen: CMS Fastest Growing

Complete? Yes

**Most Recent
RUC Meeting:** October 2008

Tab 26

**Specialty Developing
Recommendation:** ACC

**First
Identified:** October 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 1.03

2018 Work RVU:

2007 NF PE RVU: 1.15

2018 NF PE RVU: 1.15

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

93744 Deleted from CPT

Global: XXX

Issue: Cardiology Services

Screen: CMS Fastest Growing

Complete? Yes

**Most Recent
RUC Meeting:** October 2008

Tab 26

**Specialty Developing
Recommendation:** ACC

**First
Identified:** October 2008

**2017 Est.
Medicare
Utilization:**

2007 Work RVU: 1.18

2018 Work RVU:

2007 NF PE RVU: 1.19

2018 NF PE RVU: 1.19

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

93750 Interrogation of ventricular assist device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report

Global: XXX

Issue:

Screen: High Volume Growth5

Complete? No

**Most Recent
RUC Meeting:**

Tab

**Specialty Developing
Recommendation:**

**First
Identified:** October 2018

**2017 Est.
Medicare
Utilization:** 86,025

2007 Work RVU:

2018 Work RVU: 0.92

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result:

RUC Recommendation: Review action plan

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

93792	Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring under the direction of a physician or other qualified health care professional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient's/caregiver's ability to perform testing and report results	Global: XXX	Issue: Home INR Monitoring	Screen: High Volume Growth3	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 19 Specialty Developing Recommendation:	First Identified: September 2016	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: PE Only	2018 Work RVU: 0.00 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.00 PE Only		Referred to CPT September 2016 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93793	Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed	Global: XXX	Issue: Home INR Monitoring	Screen: High Volume Growth3	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 19 Specialty Developing Recommendation:	First Identified: September 2016	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain	2018 Work RVU: 0.18 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.18		Referred to CPT September 2016 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93875	Deleted from CPT	Global: XXX	Issue: Noninvasive Vascular Diagnostic Studies	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 45 Specialty Developing Recommendation: AAN, ACC, ACR, SIR, SVS	First Identified: February 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 0.22 2007 NF PE RVU: 2.38 2007 Fac PE RVU NA Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 2.38 2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT		Referred to CPT October 2010 Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: SS in process of developing draft of CPT Asst article (Aug 2011). Code was deleted		

Status Report: CMS Requests and Relativity Assessment Issues

93880 Duplex scan of extracranial arteries; complete bilateral study				Global: XXX	Issue: Duplex Scans	Screen: Codes Reported Together 75% or More- Part1 / CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 33	Specialty Developing Recommendation:	ACR, ACC, SVS	First Identified: February 2010	2017 Est. Medicare Utilization: 2,348,884	2007 Work RVU: 0.60 2007 NF PE RVU: 5.67 2007 Fac PE RVU NA Result: Increase	2018 Work RVU: 0.80 2018 NF PE RVU: 5.67 2018 Fac PE RVU: NA
RUC Recommendation: 0.80				Referred to CPT October 2010 Referred to CPT Asst <input checked="" type="checkbox"/>		Published in CPT Asst: Addressed in CPT Coding Changes	
93882 Duplex scan of extracranial arteries; unilateral or limited study				Global: XXX	Issue: Duplex Scans	Screen: CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 33	Specialty Developing Recommendation:	ACC, ACR, SVS	First Identified: January 2012	2017 Est. Medicare Utilization: 38,864	2007 Work RVU: 0.40 2007 NF PE RVU: 3.63 2007 Fac PE RVU NA Result: Increase	2018 Work RVU: 0.50 2018 NF PE RVU: 3.63 2018 Fac PE RVU: NA
RUC Recommendation: 0.50				Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	
93886 Transcranial Doppler study of the intracranial arteries; complete study				Global: XXX	Issue: Duplex Scans	Screen: Codes Reported Together 75% or More- Part1 / CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 33	Specialty Developing Recommendation:	AAN, ACC, ACR, SVS	First Identified: February 2010	2017 Est. Medicare Utilization: 90,973	2007 Work RVU: 0.94 2007 NF PE RVU: 6.77 2007 Fac PE RVU NA Result: Increase	2018 Work RVU: 0.91 2018 NF PE RVU: 6.77 2018 Fac PE RVU: NA
RUC Recommendation: 1.00				Referred to CPT October 2010 Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

93888	Transcranial Doppler study of the intracranial arteries; limited study	Global: XXX	Issue: Duplex Scans	Screen: Codes Reported Together 75% or More- Part1 / CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 33	Specialty Developing Recommendation: AAN, ACC, ACR, SVS	First Identified: February 2010	2017 Est. Medicare Utilization: 11,921	2007 Work RVU: 0.62 2007 NF PE RVU: 4.36 2007 Fac PE RVU NA Result: Increase 2018 Work RVU: 0.50 2018 NF PE RVU: 4.36 2018 Fac PE RVU: NA
RUC Recommendation: 0.70			Referred to CPT October 2010 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
93895	Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral	Global: XXX	Issue: Carotid Intima-Media Thickness Ultrasound	Screen: New Code in CPT 2015	Complete? Yes
Most Recent RUC Meeting: April 2015	Tab 37	Specialty Developing Recommendation: No Interest	First Identified: April 2014	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Not Part of RAW 2018 Work RVU: 0.00 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: Rescind April 2014 recommendation, contractor price.			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
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)	Global: XXX	Issue: Extremity Non-Invasive Arterial Physiologic Studies	Screen: CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: April 2010	Tab 27	Specialty Developing Recommendation: SVS, ACR, ACC	First Identified: October 2008	2017 Est. Medicare Utilization: 677,730	2007 Work RVU: 0.25 2007 NF PE RVU: 2.78 2007 Fac PE RVU NA Result: Maintain 2018 Work RVU: 0.25 2018 NF PE RVU: 2.78 2018 Fac PE RVU: NA
RUC Recommendation: 0.25			Referred to CPT February 2010 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

93923 Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)

Global: XXX

Issue: Extremity Non-Invasive Arterial Physiologic Studies

Screen: CMS Fastest Growing

Complete? Yes

Most Recent RUC Meeting: April 2010

Tab 27 Specialty Developing Recommendation: SVS, ACR, ACC

First Identified: February 2009

2017 Est. Medicare Utilization: 463,973

2007 Work RVU: 0.45

2018 Work RVU: 0.45

2007 NF PE RVU: 4.18

2018 NF PE RVU: 4.18

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Maintain

RUC Recommendation: 0.45

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

93924 Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study

Global: XXX

Issue: Extremity Non-Invasive Arterial Physiologic Studies

Screen: CMS Fastest Growing

Complete? Yes

Most Recent RUC Meeting: April 2010

Tab 27 Specialty Developing Recommendation: SVS, ACR, ACC

First Identified: February 2009

2017 Est. Medicare Utilization: 70,473

2007 Work RVU: 0.50

2018 Work RVU: 0.50

2007 NF PE RVU: 5.05

2018 NF PE RVU: 5.05

2007 Fac PE RVU: NA

2018 Fac PE RVU: NA

Result: Maintain

RUC Recommendation: 0.50

Referred to CPT February 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93925	Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study	Global: XXX	Issue: Duplex Scans	Screen: CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 33 Specialty Developing Recommendation: ACC, ACR, SVS	First Identified: April 2011	2017 Est. Medicare Utilization: 620,423	2007 Work RVU: 0.58 2007 NF PE RVU: 7.05 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 0.80 2018 NF PE RVU: 7.05 2018 Fac PE RVU: NA
RUC Recommendation: 0.80		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
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93926	Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study	Global: XXX	Issue: Duplex Scans	Screen: CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 33 Specialty Developing Recommendation: ACC, ACR, SVS	First Identified: April 2011	2017 Est. Medicare Utilization: 251,829	2007 Work RVU: 0.39 2007 NF PE RVU: 4.31 2007 Fac PE RVU NA Result: Increase	2018 Work RVU: 0.50 2018 NF PE RVU: 4.31 2018 Fac PE RVU: NA
RUC Recommendation: 0.60		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
93930	Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study	Global: XXX	Issue: Duplex Scans	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 33 Specialty Developing Recommendation: AAN, ACC, ACR, SIR, SVS	First Identified: November 2013	2017 Est. Medicare Utilization: 23,690	2007 Work RVU: 0.46 2007 NF PE RVU: 5.54 2007 Fac PE RVU NA Result: Increase	2018 Work RVU: 0.80 2018 NF PE RVU: 5.54 2018 Fac PE RVU: NA
RUC Recommendation: 0.80		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
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Status Report: CMS Requests and Relativity Assessment Issues

93931	Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study	Global: XXX	Issue: Duplex Scans	Screen: Codes Reported Together 75% or More- Part1 / CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 33	Specialty Developing Recommendation: AAN, ACC, ACR, SIR, SVS	First Identified: February 2010	2017 Est. Medicare Utilization: 45,467	2007 Work RVU: 0.31 2007 NF PE RVU: 3.64 2007 Fac PE RVU: NA Result: Increase
RUC Recommendation: 0.50			Referred to CPT October 2010	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
93965	Noninvasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)	Global: XXX	Issue: Non-invasive Physiologic Studies of Extremity Veins	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2016	Tab 47	Specialty Developing Recommendation: ACC, ACR, SCAI, SVS	First Identified: July 2015	2017 Est. Medicare Utilization:	2007 Work RVU: 0.35 2007 NF PE RVU: 2.83 2007 Fac PE RVU: NA Result: Deleted from CPT
RUC Recommendation: Deleted from CPT			Referred to CPT May 2016	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	Global: XXX	Issue: Duplex Scans	Screen: CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 33	Specialty Developing Recommendation: ACC, ACR, SVS	First Identified: April 2011	2017 Est. Medicare Utilization: 1,635,507	2007 Work RVU: 0.68 2007 NF PE RVU: 5.44 2007 Fac PE RVU: NA Result: Maintain
RUC Recommendation: 0.70			Referred to CPT	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	Global: XXX	Issue: Duplex Scans	Screen: Low Value-High Volume / CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 33	Specialty Developing Recommendation: ACR, SVS, ACC	First Identified: October 2010	2017 Est. Medicare Utilization: 1,748,441	2007 Work RVU: 0.45 2007 NF PE RVU: 3.67 2007 Fac PE RVU NA Result: Maintain
RUC Recommendation: 0.45			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.45 2018 NF PE RVU: 3.67 2018 Fac PE RVU: NA
93975	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study	Global: XXX	Issue: Duplex Scans	Screen: CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 33	Specialty Developing Recommendation: ACR, SVS, ACC	First Identified: November 2013	2017 Est. Medicare Utilization: 205,909	2007 Work RVU: 1.80 2007 NF PE RVU: 7.78 2007 Fac PE RVU NA Result: Decrease
RUC Recommendation: 1.30			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 1.16 2018 NF PE RVU: 7.78 2018 Fac PE RVU: NA
93976	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study	Global: XXX	Issue: Duplex Scans	Screen: CMS Fastest Growing / CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting: April 2014	Tab 33	Specialty Developing Recommendation: ACR	First Identified: October 2008	2017 Est. Medicare Utilization: 157,743	2007 Work RVU: 1.21 2007 NF PE RVU: 4.33 2007 Fac PE RVU NA Result: Decrease
RUC Recommendation: 1.00			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 0.80 2018 NF PE RVU: 4.33 2018 Fac PE RVU: NA

Status Report: CMS Requests and Relativity Assessment Issues

93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study			Global: XXX	Issue: Duplex Scans	Screen: CMS-Other - Utilization over 250,000 / CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting:	April 2014	Tab 33	Specialty Developing Recommendation:	First Identified: April 2013	2017 Est. Medicare Utilization: 297,320	2007 Work RVU: 0.65 2007 NF PE RVU: 4.85 2007 Fac PE RVU NA Result: Increase	2018 Work RVU: 0.80 2018 NF PE RVU: 4.85 2018 Fac PE RVU:NA
RUC Recommendation: 0.97				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93979	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study			Global: XXX	Issue: Duplex Scans	Screen: CMS-Other - Utilization over 250,000 / CMS Request - Final Rule for 2014	Complete? Yes
Most Recent RUC Meeting:	April 2014	Tab 33	Specialty Developing Recommendation:	First Identified: October 2013	2017 Est. Medicare Utilization: 69,893	2007 Work RVU: 0.44 2007 NF PE RVU: 3.46 2007 Fac PE RVU NA Result: Increase	2018 Work RVU: 0.50 2018 NF PE RVU: 3.46 2018 Fac PE RVU:NA
RUC Recommendation: 0.70				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
93982	Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report			Global: XXX	Issue: Endovascular Repair Procedures (EVAR)	Screen: Codes Reported Together 75%or More-Part3	Complete? Yes
Most Recent RUC Meeting:	January 2017	Tab 10	Specialty Developing Recommendation: SVS, SIR, STS, AATS	First Identified: January 2017	2017 Est. Medicare Utilization: 41	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: Deleted from CPT				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

93990 Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow) **Global:** XXX **Issue:** Doppler Flow Testing **Screen:** CMS Fastest Growing / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014

Tab 40 **Specialty Developing Recommendation:** ACR, SVS

First Identified: October 2008

2017 Est. Medicare Utilization: 124,927

2007 Work RVU: 0.25

2018 Work RVU: 0.50

2007 NF PE RVU: 4.28

2018 NF PE RVU: 4.28

2007 Fac PE RVU NA

2018 Fac PE RVU: NA

Result: Increase

RUC Recommendation: 0.60

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

93X00

Global:

Issue: Duplex Scan Arterial Inflow-Venous Outflow Upper Extremity

Screen: CMS-Other - Utilization over 30,000

Complete? No

Most Recent RUC Meeting:

Tab **Specialty Developing Recommendation:**

First Identified: September 2018

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result:

RUC Recommendation:

Referred to CPT September 2018

Referred to CPT Asst ☐

Published in CPT Asst:

93X01

Global:

Issue: Duplex Scan Arterial Inflow-Venous Outflow Upper Extremity

Screen: CMS-Other - Utilization over 30,000

Complete? No

Most Recent RUC Meeting:

Tab **Specialty Developing Recommendation:**

First Identified: September 2018

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result:

RUC Recommendation:

Referred to CPT September 2018

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	Global: XXX	Issue:	Screen: Low Value-High Volume	Complete? Yes
Most Recent RUC Meeting: February 2011	Tab 41 Specialty Developing Recommendation:	First Identified: October 2010	2017 Est. Medicare Utilization: 1,281,360	2007 Work RVU: 0.17 2007 NF PE RVU: 0.69 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 0.17 2018 NF PE RVU: 0.69 2018 Fac PE RVU: NA
RUC Recommendation: Maintain		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
94014	Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and review and interpretation by a physician or other qualified health care professional	Global: XXX	Issue: Pulmonary Tests	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: February 2009	Tab 38 Specialty Developing Recommendation: ACCP/ATS	First Identified: February 2008	2017 Est. Medicare Utilization: 194	2007 Work RVU: 0.52 2007 NF PE RVU: 0.77 2007 Fac PE RVU NA Result: Remove from Screen	2018 Work RVU: 0.52 2018 NF PE RVU: 0.77 2018 Fac PE RVU: NA
RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
94015	Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)	Global: XXX	Issue: Pulmonary Tests	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: February 2009	Tab 38 Specialty Developing Recommendation: ACCP/ATS	First Identified: February 2008	2017 Est. Medicare Utilization: 175	2007 Work RVU: 0.00 2007 NF PE RVU: 0.61 2007 Fac PE RVU NA Result: Remove from Screen	2018 Work RVU: 0.00 2018 NF PE RVU: 0.61 2018 Fac PE RVU: NA
RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

94016 Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional **Global:** XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent **Tab** 38 **Specialty Developing** ACCP/ATS **First** **2017 Est.**
RUC Meeting: February 2009 **Recommendation:** **Identified:** April 2008 **Medicare**
Utilization: 6,861 **2007 Work RVU:** 0.52 **2018 Work RVU:** 0.52
2007 NF PE RVU: 0.16 **2018 NF PE RVU:** 0.16
2007 Fac PE RVU: 0.16 **2018 Fac PE RVU:** 0.16

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

94060 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration **Global:** XXX **Issue:** Evaluation of Wheezing **Screen:** MPC List / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent **Tab** 30 **Specialty Developing** ATS, ACCP **First** **2017 Est.**
RUC Meeting: October 2012 **Recommendation:** **Identified:** October 2010 **Medicare**
Utilization: 1,202,624 **2007 Work RVU:** 0.31 **2018 Work RVU:** 0.27
2007 NF PE RVU: 1.13 **2018 NF PE RVU:** 1.13
2007 Fac PE RVU: 1.13 **2018 Fac PE RVU:** 1.13

RUC Recommendation: 0.31 and CPT Assistant article published

Referred to CPT

Result: Maintain

Referred to CPT Asst ☒ **Published in CPT Asst:** Mar 2014

94200 Maximum breathing capacity, maximal voluntary ventilation **Global:** XXX **Issue:** Lung Function Test **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent **Tab** 28 **Specialty Developing** ATS, CHEST **First** **2017 Est.**
RUC Meeting: April 2018 **Recommendation:** **Identified:** October 2017 **Medicare**
Utilization: 84,195 **2007 Work RVU:** 0.11 **2018 Work RVU:** 0.11
2007 NF PE RVU: 0.45 **2018 NF PE RVU:** 0.45
2007 Fac PE RVU: NA **2018 Fac PE RVU:** NA

RUC Recommendation: 0.05

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94240 Deleted from CPT

Global: XXX **Issue:** Pulmonary Tests

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2010

Tab 45

Specialty Developing Recommendation: ACCP, ATS

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 0.26

2018 Work RVU:

2007 NF PE RVU: 0.7

2018 NF PE RVU: 0.7

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

94260 Deleted from CPT

Global: XXX **Issue:** Pulmonary Tests

Screen: Codes Reported Together 75% or More-Part1 /

Complete? Yes

Most Recent RUC Meeting: April 2010

Tab 45

Specialty Developing Recommendation: ACCP, ATS

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 0.13

2018 Work RVU:

2007 NF PE RVU: 0.63

2018 NF PE RVU: 0.63

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

94350 Deleted from CPT

Global: XXX **Issue:** Pulmonary Tests

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2010

Tab 45

Specialty Developing Recommendation: ACCP, ATS

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 0.26

2018 Work RVU:

2007 NF PE RVU: 0.73

2018 NF PE RVU: 0.73

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94360 Deleted from CPT **Global:** XXX **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 0.26 **2018 Work RVU:** **2007 NF PE RVU:** 0.77 **2018 NF PE RVU:** 0.77 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

94370 Determination of airway closing volume, single breath tests **Global:** XXX **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 0.26 **2018 Work RVU:** **2007 NF PE RVU:** 0.69 **2018 NF PE RVU:** 0.69 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

94400 Breathing response to CO2 (CO2 response curve) **Global:** XXX **Issue:** Pulmonary Diagnostic Testing **Screen:** Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** **Specialty Developing Recommendation:** AAFP, ACCP, ATS, ACP, APTA, AOTA **First Identified:** **2017 Est. Medicare Utilization:** 1,331 **2007 Work RVU:** 0.40 **2018 Work RVU:** 0.40 **2007 NF PE RVU:** 0.89 **2018 NF PE RVU:** 0.89 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Maintain

RUC Recommendation: CPT Assistant article published **Referred to CPT** **Referred to CPT Asst** ☒ **Published in CPT Asst:** Mar 2014

Status Report: CMS Requests and Relativity Assessment Issues

94450	Breathing response to hypoxia (hypoxia response curve)	Global: XXX	Issue: Pulmonary Tests	Screen: High Volume Growth1	Complete? Yes
Most Recent RUC Meeting: February 2009	Tab 38 Specialty Developing Recommendation: ACCP/ATS	First Identified: February 2008	2017 Est. Medicare Utilization: 110	2007 Work RVU: 0.40 2007 NF PE RVU: 0.89 2007 Fac PE RVU: NA Result: Remove from Screen	2018 Work RVU: 0.40 2018 NF PE RVU: 0.89 2018 Fac PE RVU: NA
RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS		Referred to CPT			
		Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

94617	Exercise test for bronchospasm, including pre- and post-spirometry, electrocardiographic recording(s), and pulse oximetry	Global: XXX	Issue: Pulmonary Diagnostic Tests	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 05 Specialty Developing Recommendation: ATS, CHEST	First Identified: February 2016	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Decrease	2018 Work RVU: 0.70 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.70		Referred to CPT February 2016			
		Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

94618	Pulmonary stress testing (eg, 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed	Global: XXX	Issue: Pulmonary Diagnostic Tests	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 05 Specialty Developing Recommendation: ATS, CHEST	First Identified: February 2016	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU: Result: Decrease	2018 Work RVU: 0.48 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.48		Referred to CPT February 2016			
		Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

94620	Pulmonary stress testing; simple (eg, 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)	Global: XXX	Issue: Pulmonary Diagnostic Tests	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 05 Specialty Developing Recommendation: ATS, CHEST	First Identified: July 2015	2017 Est. Medicare Utilization: 270,674	2007 Work RVU: 0.64 2007 NF PE RVU: 2.06 2007 Fac PE RVU: NA Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 2.06 2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT		Referred to CPT February 2016			
		Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

94621 Cardiopulmonary exercise testing, including measurements of minute ventilation, CO2 production, O2 uptake, and electrocardiographic recordings **Global:** XXX **Issue:** Pulmonary Diagnostic Tests **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016

Tab 05 **Specialty Developing Recommendation:** ATS, CHEST

First Identified: January 2016

2017 Est. Medicare Utilization: 17,618

2007 Work RVU: 1.42

2018 Work RVU: 1.42

2007 NF PE RVU: 2.45

2018 NF PE RVU: 2.45

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 1.42

Referred to CPT February 2016

Referred to CPT Asst ☐ **Published in CPT Asst:**

94640 Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device

Global: XXX

Issue: Pulmonary Diagnostic Testing

Screen: Codes Reported Together 75% or More-Part2 /CPT Assistant Analysis 2018

Complete? Yes

Most Recent RUC Meeting: October 2012

Tab **Specialty Developing Recommendation:** AAFP, ACCP, ATS, ACP, APTA, AOTA

First Identified:

2017 Est. Medicare Utilization: 640,195

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: 0.32

2018 NF PE RVU: 0.32

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: CPT Assistant article published

Referred to CPT

Referred to CPT Asst ☒ **Published in CPT Asst:** Mar 2014

Result: Maintain

94668 Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent

Global: XXX

Issue: Pulmonary Diagnostic Testing

Screen: Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018

Complete? Yes

Most Recent RUC Meeting: October 2012

Tab **Specialty Developing Recommendation:** AAFP, ACCP, ATS, ACP, APTA, AOTA

First Identified:

2017 Est. Medicare Utilization: 11,193

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: 0.46

2018 NF PE RVU: 0.46

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: CPT Assistant article published

Referred to CPT

Referred to CPT Asst ☒ **Published in CPT Asst:** Mar 2014

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

94681 Oxygen uptake, expired gas analysis; including CO2 output, percentage oxygen extracted **Global:** XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2011

Tab 51

Specialty Developing Recommendation: AACE, TES, ACCP/ATS

First Identified: February 2008

2017 Est. Medicare Utilization: 12,046

2007 Work RVU: 0.20

2018 Work RVU: 0.20

2007 NF PE RVU: 2.16

2018 NF PE RVU: 2.16

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Remove from Screen

RUC Recommendation: Remove from screen

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

94720 Carbon monoxide diffusing capacity (eg, single breath, steady state)

Global: XXX

Issue: Pulmonary Tests

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2010

Tab 45

Specialty Developing Recommendation: ACCP, ATS

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 0.26

2018 Work RVU:

2007 NF PE RVU: 1.04

2018 NF PE RVU: 1.04

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010

Referred to CPT Asst ☐

Published in CPT Asst:

94725 Membrane diffusion capacity

Global: XXX

Issue: Pulmonary Tests

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2010

Tab 45

Specialty Developing Recommendation: ACCP, ATS

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 0.26

2018 Work RVU:

2007 NF PE RVU: 2.43

2018 NF PE RVU: 2.43

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT October 2010

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

94726 Plethysmography for determination of lung volumes and, when performed, airway resistance **Global:** XXX **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011

Tab 19 **Specialty Developing Recommendation:** ACCP, ATS

First Identified: February 2010

2017 Est. Medicare Utilization: 655,472

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 0.26
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.31

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

94727 Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes

Global: XXX **Issue:** Pulmonary Function Testing

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2011

Tab 19 **Specialty Developing Recommendation:** ACCP, ATS

First Identified: February 2010

2017 Est. Medicare Utilization: 365,565

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 0.26
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.31

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

94728 Airway resistance by impulse oscillometry

Global: XXX **Issue:** Pulmonary Function Testing

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2011

Tab 19 **Specialty Developing Recommendation:** ACCP, ATS

First Identified: February 2010

2017 Est. Medicare Utilization: 7,100

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 0.26
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.31

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94729 Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011

Tab 19 **Specialty Developing Recommendation:** ACCP, ATS

First Identified: February 2010

2017 Est. Medicare Utilization: 1,090,316

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU Result: Decrease

2018 Work RVU: 0.19
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.19

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

94760 Noninvasive ear or pulse oximetry for oxygen saturation; single determination **Global:** XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009

Tab 32 **Specialty Developing Recommendation:** ACCP, ATS

First Identified: NA

2017 Est. Medicare Utilization: 51,543

2007 Work RVU: 0.00
2007 NF PE RVU: 0.05
2007 Fac PE RVU NA
Result: PE Only

2018 Work RVU: 0.00
2018 NF PE RVU: 0.05
2018 Fac PE RVU: NA

RUC Recommendation: New PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

94761 Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise) **Global:** XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009

Tab 32 **Specialty Developing Recommendation:** ACCP, ATS

First Identified: NA

2017 Est. Medicare Utilization: 14,141

2007 Work RVU: 0.00
2007 NF PE RVU: 0.08
2007 Fac PE RVU NA
Result: PE Only

2018 Work RVU: 0.00
2018 NF PE RVU: 0.08
2018 Fac PE RVU: NA

RUC Recommendation: New PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94762 Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure) **Global:** XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Fastest Growing, CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab** 32 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** October 2008 **2017 Est. Medicare Utilization:** 236,162 **2007 Work RVU:** 0.00 **2018 Work RVU:** 0.00 **2007 NF PE RVU:** 0.56 **2018 NF PE RVU:** 0.56 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** PE Only

RUC Recommendation: New PE inputs **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

94770 Carbon dioxide, expired gas determination by infrared analyzer **Global:** XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 57 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2017 Est. Medicare Utilization:** 6,458 **2007 Work RVU:** 0.15 **2018 Work RVU:** 0.15 **2007 NF PE RVU:** 0.76 **2018 NF PE RVU:** 0.76 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** PE Only

RUC Recommendation: Refer to CPT Assistant. Remove office-based PE inputs **Referred to CPT** **Referred to CPT Asst** ☒ **Published in CPT Asst:** Mar 2014

95004 Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests **Global:** XXX **Issue:** Percutaneous Allergy Tests **Screen:** Low Value-Billed in Multiple Units / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 27 **Specialty Developing Recommendation:** AAAAI, AAOA, ACAAI **First Identified:** October 2010 **2017 Est. Medicare Utilization:** 11,139,933 **2007 Work RVU:** 0.00 **2018 Work RVU:** 0.01 **2007 NF PE RVU:** 0.12 **2018 NF PE RVU:** 0.12 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Maintain

RUC Recommendation: 0.01 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95010 Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests **Global:** XXX **Issue:** Percutaneous Allergy Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2011

Tab 31

Specialty Developing Recommendation: JCAAI, ACAAI, AAAAI

First Identified: October 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 0.15

2018 Work RVU:

2007 NF PE RVU: 0.31

2018 NF PE RVU: 0.31

2007 Fac PE RVU 0.06

2018 Fac PE RVU:0.06

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

95012 Nitric oxide expired gas determination

Global: XXX

Issue:

Screen: High Volume Growth5

Complete? No

Most Recent RUC Meeting:

Tab

Specialty Developing Recommendation:

First Identified: October 2018

2017 Est. Medicare Utilization: 111,353

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: 0.48

2018 NF PE RVU: 0.48

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result:

RUC Recommendation: Review action plan

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95015 Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests

Global: XXX

Issue: Intracutaneous Allergy Tests

Screen: Low Value-Billed in Multiple Units

Complete? Yes

Most Recent RUC Meeting: April 2011

Tab 31

Specialty Developing Recommendation: JCAAI, ACAAI, AAAAI

First Identified: October 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 0.15

2018 Work RVU:

2007 NF PE RVU: 0.16

2018 NF PE RVU: 0.16

2007 Fac PE RVU 0.06

2018 Fac PE RVU:0.06

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95017	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests	Global: XXX	Issue: Percutaneous Allergy Testing	Screen: Low Value-Billed in Multiple Units	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 29 Specialty Developing Recommendation: JCAAI	First Identified: October 2010	2017 Est. Medicare Utilization: 26,122	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 0.07 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.07		Referred to CPT February 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
95018	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests	Global: XXX	Issue: Percutaneous Allergy Testing	Screen: Low Value-Billed in Multiple Units	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 29 Specialty Developing Recommendation: JCAAI	First Identified: October 2010	2017 Est. Medicare Utilization: 113,064	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Decrease	2018 Work RVU: 0.14 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.14		Referred to CPT February 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests	Global: XXX	Issue: Intracutaneous Allergy Tests	Screen: Low Value-Billed in Multiple Units / Negative IWPUT	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 19 Specialty Developing Recommendation: JCAAI, ACAAI, AAAAI, AAOA	First Identified: October 2010	2017 Est. Medicare Utilization: 1,804,911	2007 Work RVU: 0.00 2007 NF PE RVU: 0.17 2007 Fac PE RVU NA Result: PE Only	2018 Work RVU: 0.01 2018 NF PE RVU: 0.17 2018 Fac PE RVU: NA
RUC Recommendation: New PE Inputs.		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

95027 Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests **Global:** XXX **Issue:** Intracutaneous Allergy Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: February 2011

Tab 41

Specialty Developing Recommendation: JCAAI, ACAAI, AAAAI

First Identified: October 2010

2017 Est. Medicare Utilization: 207,476

2007 Work RVU: 0.00

2018 Work RVU: 0.01

2007 NF PE RVU: 0.17

2018 NF PE RVU: 0.17

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.01

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

95115 Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection **Global:** XXX **Issue:** Immunotherapy Injections **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012

Tab 48

Specialty Developing Recommendation: JCAAI, AAOA

First Identified: January 2012

2017 Est. Medicare Utilization: 1,115,943

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: 0.35

2018 NF PE RVU: 0.35

2007 Fac PE RVU 0.29

2018 Fac PE RVU:0.29

Result: PE Only

RUC Recommendation: New PE Inputs

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

95117 Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections **Global:** XXX **Issue:** Immunotherapy Injections **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012

Tab 48

Specialty Developing Recommendation: JCAAI, AAOA

First Identified: September 2011

2017 Est. Medicare Utilization: 2,716,541

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: 0.44

2018 NF PE RVU: 0.44

2007 Fac PE RVU 0.38

2018 Fac PE RVU:0.38

Result: PE Only

RUC Recommendation: New PE Inputs

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

95144 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials) **Global:** XXX **Issue:** Antigen Therapy Services **Screen:** Low Value-Billed in Multiple Units / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 49

Specialty Developing Recommendation:

AAOHNS, AAOA, ACAAI

First Identified: October 2010

2017 Est. Medicare Utilization: 180,854

2007 Work RVU: 0.06

2018 Work RVU: 0.06

2007 NF PE RVU: 0.21

2018 NF PE RVU: 0.21

2007 Fac PE RVU 0.02

2018 Fac PE RVU:0.02

Result: Maintain

RUC Recommendation: 0.06

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

95148 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 4 single stinging insect venoms **Global:** XXX **Issue:**

Screen: Low Value-Billed in Multiple Units

Complete? Yes

Most Recent RUC Meeting: October 2010

Tab 73

Specialty Developing Recommendation:

First Identified: October 2010

2017 Est. Medicare Utilization: 16,132

2007 Work RVU: 0.06

2018 Work RVU: 0.06

2007 NF PE RVU: 0.67

2018 NF PE RVU: 0.67

2007 Fac PE RVU 0.03

2018 Fac PE RVU:0.03

Result: Maintain

RUC Recommendation: 0.06

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

95165 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses) **Global:** XXX **Issue:** Antigen Therapy Services **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 49

Specialty Developing Recommendation:

AAOHNS, AAOA, ACAAI

First Identified: October 2010

2017 Est. Medicare Utilization: 7,187,317

2007 Work RVU: 0.06

2018 Work RVU: 0.06

2007 NF PE RVU: 0.21

2018 NF PE RVU: 0.21

2007 Fac PE RVU 0.02

2018 Fac PE RVU:0.02

Result: Maintain

RUC Recommendation: 0.06

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

95249 Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording **Global:** XXX **Issue:** Continuous Glucose Monitoring **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab** 08 **Specialty Developing Recommendation:** AACE, ES, ACP **First Identified:** **2017 Est. Medicare Utilization:** **2007 Work RVU:** **2018 Work RVU:** 0.00 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU** **2018 Fac PE RVU:** **Result:** PE Only

RUC Recommendation: PE Only. Referral to CPT Assistant **Referred to CPT** June 2017 **Referred to CPT Asst** ☒ **Published in CPT Asst:** June 2018

95250 Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording **Global:** XXX **Issue:** Continuous Glucose Monitoring **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 08 **Specialty Developing Recommendation:** AACE, ES **First Identified:** October 2013 **2017 Est. Medicare Utilization:** 75,328 **2007 Work RVU:** 0.00 **2018 Work RVU:** 0.00 **2007 NF PE RVU:** 3.95 **2018 NF PE RVU:** 3.95 **2007 Fac PE RVU** NA **2018 Fac PE RVU:** NA **Result:** PE Only

RUC Recommendation: New PE inputs **Referred to CPT** October 2015 & February 2017 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

95251 Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report **Global:** XXX **Issue:** Continuous Glucose Monitoring **Screen:** High Volume Growth **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 08 **Specialty Developing Recommendation:** AACE, ES **First Identified:** April 2013 **2017 Est. Medicare Utilization:** 85,342 **2007 Work RVU:** 0.85 **2018 Work RVU:** 0.70 **2007 NF PE RVU:** 0.21 **2018 NF PE RVU:** 0.21 **2007 Fac PE RVU** 0.21 **2018 Fac PE RVU:** 0.21 **Result:** Decrease

RUC Recommendation: 0.70 **Referred to CPT** February 2017 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95800 Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time **Global:** XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 28

Specialty Developing Recommendation:

ACNS, AAN, ACCP/ATS, AASM

First Identified: October 2009

2017 Est. Medicare Utilization: 18,081

2007 Work RVU:

2018 Work RVU: 1.05

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 1.05

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

95801 Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone) **Global:** XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 28

Specialty Developing Recommendation:

ACNS, AAN, ACCP/ATS, AASM

First Identified: October 2009

2017 Est. Medicare Utilization: 822

2007 Work RVU:

2018 Work RVU: 1.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 1.00

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

95803 Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording) **Global:** XXX **Issue:** Sleep Testing **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 28

Specialty Developing Recommendation:

ACNS, AAN, ACCP/ATS, AASM

First Identified: NA

2017 Est. Medicare Utilization: 345

2007 Work RVU:

2018 Work RVU: 0.90

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 0.90 and New PE inputs

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95805 Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness **Global:** XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent
RUC Meeting: April 2010

Tab 28

Specialty Developing
Recommendation:

ACNS, AAN,
ACCP/ATS,
AASM

First
Identified: October 2009

2017 Est.
Medicare
Utilization: 3,624

2007 Work RVU: 1.88

2018 Work RVU: 1.20

2007 NF PE RVU: 14.7

2018 NF PE RVU: 14.7

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 1.20

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

95806 Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement) **Global:** XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent
RUC Meeting: April 2010

Tab 28

Specialty Developing
Recommendation:

ACNS, AAN,
ACCP/ATS,
AASM

First
Identified: October 2009

2017 Est.
Medicare
Utilization: 60,074

2007 Work RVU: 1.66

2018 Work RVU: 1.25

2007 NF PE RVU: 3.46

2018 NF PE RVU: 3.46

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 1.28

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

95807 Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist **Global:** XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent
RUC Meeting: April 2010

Tab 28

Specialty Developing
Recommendation:

ACNS, AAN,
ACCP/ATS,
AASM

First
Identified: October 2009

2017 Est.
Medicare
Utilization: 3,995

2007 Work RVU: 1.66

2018 Work RVU: 1.28

2007 NF PE RVU: 11.82

2018 NF PE RVU: 11.82

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 1.25

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95808 Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist **Global:** XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 28

Specialty Developing Recommendation:

ACNS, AAN,
ACCP/ATS,
AASM

First Identified: October 2009

2017 Est. Medicare Utilization: 739

2007 Work RVU: 2.65

2018 Work RVU: 1.74

2007 NF PE RVU: 13.79

2018 NF PE RVU: 13.79

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 1.74

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

95810 Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist **Global:** XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 28

Specialty Developing Recommendation:

ACNS, AAN,
ACCP/ATS,
AASM

First Identified: February 2010

2017 Est. Medicare Utilization: 299,765

2007 Work RVU: 3.52

2018 Work RVU: 2.50

2007 NF PE RVU: 17.54

2018 NF PE RVU: 17.54

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 2.50

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

95811 Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist **Global:** XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010

Tab 28

Specialty Developing Recommendation:

ACNS, AAN,
ACCP/ATS,
AASM

First Identified: October 2009

2017 Est. Medicare Utilization: 365,528

2007 Work RVU: 3.79

2018 Work RVU: 2.60

2007 NF PE RVU: 19.32

2018 NF PE RVU: 19.32

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Decrease

RUC Recommendation: 2.60

Referred to CPT October 2009

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95812 Electroencephalogram (EEG) extended monitoring; 41-60 minutes				Global: XXX	Issue: Long-Term EEG Monitoring	Screen: CMS Request - Final Rule for 2016	Complete? Yes
Most Recent RUC Meeting: October 2018	Tab 13	Specialty Developing Recommendation: AAN, ACNS	First Identified: July 2015	2017 Est. Medicare Utilization: 25,942	2007 Work RVU: 1.08	2018 Work RVU: 1.08	
					2007 NF PE RVU: 4.49	2018 NF PE RVU: 4.49	
RUC Recommendation: 1.08			Referred to CPT		2007 Fac PE RVU NA	2018 Fac PE RVU: NA	
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain		
95813 Electroencephalogram (EEG) extended monitoring; greater than 1 hour				Global: XXX	Issue: Long-Term EEG Monitoring	Screen: CMS Request - Final Rule for 2016	Complete? Yes
Most Recent RUC Meeting: October 2018	Tab 13	Specialty Developing Recommendation: AAN, ACNS	First Identified: July 2015	2017 Est. Medicare Utilization: 30,529	2007 Work RVU: 1.73	2018 Work RVU: 1.63	
					2007 NF PE RVU: 5.4	2018 NF PE RVU: 5.4	
RUC Recommendation: 1.63			Referred to CPT		2007 Fac PE RVU NA	2018 Fac PE RVU: NA	
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease		
95816 Electroencephalogram (EEG); including recording awake and drowsy				Global: XXX	Issue: Electroencephalogram	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: October 2012	Tab 22	Specialty Developing Recommendation:	First Identified: January 2012	2017 Est. Medicare Utilization: 285,813	2007 Work RVU: 1.08	2018 Work RVU: 1.08	
					2007 NF PE RVU: 4.1	2018 NF PE RVU: 4.1	
RUC Recommendation: 1.08			Referred to CPT		2007 Fac PE RVU NA	2018 Fac PE RVU: NA	
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain		
95819 Electroencephalogram (EEG); including recording awake and asleep				Global: XXX	Issue: Electroencephalogram	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: October 2012	Tab 22	Specialty Developing Recommendation: AAN, ACNS	First Identified: September 2011	2017 Est. Medicare Utilization: 226,110	2007 Work RVU: 1.08	2018 Work RVU: 1.08	
					2007 NF PE RVU: 3.76	2018 NF PE RVU: 3.76	
RUC Recommendation: 1.08			Referred to CPT		2007 Fac PE RVU NA	2018 Fac PE RVU: NA	
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain		

Status Report: CMS Requests and Relativity Assessment Issues

95822 Electroencephalogram (EEG); recording in coma or sleep only **Global:** XXX **Issue:** Electroencephalogram **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab** 22 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** January 2012 **2017 Est. Medicare Utilization:** 28,428 **2007 Work RVU:** 1.08 **2018 Work RVU:** 1.08 **2007 NF PE RVU:** 4.82 **2018 NF PE RVU:** 4.82 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Maintain

RUC Recommendation: 1.08

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95827 Electroencephalogram (EEG); all night recording **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2017 Est. Medicare Utilization:** 1,790 **2007 Work RVU:** 1.08 **2018 Work RVU:** 1.08 **2007 NF PE RVU:** 4.89 **2018 NF PE RVU:** 4.89 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95831 Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk **Global:** XXX **Issue:** Muscle Testing **Screen:** High Volume Growth3 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 33 **Specialty Developing Recommendation:** AAN, AANEM, AAPM, AAPMR, ACP, APTA **First Identified:** October 2015 **2017 Est. Medicare Utilization:** 55,233 **2007 Work RVU:** 0.28 **2018 Work RVU:** 0.28 **2007 NF PE RVU:** 0.44 **2018 NF PE RVU:** 0.44 **2007 Fac PE RVU:** 0.12 **2018 Fac PE RVU:** 0.12

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

95832	Muscle testing, manual (separate procedure) with report; hand, with or without comparison with normal side	Global: XXX	Issue: Muscle Testing	Screen: High Volume Growth3 / CMS-Other - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 33	Specialty Developing Recommendation: AAN, AANEM, AAPM, AAPMR, ACP, APTA	First Identified: January 2018	2017 Est. Medicare Utilization: 5,234	2007 Work RVU: 0.29 2007 NF PE RVU: 0.34 2007 Fac PE RVU: 0.12 2018 Work RVU: 0.29 2018 NF PE RVU: 0.34 2018 Fac PE RVU: 0.12
RUC Recommendation: Refer to CPT for deletion.			Referred to CPT September 2018	Result: Deleted from CPT	
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
95833	Muscle testing, manual (separate procedure) with report; total evaluation of body, excluding hands	Global: XXX	Issue: Muscle Testing	Screen: High Volume Growth3 / CMS-Other - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 33	Specialty Developing Recommendation: AAN, AANEM, AAPM, AAPMR, ACP, APTA	First Identified: January 2018	2017 Est. Medicare Utilization: 1,308	2007 Work RVU: 0.47 2007 NF PE RVU: 0.55 2007 Fac PE RVU: 0.21 2018 Work RVU: 0.47 2018 NF PE RVU: 0.55 2018 Fac PE RVU: 0.21
RUC Recommendation: Refer to CPT for deletion.			Referred to CPT September 2018	Result: Deleted from CPT	
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
95834	Muscle testing, manual (separate procedure) with report; total evaluation of body, including hands	Global: XXX	Issue: Muscle Testing	Screen: High Volume Growth3 / CMS-Other - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 33	Specialty Developing Recommendation: AAN, AANEM, AAPM, AAPMR, ACP, APTA	First Identified: January 2018	2017 Est. Medicare Utilization: 454	2007 Work RVU: 0.60 2007 NF PE RVU: 0.61 2007 Fac PE RVU: 0.26 2018 Work RVU: 0.60 2018 NF PE RVU: 0.61 2018 Fac PE RVU: 0.26
RUC Recommendation: Refer to CPT for deletion.			Referred to CPT September 2018	Result: Deleted from CPT	
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

95860 Needle electromyography; 1 extremity with or without related paraspinal areas		Global: XXX	Issue: EMG in Conjunction with Nerve Testing	Screen: Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More-Part1 / Harvard-Valued Annual Allowed Charges over \$10 million	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 32	Specialty Developing Recommendation: AAN, AAPMR, AANEM, APTA	First Identified: October 2009	2017 Est. Medicare Utilization: 2,805	2007 Work RVU: 0.96 2007 NF PE RVU: 1.36 2007 Fac PE RVU NA 2018 Work RVU: 0.96 2018 NF PE RVU: 1.36 2018 Fac PE RVU: NA
RUC Recommendation: 0.96			Referred to CPT February 2011 & October 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain
<hr/>					
95861 Needle electromyography; 2 extremities with or without related paraspinal areas		Global: XXX	Issue: EMG in Conjunction with Nerve Testing	Screen: Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 32	Specialty Developing Recommendation: AAN, AAPMR, AANEM, APTA	First Identified: February 2010	2017 Est. Medicare Utilization: 35,050	2007 Work RVU: 1.54 2007 NF PE RVU: 1.48 2007 Fac PE RVU NA 2018 Work RVU: 1.54 2018 NF PE RVU: 1.48 2018 Fac PE RVU: NA
RUC Recommendation: 1.54			Referred to CPT February 2011 & October 2011 & February 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

95863 Needle electromyography; 3 extremities with or without related paraspinal areas **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2017 Est. Medicare Utilization:** 302 **2007 Work RVU:** 1.87 **2018 Work RVU:** 1.87 **2007 NF PE RVU:** 1.79 **2018 NF PE RVU:** 1.79 **2007 Fac PE RVU** NA **2018 Fac PE RVU:**NA

RUC Recommendation: 1.87

Referred to CPT February 2011 & October 2011

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95864 Needle electromyography; 4 extremities with or without related paraspinal areas **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2017 Est. Medicare Utilization:** 3,436 **2007 Work RVU:** 1.99 **2018 Work RVU:** 1.99 **2007 NF PE RVU:** 2.53 **2018 NF PE RVU:** 2.53 **2007 Fac PE RVU** NA **2018 Fac PE RVU:**NA

RUC Recommendation: 1.99

Referred to CPT February 2011 & October 2011

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95867 Needle electromyography; cranial nerve supplied muscle(s), unilateral **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2017 Est. Medicare Utilization:** 1,117 **2007 Work RVU:** 0.79 **2018 Work RVU:** 0.79 **2007 NF PE RVU:** 0.98 **2018 NF PE RVU:** 0.98 **2007 Fac PE RVU** NA **2018 Fac PE RVU:**NA

RUC Recommendation: 0.79

Referred to CPT October 2011

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95868	Needle electromyography; cranial nerve supplied muscles, bilateral	Global: XXX	Issue: EMG in Conjunction with Nerve Testing	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 32	Specialty Developing Recommendation: AAN, AAPMR, AANEM, APTA	First Identified:	2017 Est. Medicare Utilization: 2,738	2007 Work RVU: 1.18 2007 NF PE RVU: 1.26 2007 Fac PE RVU NA 2018 Work RVU: 1.18 2018 NF PE RVU: 1.26 2018 Fac PE RVU: NA
RUC Recommendation: 1.18			Referred to CPT October 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain
<hr/>					
95869	Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)	Global: XXX	Issue: EMG in Conjunction with Nerve Testing	Screen: Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 32	Specialty Developing Recommendation: AAN, AAPMR, AANEM, APTA	First Identified: October 2011	2017 Est. Medicare Utilization: 560	2007 Work RVU: 0.37 2007 NF PE RVU: 0.53 2007 Fac PE RVU NA 2018 Work RVU: 0.37 2018 NF PE RVU: 0.53 2018 Fac PE RVU: NA
RUC Recommendation: 0.37			Referred to CPT October 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain
<hr/>					
95870	Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters	Global: XXX	Issue: EMG in Conjunction with Nerve Testing	Screen: Codes Reported Together 75% or More-Part1 / Negative IWPUT	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 19	Specialty Developing Recommendation: AAN, AAPMR, AANEM, APTA	First Identified: October 2011	2017 Est. Medicare Utilization: 39,780	2007 Work RVU: 0.37 2007 NF PE RVU: 0.53 2007 Fac PE RVU NA 2018 Work RVU: 0.37 2018 NF PE RVU: 0.53 2018 Fac PE RVU: NA
RUC Recommendation: 0.37			Referred to CPT October 2011 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

95885 Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011

Tab 20

Specialty Developing Recommendation: AAN, AAPMR, AANEM, ACNS, APTA

First Identified: February 2010

2017 Est. Medicare Utilization: 140,211

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 0.35
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.35

Referred to CPT February 2011 and October 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

95886 Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)

Global: ZZZ

Issue: EMG in Conjunction with Nerve Testing

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2011

Tab 20

Specialty Developing Recommendation: AAN, AAPMR, AANEM, ACNS, APTA

First Identified: February 2010

2017 Est. Medicare Utilization: 955,386

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 0.86
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.92

Referred to CPT February 2011 and October 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

95887 Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)

Global: ZZZ

Issue: EMG in Conjunction with Nerve Testing

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2011

Tab 20

Specialty Developing Recommendation: AAN, AAPMR, AANEM, ACNS, APTA

First Identified: February 2010

2017 Est. Medicare Utilization: 14,162

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 0.71
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.73

Referred to CPT February 2011 and October 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

958X3

Global:

Issue: Neurostimulator Services

Screen: High Volume Growth2 /
CMS Request - Final
Rule for 2016

Complete? Yes

Most Recent
RUC Meeting: October 2017

Tab 07

Specialty Developing
Recommendation:

AAN,
AANS/CNS,
ACNS

First
Identified: June 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: 0.95 and Refer to CPT Assistant

Referred to CPT June 2017

Referred to CPT Asst ☒

Published in CPT Asst: Specialty societies are drafting the article for the February 2019 publication.

Result: Maintain

958X4

Global:

Issue: Neurostimulator Services

Screen: High Volume Growth2 /
CMS Request - Final
Rule for 2016

Complete? Yes

Most Recent
RUC Meeting: October 2017

Tab 07

Specialty Developing
Recommendation:

AAN,
AANS/CNS,
ACNS

First
Identified: June 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: 1.19 and Refer to CPT Assistant

Referred to CPT June 2017

Referred to CPT Asst ☒

Published in CPT Asst: Specialty societies are drafting the article for the February 2019 publication.

Result: Maintain

958X5

Global:

Issue: Neurostimulator Services

Screen: High Volume Growth2 /
CMS Request - Final
Rule for 2016

Complete? Yes

Most Recent
RUC Meeting: October 2017

Tab 07

Specialty Developing
Recommendation:

AAN,
AANS/CNS,
ACNS

First
Identified: June 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: 1.25 and Refer to CPT Assistant

Referred to CPT June 2017

Referred to CPT Asst ☒

Published in CPT Asst: Specialty societies are drafting the article for the February 2019 publication.

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

958X6				Global:	Issue: Neurostimulator Services	Screen: High Volume Growth2 / CMS Request - Final Rule for 2016	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 07	Specialty Developing Recommendation:	AAN, AANS/CNS, ACNS	First Identified: June 2017	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.00 and Refer to CPT Assistant				Referred to CPT June 2017		Result: Maintain	
				Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Specialty societies are drafting the article for the February 2019 publication.		
<hr/>							
95900	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study			Global: XXX	Issue: EMG in Conjunction with Nerve Testing	Screen: MPC List / Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 32	Specialty Developing Recommendation:	AAN, AAPMR, AANEM, APTA	First Identified: October 2010	2017 Est. Medicare Utilization:	2007 Work RVU: 0.42 2007 NF PE RVU: 1.18 2007 Fac PE RVU NA	2018 Work RVU: 2018 NF PE RVU: 1.18 2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT				Referred to CPT October 2011 & February 2012		Result: Deleted from CPT	
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>							
95903	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study			Global: XXX	Issue: EMG in Conjunction with Nerve Testing	Screen: CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part1	Complete? Yes
Most Recent RUC Meeting: April 2012	Tab 32	Specialty Developing Recommendation:	AAN, AAPMR, AANEM, APTA	First Identified: September 2011	2017 Est. Medicare Utilization:	2007 Work RVU: 0.60 2007 NF PE RVU: 1.15 2007 Fac PE RVU NA	2018 Work RVU: 2018 NF PE RVU: 1.15 2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT				Referred to CPT October 2011 and February 2012 & February 2012		Result: Deleted from CPT	
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

95904 Nerve conduction, amplitude and latency/velocity study, each nerve; sensory **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 / Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 0.34 **2018 Work RVU:** **2007 NF PE RVU:** 1.03 **2018 NF PE RVU:** 1.03 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 & October 2011 & February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95907 Nerve conduction studies; 1-2 studies **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2017 Est. Medicare Utilization:** 8,250 **2007 Work RVU:** **2018 Work RVU:** 1.00 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:**

RUC Recommendation: 1.00 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95908 Nerve conduction studies; 3-4 studies **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2017 Est. Medicare Utilization:** 65,823 **2007 Work RVU:** **2018 Work RVU:** 1.25 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:**

RUC Recommendation: 1.37 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95909 Nerve conduction studies; 5-6 studies

Global: XXX

Issue: EMG in Conjunction with Nerve Testing

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2012

Tab 32

Specialty Developing Recommendation:

AAN,
AAPMR,
AANEM,
APTA

First Identified:

2017 Est. Medicare Utilization: 137,581

2007 Work RVU:

2007 NF PE RVU:

2007 Fac PE RVU

2018 Work RVU: 1.50

2018 NF PE RVU:

2018 Fac PE RVU:

RUC Recommendation: 1.77

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

95910 Nerve conduction studies; 7-8 studies

Global: XXX

Issue: EMG in Conjunction with Nerve Testing

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2012

Tab 32

Specialty Developing Recommendation:

AAN,
AAPMR,
AANEM,
APTA

First Identified:

2017 Est. Medicare Utilization: 163,490

2007 Work RVU:

2007 NF PE RVU:

2007 Fac PE RVU

2018 Work RVU: 2.00

2018 NF PE RVU:

2018 Fac PE RVU:

RUC Recommendation: 2.80

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

95911 Nerve conduction studies; 9-10 studies

Global: XXX

Issue: EMG in Conjunction with Nerve Testing

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2012

Tab 32

Specialty Developing Recommendation:

AAN,
AAPMR,
AANEM,
APTA

First Identified:

2017 Est. Medicare Utilization: 171,016

2007 Work RVU:

2007 NF PE RVU:

2007 Fac PE RVU

2018 Work RVU: 2.50

2018 NF PE RVU:

2018 Fac PE RVU:

RUC Recommendation: 3.34

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

95912 Nerve conduction studies; 11-12 studies

Global: XXX

Issue: EMG in Conjunction with Nerve Testing

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2012

Tab 32

Specialty Developing Recommendation:

AAN, AAPMR, AANEM, APTA

First Identified:

2017 Est. Medicare Utilization: 80,364

2007 Work RVU:

2018 Work RVU: 3.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: 4.00

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

95913 Nerve conduction studies; 13 or more studies

Global: XXX

Issue: EMG in Conjunction with Nerve Testing

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2012

Tab 32

Specialty Developing Recommendation:

AAN, AAPMR, AANEM, APTA

First Identified:

2017 Est. Medicare Utilization: 82,625

2007 Work RVU:

2018 Work RVU: 3.56

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: 4.20

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

95921 Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded R-R interval, Valsalva ratio, and 30:15 ratio

Global: XXX

Issue: Autonomic Function Testing

Screen: Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: April 2012

Tab 33

Specialty Developing Recommendation:

AAN, AANEM

First Identified: October 2009

2017 Est. Medicare Utilization: 44,276

2007 Work RVU: 0.90

2018 Work RVU: 0.90

2007 NF PE RVU: 0.82

2018 NF PE RVU: 0.82

2007 Fac PE RVU NA

2018 Fac PE RVU: NA

RUC Recommendation: 0.90

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

95922 Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt **Global:** XXX **Issue:** Autonomic Function Testing **Screen:** High Volume Growth1 / CMS Fastest Growing / Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012

Tab 33 **Specialty Developing Recommendation:** AAN, AANEM

First Identified: February 2008

2017 Est. Medicare Utilization: 3,207

2007 Work RVU: 0.96

2018 Work RVU: 0.96

2007 NF PE RVU: 1

2018 NF PE RVU: 1

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: 0.96

Referred to CPT February 2012

Referred to CPT Asst ☒ **Published in CPT Asst:** Dec 2008

Result: Maintain

95923 Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (QSART), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential **Global:** XXX **Issue:** Autonomic Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012

Tab 33 **Specialty Developing Recommendation:** AAN, AANEM

First Identified:

2017 Est. Medicare Utilization: 116,555

2007 Work RVU: 0.90

2018 Work RVU: 0.90

2007 NF PE RVU: 1.99

2018 NF PE RVU: 1.99

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: 0.90

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

95924 Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt **Global:** XXX **Issue:** Autonomic Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2012

Tab 06 **Specialty Developing Recommendation:** AAN, AANEM

First Identified:

2017 Est. Medicare Utilization: 20,895

2007 Work RVU:

2018 Work RVU: 1.73

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: 1.73

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

95925	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs	Global: XXX	Issue: Evoked Potentials and Reflex Studies	Screen: Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013	Complete? Yes
Most Recent RUC Meeting: January 2013	Tab 34 Specialty Developing Recommendation: AAN, AANEM, ACNS, AAPMR	First Identified: February 2010	2017 Est. Medicare Utilization: 9,825	2007 Work RVU: 0.54 2007 NF PE RVU: 1.63 2007 Fac PE RVU NA	2018 Work RVU: 0.54 2018 NF PE RVU: 1.63 2018 Fac PE RVU: NA
RUC Recommendation: 0.54 and New PE Inputs		Referred to CPT October 2010 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		Result: Maintain	

95926	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs	Global: XXX	Issue: Evoked Potentials and Reflex Studies	Screen: Codes Reported Together 75% or More-Part1/ CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013	Complete? Yes
Most Recent RUC Meeting: January 2013	Tab 34 Specialty Developing Recommendation: AAN, AANEM, ACNS, AAPMR	First Identified: February 2010	2017 Est. Medicare Utilization: 10,393	2007 Work RVU: 0.54 2007 NF PE RVU: 1.59 2007 Fac PE RVU NA	2018 Work RVU: 0.54 2018 NF PE RVU: 1.59 2018 Fac PE RVU: NA
RUC Recommendation: 0.54 and New PE Inputs		Referred to CPT October 2010 Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		Result: Maintain	

Status Report: CMS Requests and Relativity Assessment Issues

95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs	Global: XXX	Issue: Evoked Potentials and Reflex Studies	Screen: Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 36	Specialty Developing Recommendation: AAN, AANEM, AAPMR, ACNS	First Identified: February 2010	2017 Est. Medicare Utilization: 229	2007 Work RVU: 1.50 2007 NF PE RVU: 3.25 2007 Fac PE RVU NA 2018 Work RVU: 1.50 2018 NF PE RVU: 3.25 2018 Fac PE RVU: NA
RUC Recommendation: 1.50			Referred to CPT October 2010	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
				Result: Maintain	

95929	Central motor evoked potential study (transcranial motor stimulation); lower limbs	Global: XXX	Issue: Evoked Potentials and Reflex Studies	Screen: Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013	Complete? Yes
Most Recent RUC Meeting: April 2013	Tab 36	Specialty Developing Recommendation: AAN, AANEM, AAPMR, ACNS	First Identified: February 2010	2017 Est. Medicare Utilization: 1,228	2007 Work RVU: 1.50 2007 NF PE RVU: 3.48 2007 Fac PE RVU NA 2018 Work RVU: 1.50 2018 NF PE RVU: 3.48 2018 Fac PE RVU: NA
RUC Recommendation: 1.50			Referred to CPT October 2010	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
				Result: Maintain	

95930	Visual evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report	Global: XXX	Issue: Visual Evoked Potential Testing	Screen: High Volume Growth3	Complete? Yes
Most Recent RUC Meeting: October 2016	Tab 11	Specialty Developing Recommendation: AAO, AOA (optometry), ACNS	First Identified: October 2015	2017 Est. Medicare Utilization: 77,806	2007 Work RVU: 0.35 2007 NF PE RVU: 2.34 2007 Fac PE RVU NA 2018 Work RVU: 0.35 2018 NF PE RVU: 2.34 2018 Fac PE RVU: NA
RUC Recommendation: 0.35			Referred to CPT May 2016	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:
				Result: Maintain	

Status Report: CMS Requests and Relativity Assessment Issues

95934 H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** **First Identified:** **2017 Est. Medicare Utilization:** **2007 Work RVU:** 0.51 **2018 Work RVU:** **2007 NF PE RVU:** 0.55 **2018 NF PE RVU:** 0.55 **2007 Fac PE RVU** NA **2018 Fac PE RVU:**NA
RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 & February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95936 H-reflex, amplitude and latency study; record muscle other than gastrocnemius/soleus muscle **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab** 32 **Specialty Developing Recommendation:** **First Identified:** **2017 Est. Medicare Utilization:** **2007 Work RVU:** 0.55 **2018 Work RVU:** **2007 NF PE RVU:** 0.49 **2018 NF PE RVU:** 0.49 **2007 Fac PE RVU** NA **2018 Fac PE RVU:**NA
RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 & February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95938 Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs **Global:** XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 34 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS **First Identified:** **2017 Est. Medicare Utilization:** 72,178 **2007 Work RVU:** **2018 Work RVU:** 0.86 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU** **2018 Fac PE RVU:**
RUC Recommendation: 0.86 and new PE inputs **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95939 Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs **Global:** XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013

Tab 34

Specialty Developing Recommendation:

AAN,
AANEM,
AAPMR,
ACNS

First Identified:

2017 Est. Medicare Utilization: 31,526

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 2.25
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 2.25 and new PE inputs

Referred to CPT October 2010

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

95940 Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)

Global: XXX

Issue: Intraoperative Neurophysiology Monitoring

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: January 2012

Tab 12

Specialty Developing Recommendation:

First Identified: January 2012

2017 Est. Medicare Utilization: 16,425

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 0.60
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.60

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

95941 Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)

Global: XXX

Issue: Intraoperative Neurophysiology Monitoring

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: January 2012

Tab 12

Specialty Developing Recommendation:

First Identified: January 2012

2017 Est. Medicare Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 0.00
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 2.00

Referred to CPT February 2012

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

95943	Simultaneous, independent, quantitative measures of both parasympathetic function and sympathetic function, based on time-frequency analysis of heart rate variability concurrent with time-frequency analysis of continuous respiratory activity, with mean heart rate and blood pressure measures, during rest, paced (deep) breathing, Valsalva maneuvers, and head-up postural change	Global: XXX	Issue: Autonomic Function Testing	Screen: Codes Reported Together 75% or More- Part1 / Contractor Priced High Volume	Complete? No
Most Recent RUC Meeting: October 2012	Tab 06	Specialty Developing Recommendation: AAN, AANEM	First Identified: January 2018	2017 Est. Medicare Utilization: 31,418	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain 2018 Work RVU: 0.00 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: Survey			Referred to CPT February 2012 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
<hr/>					
95950	Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours	Global: XXX	Issue: Long-Term EEG Monitoring	Screen: CMS Fastest Growing	Complete? Yes
Most Recent RUC Meeting: October 2018	Tab 13	Specialty Developing Recommendation: AAN, ACNS	First Identified: February 2009	2017 Est. Medicare Utilization: 738	2007 Work RVU: 1.51 2007 NF PE RVU: 4.18 2007 Fac PE RVU Result: Deleted from CPT 2018 Work RVU: 1.51 2018 NF PE RVU: 4.18 2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
<hr/>					
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	Global: XXX	Issue: Long-Term EEG Monitoring	Screen: High Volume Growth4	Complete? Yes
Most Recent RUC Meeting: October 2018	Tab 13	Specialty Developing Recommendation:	First Identified: October 2016	2017 Est. Medicare Utilization: 161,659	2007 Work RVU: 0.00 2007 NF PE RVU: 0 2007 Fac PE RVU Result: Deleted from CPT 2018 Work RVU: 0.00 2018 NF PE RVU: 0 2018 Fac PE RVU: 0
RUC Recommendation: Deleted from CPT			Referred to CPT May 2018 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

95953 Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent
RUC Meeting: October 2018

Tab 13 **Specialty Developing** AAN, ACNS
Recommendation:

First
Identified: February 2009

2017 Est.
Medicare
Utilization: 23,260

2007 Work RVU: 3.30

2018 Work RVU: 3.08

2007 NF PE RVU: 7.52

2018 NF PE RVU: 7.52

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

95954 Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (eg, thiopental activation test) **Global:** XXX **Issue:** EEG Monitoring **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent
RUC Meeting: February 2008

Tab S **Specialty Developing** AAN, ACNS
Recommendation:

First
Identified: February 2008

2017 Est.
Medicare
Utilization: 1,085

2007 Work RVU: 2.45

2018 Work RVU: 2.45

2007 NF PE RVU: 4.38

2018 NF PE RVU: 4.38

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Remove from Screen

RUC Recommendation: Remove from screen

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

95956 Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours, attended by a technologist or nurse **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent
RUC Meeting: October 2018

Tab 13 **Specialty Developing** AAN, ACNS
Recommendation:

First
Identified: October 2008

2017 Est.
Medicare
Utilization: 3,840

2007 Work RVU: 3.08

2018 Work RVU: 3.61

2007 NF PE RVU: 15.47

2018 NF PE RVU: 15.47

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Deleted from CPT

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☒

Published in CPT Asst: Dec 2009

Status Report: CMS Requests and Relativity Assessment Issues

95957 Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis) **Global:** XXX **Issue:** Electroencephalogram (EEG) Exended Monitoring **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016

Tab 50 **Specialty Developing Recommendation:** AAN

First Identified: July 2015

2017 Est. Medicare Utilization: 64,943

2007 Work RVU: 1.98
2007 NF PE RVU: 3.37
2007 Fac PE RVU NA
2018 Work RVU: 1.98
2018 NF PE RVU: 3.37
2018 Fac PE RVU: NA
Result: Maintain

RUC Recommendation: 1.98

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95970 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming **Global:** XXX **Issue:** Neurostimulator Services **Screen:** Harvard Valued - Utilization over 100,000 / CMS Request - Final Rule for 2016 / High Volume Growth3 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: October 2017

Tab 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS

First Identified: February 2010

2017 Est. Medicare Utilization: 39,811

2007 Work RVU: 0.45
2007 NF PE RVU: 0.86
2007 Fac PE RVU 0.14
2018 Work RVU: 0.45
2018 NF PE RVU: 0.86
2018 Fac PE RVU: 0.14
Result: Maintain

RUC Recommendation: 0.45

Referred to CPT June 2017
Referred to CPT Asst ☒ **Published in CPT Asst:** Jul 2016

95971 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming **Global:** XXX **Issue:** Neurostimulator Services **Screen:** Harvard Valued - Utilization over 100,000 / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2017

Tab 07 **Specialty Developing Recommendation:** AUA, ACOG, AAPM, SIS, ACNS

First Identified: October 2009

2017 Est. Medicare Utilization: 24,025

2007 Work RVU: 0.78
2007 NF PE RVU: 0.66
2007 Fac PE RVU 0.22
2018 Work RVU: 0.78
2018 NF PE RVU: 0.66
2018 Fac PE RVU: 0.22
Result: Maintain

RUC Recommendation: 0.78

Referred to CPT February 2015, June 2017
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95972 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming

Global: XXX **Issue:** Neurostimulator Services **Screen:** Harvard Valued - Utilization over 100,000 / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2017

Tab 07

Specialty Developing Recommendation:

AUA, ACOG, AAPM, SIS, ACNS

First Identified: February 2010

2017 Est. Medicare Utilization: 57,542

2007 Work RVU: 1.50

2018 Work RVU: 0.80

2007 NF PE RVU: 1.21

2018 NF PE RVU: 1.21

2007 Fac PE RVU 0.48

2018 Fac PE RVU:0.48

RUC Recommendation: 0.80

Referred to CPT May 2014 February , June 2017

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

95973 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

Global: ZZZ

Issue: Implanted Neurostimulator Electronic Analysis

Screen: Harvard Valued - Utilization over 100,000 / Final Rule for 2015

Complete? Yes

Most Recent RUC Meeting: April 2015

Tab 21

Specialty Developing Recommendation:

AANS/CNS, ACOG, ASA, AUA, ISIS

First Identified: February 2010

2017 Est. Medicare Utilization:

2007 Work RVU: 0.92

2018 Work RVU:

2007 NF PE RVU: 0.61

2018 NF PE RVU: 0.61

2007 Fac PE RVU 0.32

2018 Fac PE RVU:0.32

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

95974 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour

Global: XXX **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab 07** **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 11,928 **2007 Work RVU:** 3.00 **2018 Work RVU:** 3.00 **2007 NF PE RVU:** 1.65 **2018 NF PE RVU:** 1.65 **2007 Fac PE RVU:** 1.19 **2018 Fac PE RVU:** 1.19

RUC Recommendation: Code Deleted from CPT **Referred to CPT:** June 2017 **Referred to CPT Asst:** ☒ **Published in CPT Asst:** Jul 2016 **Result:** Deleted from CPT

95975 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

Global: ZZZ **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab 07** **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 190 **2007 Work RVU:** 1.70 **2018 Work RVU:** 1.70 **2007 NF PE RVU:** 0.86 **2018 NF PE RVU:** 0.86 **2007 Fac PE RVU:** 0.67 **2018 Fac PE RVU:** 0.67

RUC Recommendation: Code Deleted from CPT **Referred to CPT:** June 2017 **Referred to CPT Asst:** ☒ **Published in CPT Asst:** Jul 2016 **Result:** Deleted from CPT

95978 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour

Global: XXX **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab 07** **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 36,894 **2007 Work RVU:** 3.50 **2018 Work RVU:** 3.50 **2007 NF PE RVU:** 1.91 **2018 NF PE RVU:** 1.91 **2007 Fac PE RVU:** 1.24 **2018 Fac PE RVU:** 1.24

RUC Recommendation: Code Deleted from CPT **Referred to CPT:** June 2017 **Referred to CPT Asst:** ☒ **Published in CPT Asst:** Jul 2016 **Result:** Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

95979 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; each additional 30 minutes after first hour (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab 07** **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 5,972 **2007 Work RVU:** 1.64 **2018 Work RVU:** 1.64 **2007 NF PE RVU:** 0.84 **2018 NF PE RVU:** 0.84 **2007 Fac PE RVU:** 0.64 **2018 Fac PE RVU:** 0.64 **RUC Recommendation:** Code Deleted from CPT **Referred to CPT:** June 2017 **Referred to CPT Asst:** ☒ **Published in CPT Asst:** Jul 2016 **Result:** Deleted from CPT

95980 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming **Global:** XXX **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab 07** **Specialty Developing Recommendation:** No Interest **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 454 **2007 Work RVU:** 0.80 **2018 Work RVU:** 0.80 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** Not part of family **Referred to CPT:** June 2017 **Referred to CPT Asst:** ☐ **Published in CPT Asst:** **Result:** Maintain

95981 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming **Global:** XXX **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab 07** **Specialty Developing Recommendation:** No Interest **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 766 **2007 Work RVU:** 0.30 **2018 Work RVU:** 0.30 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **RUC Recommendation:** Not part of family **Referred to CPT:** June 2017 **Referred to CPT Asst:** ☐ **Published in CPT Asst:** **Result:** Maintain

Status Report: CMS Requests and Relativity Assessment Issues

95982 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming

Global: XXX **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent **Tab** 07 **Specialty Developing** No Interest **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 1,301 **2007 Work RVU:** **2018 Work RVU:** 0.65
RUC Meeting: January 2016 **Recommendation:** **2007 NF PE RVU:** **2018 NF PE RVU:**
RUC Recommendation: Not part of family **Referred to CPT** June 2017 **2007 Fac PE RVU** **2018 Fac PE RVU:**
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Maintain

95990 Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed;

Global: XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent **Tab** 07 **Specialty Developing** ASA, AAPM, NASS, AAMP&R, AANS/CNS, ISIS **First Identified:** April 2010 **2017 Est. Medicare Utilization:** 2,615 **2007 Work RVU:** 0.00 **2018 Work RVU:** 0.00
RUC Meeting: February 2011 **Recommendation:** **2007 NF PE RVU:** 1.53 **2018 NF PE RVU:** 1.53
RUC Recommendation: 0.00 **Referred to CPT** October 2010 **2007 Fac PE RVU** NA **2018 Fac PE RVU:** NA
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Maintain

95991 Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional

Global: XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent **Tab** 07 **Specialty Developing** ASA, AAPM **First Identified:** February 2008 **2017 Est. Medicare Utilization:** 11,502 **2007 Work RVU:** 0.77 **2018 Work RVU:** 0.77
RUC Meeting: February 2011 **Recommendation:** **2007 NF PE RVU:** 1.53 **2018 NF PE RVU:** 1.53
RUC Recommendation: 0.77 **Referred to CPT** October 2010 **2007 Fac PE RVU** NA **2018 Fac PE RVU:** NA
Referred to CPT Asst ☐ **Published in CPT Asst:** **Result:** Maintain

Status Report: CMS Requests and Relativity Assessment Issues

95992 Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day **Global:** XXX **Issue:** **Screen:** Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 33 **Specialty Developing Recommendation:** **First Identified:** January 2018 **2017 Est. Medicare Utilization:** 90,954 **2007 Work RVU:** **2018 Work RVU:** 0.75 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Maintain **2018 Fac PE RVU:**

RUC Recommendation: Remove from Modifier -51 Exempt list. **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

95X01 **Global:** **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2017 Est. Medicare Utilization:** **2007 Work RVU:** **2018 Work RVU:** **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** PE Only **2018 Fac PE RVU:**

RUC Recommendation: PE Only **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

95X02 **Global:** **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2017 Est. Medicare Utilization:** **2007 Work RVU:** **2018 Work RVU:** **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** PE Only **2018 Fac PE RVU:**

RUC Recommendation: PE Only **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

95X03 **Global:** **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2017 Est. Medicare Utilization:** **2007 Work RVU:** **2018 Work RVU:** **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** PE Only **2018 Fac PE RVU:**

RUC Recommendation: PE Only **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95X04

Global:

Issue: Long-Term EEG Monitoring Screen: High Volume Growth4

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 13

Specialty Developing
Recommendation: AAN, ACNS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: PE Only

Referred to CPT
Referred to CPT Asst

☐

Published in CPT Asst:

95X05

Global:

Issue: Long-Term EEG Monitoring Screen: High Volume Growth4

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 13

Specialty Developing
Recommendation: AAN, ACNS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: PE Only

Referred to CPT
Referred to CPT Asst

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Published in CPT Asst:

95X06

Global:

Issue: Long-Term EEG Monitoring Screen: High Volume Growth4

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 13

Specialty Developing
Recommendation: AAN, ACNS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: PE Only

Referred to CPT
Referred to CPT Asst

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Published in CPT Asst:

95X07

Global:

Issue: Long-Term EEG Monitoring Screen: High Volume Growth4

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 13

Specialty Developing
Recommendation: AAN, ACNS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: PE Only

Referred to CPT
Referred to CPT Asst

☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

95X08

Global:

Issue: Long-Term EEG Monitoring Screen: High Volume Growth4

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 13

Specialty Developing
Recommendation: AAN, ACNS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: PE Only

Referred to CPT
Referred to CPT Asst

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Published in CPT Asst:

95X09

Global:

Issue: Long-Term EEG Monitoring Screen: High Volume Growth4

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 13

Specialty Developing
Recommendation: AAN, ACNS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: PE Only

Referred to CPT
Referred to CPT Asst

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Published in CPT Asst:

95X10

Global:

Issue: Long-Term EEG Monitoring Screen: High Volume Growth4

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 13

Specialty Developing
Recommendation: AAN, ACNS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: PE Only

Referred to CPT
Referred to CPT Asst

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Published in CPT Asst:

95X11

Global:

Issue: Long-Term EEG Monitoring Screen: High Volume Growth4

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 13

Specialty Developing
Recommendation: AAN, ACNS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: PE Only

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: PE Only

Referred to CPT
Referred to CPT Asst

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Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

95X12	Global:	Issue: Long-Term EEG Monitoring	Screen: High Volume Growth4	Complete? Yes		
Most Recent RUC Meeting: October 2018	Tab 13	Specialty Developing Recommendation: AAN, ACNS	First Identified: May 2018	2017 Est. Medicare Utilization:	2007 Work RVU:	2018 Work RVU:
					2007 NF PE RVU:	2018 NF PE RVU:
					2007 Fac PE RVU	2018 Fac PE RVU:
RUC Recommendation: PE Only			Referred to CPT		Result: PE Only	
			Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	

95X13	Global:	Issue: Long-Term EEG Monitoring	Screen: High Volume Growth4	Complete? Yes		
Most Recent RUC Meeting: October 2018	Tab 13	Specialty Developing Recommendation: AAN, ACNS	First Identified: May 2018	2017 Est. Medicare Utilization:	2007 Work RVU:	2018 Work RVU:
					2007 NF PE RVU:	2018 NF PE RVU:
					2007 Fac PE RVU	2018 Fac PE RVU:
RUC Recommendation: PE Only			Referred to CPT		Result: PE Only	
			Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	

95X14	Global:	Issue: Long-Term EEG Monitoring	Screen: High Volume Growth4	Complete? Yes		
Most Recent RUC Meeting: October 2018	Tab 13	Specialty Developing Recommendation: AAN, ACNS	First Identified: May 2018	2017 Est. Medicare Utilization:	2007 Work RVU:	2018 Work RVU:
					2007 NF PE RVU:	2018 NF PE RVU:
					2007 Fac PE RVU	2018 Fac PE RVU:
RUC Recommendation: 2.00			Referred to CPT		Result: Decrease	
			Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	

95X15	Global:	Issue: Long-Term EEG Monitoring	Screen: High Volume Growth4	Complete? Yes		
Most Recent RUC Meeting: October 2018	Tab 13	Specialty Developing Recommendation: AAN, ACNS	First Identified: May 2018	2017 Est. Medicare Utilization:	2007 Work RVU:	2018 Work RVU:
					2007 NF PE RVU:	2018 NF PE RVU:
					2007 Fac PE RVU	2018 Fac PE RVU:
RUC Recommendation: 2.50			Referred to CPT		Result: Decrease	
			Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

95X16

Global:

Issue: Long-Term EEG Monitoring Screen: High Volume Growth4

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 13

Specialty Developing
Recommendation: AAN, ACNS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 3.00

Referred to CPT
Referred to CPT Asst

☐

Published in CPT Asst:

95X17

Global:

Issue: Long-Term EEG Monitoring Screen: High Volume Growth4

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 13

Specialty Developing
Recommendation: AAN, ACNS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 3.86

Referred to CPT
Referred to CPT Asst

☐

Published in CPT Asst:

95X18

Global:

Issue: Long-Term EEG Monitoring Screen: High Volume Growth4

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 13

Specialty Developing
Recommendation: AAN, ACNS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 3.86

Referred to CPT
Referred to CPT Asst

☐

Published in CPT Asst:

95X19

Global:

Issue: Long-Term EEG Monitoring Screen: High Volume Growth4

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 13

Specialty Developing
Recommendation: AAN, ACNS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.70

Referred to CPT
Referred to CPT Asst

☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

95X20

Global:

Issue: Long-Term EEG Monitoring Screen: High Volume Growth4

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 13

Specialty Developing
Recommendation: AAN, ACNS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 4.75

Referred to CPT
Referred to CPT Asst

☐

Published in CPT Asst:

95X21

Global:

Issue: Long-Term EEG Monitoring Screen: High Volume Growth4

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 13

Specialty Developing
Recommendation: AAN, ACNS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 6.00

Referred to CPT
Referred to CPT Asst

☐

Published in CPT Asst:

95X22

Global:

Issue: Long-Term EEG Monitoring Screen: High Volume Growth4

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 13

Specialty Developing
Recommendation: AAN, ACNS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 5.40

Referred to CPT
Referred to CPT Asst

☐

Published in CPT Asst:

95X23

Global:

Issue: Long-Term EEG Monitoring Screen: High Volume Growth4

Complete? Yes

Most Recent
RUC Meeting: October 2018

Tab 13

Specialty Developing
Recommendation: AAN, ACNS

First
Identified: May 2018

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU
Result: Decrease

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 7.58

Referred to CPT
Referred to CPT Asst

☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

96101 Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report **Global:** XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 223,334 **2007 Work RVU:** 1.86 **2018 Work RVU:** 1.86 **2007 NF PE RVU:** 0.58 **2018 NF PE RVU:** 0.58 **2007 Fac PE RVU:** 0.56 **2018 Fac PE RVU:** 0.56

RUC Recommendation: Deleted from CPT

Referred to CPT June 2017

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

96102 Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face **Global:** XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 36,732 **2007 Work RVU:** 0.50 **2018 Work RVU:** 0.50 **2007 NF PE RVU:** 0.8 **2018 NF PE RVU:** 0.8 **2007 Fac PE RVU:** 0.15 **2018 Fac PE RVU:** 0.15

RUC Recommendation: Deleted from CPT

Referred to CPT June 2017

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

96103 Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report **Global:** XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** High Volume Growth2 / Different Performing Specialty from Survey2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** April 2013 **2017 Est. Medicare Utilization:** 200,065 **2007 Work RVU:** 0.51 **2018 Work RVU:** 0.51 **2007 NF PE RVU:** 0.49 **2018 NF PE RVU:** 0.49 **2007 Fac PE RVU:** 0.15 **2018 Fac PE RVU:** 0.15

RUC Recommendation: Deleted from CPT

Referred to CPT June 2017

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	Global: XXX	Issue: Psychological and Neuro-psychological Testing	Screen: CMS Request/Speech Language Pathology Request / CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 20	Specialty Developing Recommendation: APA (psychology), AAP, ASHA, AAN	First Identified: January 2016	2017 Est. Medicare Utilization: 875	2007 Work RVU: 0.00 2007 NF PE RVU: 1.83 2007 Fac PE RVU NA 2018 Work RVU: 1.75 2018 NF PE RVU: 1.83 2018 Fac PE RVU: NA
RUC Recommendation: 1.75			Referred to CPT June 2017 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease
96110	Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument	Global: XXX	Issue: Psychological and Neuro-psychological Testing	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 08	Specialty Developing Recommendation: APA (psychology), AAP, ASHA, AAN	First Identified: January 2017	2017 Est. Medicare Utilization:	2007 Work RVU: 0.00 2007 NF PE RVU: 0.18 2007 Fac PE RVU NA 2018 Work RVU: 0.00 2018 NF PE RVU: 0.18 2018 Fac PE RVU: NA
RUC Recommendation: New PE Inputs			Referred to CPT June 2017 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: PE Only
96111	Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report	Global: XXX	Issue: Psychological and Neuro-psychological Testing	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 08	Specialty Developing Recommendation: APA (psychology), AAP, ASHA, AAN	First Identified: January 2017	2017 Est. Medicare Utilization: 837	2007 Work RVU: 2.60 2007 NF PE RVU: 0.96 2007 Fac PE RVU 0.92 2018 Work RVU: 2.60 2018 NF PE RVU: 0.96 2018 Fac PE RVU: 0.92
RUC Recommendation: Deleted from CPT			Referred to CPT June 2017 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

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 **Global:** XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 167,929 **2007 Work RVU:** 1.86 **2018 Work RVU:** 1.86 **2007 NF PE RVU:** 0.76 **2018 NF PE RVU:** 0.76 **2007 Fac PE RVU:** 0.59 **2018 Fac PE RVU:** 0.59
RUC Meeting: October 2017
RUC Recommendation: 1.86 **Referred to CPT** June 2017 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

96118 Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report **Global:** XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 675,380 **2007 Work RVU:** 1.86 **2018 Work RVU:** 1.86 **2007 NF PE RVU:** 1.25 **2018 NF PE RVU:** 1.25 **2007 Fac PE RVU:** 0.56 **2018 Fac PE RVU:** 0.56
RUC Meeting: October 2017
RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

96119 Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face **Global:** XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent **Tab** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 188,628 **2007 Work RVU:** 0.55 **2018 Work RVU:** 0.55 **2007 NF PE RVU:** 1.15 **2018 NF PE RVU:** 1.15 **2007 Fac PE RVU:** 0.17 **2018 Fac PE RVU:** 0.17
RUC Meeting: October 2017
RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

96120 Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report **Global:** XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** High Volume Growth2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017

Tab 08

Specialty Developing Recommendation: APA (psychology), AAP, ASHA, AAN

First Identified: April 2013

2017 Est. Medicare Utilization: 33,131

2007 Work RVU: 0.51
2007 NF PE RVU: 1.04
2007 Fac PE RVU: 0.15

2018 Work RVU: 0.51
2018 NF PE RVU: 1.04
2018 Fac PE RVU: 0.15

RUC Recommendation: Deleted from CPT

Referred to CPT June 2017

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

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

Global: XXX

Issue: Psychological and Neuro-psychological Testing

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: October 2017

Tab 20

Specialty Developing Recommendation: APA (psychology), AAP, ASHA, AAN

First Identified: January 2016

2017 Est. Medicare Utilization: 2,405

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU:

2018 Work RVU: 1.70
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.70

Referred to CPT June 2017

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

96127 Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

Global: XXX

Issue: Psychological and Neuro-psychological Testing

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: October 2017

Tab 08

Specialty Developing Recommendation: APA (psychology), AAP, ASHA, AAN

First Identified: January 2016

2017 Est. Medicare Utilization: 116,720

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU:

2018 Work RVU: 0.00
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: New PE Inputs

Referred to CPT June 2017

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

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			Global: XXX	Issue: Health and Behavior Assessment and Intervention	Screen: Negative IWPUT	Complete?	No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified:	September 2018	2017 Est. Medicare Utilization:	59,918	2007 Work RVU: 0.50 2007 NF PE RVU: 0.16 2007 Fac PE RVU 0.16 Result: Deleted from CPT	2018 Work RVU: 0.50 2018 NF PE RVU: 0.16 2018 Fac PE RVU:0.16
RUC Recommendation: Deleted from CPT			Referred to CPT September 2018 Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:			

96151	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; re-assessment			Global: XXX	Issue: Health and Behavior Assessment and Intervention	Screen: Negative IWPUT	Complete?	No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified:	September 2018	2017 Est. Medicare Utilization:	5,991	2007 Work RVU: 0.48 2007 NF PE RVU: 0.16 2007 Fac PE RVU 0.15 Result: Deleted from CPT	2018 Work RVU: 0.48 2018 NF PE RVU: 0.16 2018 Fac PE RVU:0.15
RUC Recommendation: Deleted from CPT			Referred to CPT September 2018 Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:			

96152	Health and behavior intervention, each 15 minutes, face-to-face; individual			Global: XXX	Issue: Health and Behavior Assessment and Intervention	Screen: Negative IWPUT	Complete?	No
Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified:	September 2018	2017 Est. Medicare Utilization:	112,305	2007 Work RVU: 0.46 2007 NF PE RVU: 0.15 2007 Fac PE RVU 0.14 Result: Deleted from CPT	2018 Work RVU: 0.46 2018 NF PE RVU: 0.15 2018 Fac PE RVU:0.14
RUC Recommendation: Deleted from CPT			Referred to CPT September 2018 Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:			

Status Report: CMS Requests and Relativity Assessment Issues

96153 Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients) **Global:** XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2018 **2017 Est. Medicare Utilization:** 44,442 **2007 Work RVU:** 0.10 **2018 Work RVU:** 0.10 **2007 NF PE RVU:** 0.04 **2018 NF PE RVU:** 0.04 **2007 Fac PE RVU:** 0.03 **2018 Fac PE RVU:** 0.03 **RUC Recommendation:** Deleted from CPT **Result:** Deleted from CPT **Referred to CPT** September 2018 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

96154 Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present) **Global:** XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** No

Most Recent RUC Meeting: April 2018 **Tab** 33 **Specialty Developing Recommendation:** APA (psychology), NASW **First Identified:** April 2017 **2017 Est. Medicare Utilization:** 15,227 **2007 Work RVU:** 0.45 **2018 Work RVU:** 0.45 **2007 NF PE RVU:** 0.15 **2018 NF PE RVU:** 0.15 **2007 Fac PE RVU:** 0.14 **2018 Fac PE RVU:** 0.14 **RUC Recommendation:** Deleted from CPT **Result:** Deleted from CPT **Referred to CPT** September 2018 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

96155 Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present) **Global:** XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** No

Most Recent RUC Meeting: **Tab** **Specialty Developing Recommendation:** **First Identified:** September 2018 **2017 Est. Medicare Utilization:** **2007 Work RVU:** 0.44 **2018 Work RVU:** 0.44 **2007 NF PE RVU:** 0.16 **2018 NF PE RVU:** 0.16 **2007 Fac PE RVU:** 0.15 **2018 Fac PE RVU:** 0.15 **RUC Recommendation:** Deleted from CPT **Result:** Deleted from CPT **Referred to CPT** September 2018 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

961X0			Global:	Issue: Health and Behavior Assessment and Intervention	Screen: Negative IWPUT	Complete? No
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Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2018	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation:			Referred to CPT September 2018 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

961X1			Global:	Issue: Health and Behavior Assessment and Intervention	Screen: Negative IWPUT	Complete? No
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Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2018	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation:			Referred to CPT September 2018 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

961X2			Global:	Issue: Health and Behavior Assessment and Intervention	Screen: Negative IWPUT	Complete? No
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Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2018	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation:			Referred to CPT September 2018 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

961X3			Global:	Issue: Health and Behavior Assessment and Intervention	Screen: Negative IWPUT	Complete? No
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Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2018	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation:			Referred to CPT September 2018 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

961X4			Global:	Issue: Health and Behavior Assessment and Intervention	Screen: Negative IWPUT	Complete? No
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Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2018	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation:			Referred to CPT September 2018 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

961X5			Global:	Issue: Health and Behavior Assessment and Intervention	Screen: Negative IWPUT	Complete? No
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Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2018	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation:			Referred to CPT September 2018 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

961X6			Global:	Issue: Health and Behavior Assessment and Intervention	Screen: Negative IWPUT	Complete? No
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Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2018	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation:			Referred to CPT September 2018 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

961X7			Global:	Issue: Health and Behavior Assessment and Intervention	Screen: Negative IWPUT	Complete? No
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Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2018	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation:			Referred to CPT September 2018 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

961X8			Global:	Issue: Health and Behavior Assessment and Intervention	Screen: Negative IWPUT	Complete? No
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Most Recent RUC Meeting:	Tab	Specialty Developing Recommendation:	First Identified: September 2018	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation:			Referred to CPT September 2018 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

96360 Intravenous infusion, hydration; initial, 31 minutes to 1 hour **Global:** XXX **Issue:** IV Hydration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 25 **Specialty Developing Recommendation:** ASCO, ASH **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 240,459 **2007 Work RVU:** **2018 Work RVU:** 0.17 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Maintain

RUC Recommendation: 0.17 **Referred to CPT** N/A **Referred to CPT Asst** ☐ **Published in CPT Asst:**

96361 Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** IV Hydration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 25 **Specialty Developing Recommendation:** ASCO, ASH **First Identified:** July 2015 **2017 Est. Medicare Utilization:** 492,505 **2007 Work RVU:** **2018 Work RVU:** 0.09 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Maintain

RUC Recommendation: 0.09 **Referred to CPT** N/A **Referred to CPT Asst** ☐ **Published in CPT Asst:**

96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour **Global:** XXX **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 28 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ISDA **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 1,275,255 **2007 Work RVU:** **2018 Work RVU:** 0.21 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU:** **2018 Fac PE RVU:** **Result:** Maintain

RUC Recommendation: 0.21 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96366 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes¹ **Complete?** Yes

Most Recent RUC Meeting: January 2013

Tab 28 Specialty Developing Recommendation: ACRh, ASCO, ASH, ISDA

First Identified: April 2013

2017 Est. Medicare Utilization: 614,196

2007 Work RVU:

2018 Work RVU: 0.18

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: 0.18

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

96367 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes¹ **Complete?** Yes

Most Recent RUC Meeting: January 2013

Tab 28 Specialty Developing Recommendation: ACRh, ASCO, ASH, ISDA

First Identified: September 2011

2017 Est. Medicare Utilization: 1,523,880

2007 Work RVU:

2018 Work RVU: 0.19

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: 0.19

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

96368 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes¹ **Complete?** Yes

Most Recent RUC Meeting: January 2013

Tab 28 Specialty Developing Recommendation: ACRh, ASCO, ASH, ISDA

First Identified: April 2013

2017 Est. Medicare Utilization: 140,592

2007 Work RVU:

2018 Work RVU: 0.17

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: 0.17

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular			Global: XXX	Issue: Application of On-body Injector with Subcutaneous Injection	Screen: Different Performing Specialty from Survey2 / CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting:	January 2017	Tab 26	Specialty Developing Recommendation:	ASCO, ASH, AAFP, ACRh	First Identified: April 2013	2017 Est. Medicare Utilization: 9,666,264	2007 Work RVU: 0.17 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain
RUC Recommendation:	0.17				Referred to CPT N/A Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug			Global: XXX	Issue: Application of On-body Injector with Subcutaneous Injection	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting:	January 2017	Tab 26	Specialty Developing Recommendation:	ASCO, ASH, ACRh	First Identified: July 2015	2017 Est. Medicare Utilization: 278,173	2007 Work RVU: 0.18 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain
RUC Recommendation:	0.18				Referred to CPT N/A Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)			Global: ZZZ	Issue: Application of On-body Injector with Subcutaneous Injection	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting:	January 2017	Tab 26	Specialty Developing Recommendation:	ASCO, ASH, ACRh	First Identified: July 2015	2017 Est. Medicare Utilization: 1,411,482	2007 Work RVU: 0.10 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain
RUC Recommendation:	0.10				Referred to CPT N/A Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:

Status Report: CMS Requests and Relativity Assessment Issues

96377 Application of on-body injector (includes cannula insertion) for timed subcutaneous injection

Global: XXX

Issue: Application of On-body Injector with Subcutaneous Injection

Screen: should be on N/R LOI just added to track

Complete? Yes

Most Recent RUC Meeting: January 2017

Tab 26

Specialty Developing Recommendation: ASCO, ASH

First Identified: January 2016

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU: 0.17

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Not Part of RAW

RUC Recommendation: 0.17

Referred to CPT N/A

Referred to CPT Asst ☐

Published in CPT Asst:

963X0

Global:

Issue: Psychological and Neuro-psychological Testing

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: October 2017

Tab 08

Specialty Developing Recommendation: APA (psychology), AAP, ASHA, AAN

First Identified: June 2017

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 2.50

Referred to CPT June 2017

Referred to CPT Asst ☐

Published in CPT Asst:

963X1

Global:

Issue: Psychological and Neuro-psychological Testing

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: October 2017

Tab 08

Specialty Developing Recommendation: APA (psychology), AAP, ASHA, AAN

First Identified: June 2017

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 1.10

Referred to CPT June 2017

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

963X2

Global:

Issue: Psychological and Neuro-psychological Testing

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: October 2017

Tab 08

Specialty Developing Recommendation:

APA (psychology), AAP, ASHA, AAN

First Identified: June 2017

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: 1.71

Referred to CPT June 2017

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

963X3

Global:

Issue: Psychological and Neuro-psychological Testing

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: October 2017

Tab 20

Specialty Developing Recommendation:

APA (psychology), AAP, ASHA, AAN

First Identified: June 2017

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: 2.50

Referred to CPT June 2017

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

963X4

Global:

Issue: Psychological and Neuro-psychological Testing

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: October 2017

Tab 20

Specialty Developing Recommendation:

APA (psychology), AAP, ASHA, AAN

First Identified: June 2017

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: 1.90

Referred to CPT June 2017

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

963X5

Global:

Issue: Psychological and Neuro-psychological Testing

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent
RUC Meeting: October 2017

Tab 08

Specialty Developing
Recommendation:

APA
(psychology),
AAP, ASHA,
AAN

First
Identified: June 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: 2.50

Referred to CPT June 2017

Referred to CPT Asst ☐ Published in CPT Asst:

Result: Decrease

963X6

Global:

Issue: Psychological and Neuro-psychological Testing

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent
RUC Meeting: October 2017

Tab 08

Specialty Developing
Recommendation:

APA
(psychology),
AAP, ASHA,
AAN

First
Identified: June 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: 1.90

Referred to CPT June 2017

Referred to CPT Asst ☐ Published in CPT Asst:

Result: Decrease

963X7

Global:

Issue: Psychological and Neuro-psychological Testing

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent
RUC Meeting: October 2017

Tab 20

Specialty Developing
Recommendation:

APA
(psychology),
AAP, ASHA,
AAN

First
Identified: June 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: 0.55

Referred to CPT June 2017

Referred to CPT Asst ☐ Published in CPT Asst:

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

963X8				Global:	Issue: Psychological and Neuro-psychological Testing	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 20	Specialty Developing Recommendation:	APA (psychology), AAP, ASHA, AAN	First Identified: June 2017	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 0.46				Referred to CPT June 2017 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Decrease	

963X9				Global:	Issue: Psychological and Neuro-psychological Testing	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 20	Specialty Developing Recommendation:	APA (psychology), AAP, ASHA, AAN	First Identified: June 2017	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: New PE Inputs				Referred to CPT June 2017 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: PE Only	

96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic			Global: XXX	Issue: Chemotherapy Administration	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 27	Specialty Developing Recommendation:	ASBMT, ASCO, ASH, ACRh	First Identified: July 2015	2017 Est. Medicare Utilization: 738,651	2007 Work RVU: 0.21 2007 NF PE RVU: 1.34 2007 Fac PE RVU NA	2018 Work RVU: 0.21 2018 NF PE RVU: 1.34 2018 Fac PE RVU: NA
RUC Recommendation: 0.21				Referred to CPT N/A Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Maintain	

Status Report: CMS Requests and Relativity Assessment Issues

96402 Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic **Global:** XXX **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 27

Specialty Developing Recommendation:

ASBMT, ASCO, ASH, AUA

First Identified: July 2015

2017 Est. Medicare Utilization: 400,554

2007 Work RVU: 0.19

2018 Work RVU: 0.19

2007 NF PE RVU: 0.94

2018 NF PE RVU: 0.94

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.19

Referred to CPT N/A

Referred to CPT Asst ☐

Published in CPT Asst:

96405 Chemotherapy administration; intralesional, up to and including 7 lesions

Global: 000

Issue: Chemotherapy Administration

Screen: CMS Request - Practice Expense Review

Complete? Yes

Most Recent RUC Meeting: April 2008

Tab 55

Specialty Developing Recommendation:

ASCO

First Identified: NA

2017 Est. Medicare Utilization: 5,657

2007 Work RVU: 0.52

2018 Work RVU: 0.52

2007 NF PE RVU: 2.71

2018 NF PE RVU: 2.71

2007 Fac PE RVU 0.24

2018 Fac PE RVU:0.24

Result: PE Only

RUC Recommendation: New PE inputs

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

96406 Chemotherapy administration; intralesional, more than 7 lesions

Global: 000

Issue: Chemotherapy Administration

Screen: CMS Request - Practice Expense Review

Complete? Yes

Most Recent RUC Meeting: April 2008

Tab 55

Specialty Developing Recommendation:

ASCO

First Identified: NA

2017 Est. Medicare Utilization: 372

2007 Work RVU: 0.80

2018 Work RVU: 0.80

2007 NF PE RVU: 3.08

2018 NF PE RVU: 3.08

2007 Fac PE RVU 0.29

2018 Fac PE RVU:0.29

Result: PE Only

RUC Recommendation: New PE inputs

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

96409 Chemotherapy administration; intravenous, push technique, single or initial substance/drug

Global: XXX

Issue: Chemotherapy Administration

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: January 2017

Tab 27

Specialty Developing Recommendation:

ASBMT, ASCO, ASH

First Identified: July 2015

2017 Est. Medicare Utilization: 111,109

2007 Work RVU: 0.24

2018 Work RVU: 0.24

2007 NF PE RVU: 2.88

2018 NF PE RVU: 2.88

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.24

Referred to CPT N/A

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

96411	Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Chemotherapy Administration	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 27	Specialty Developing Recommendation: ASBMT, ASCO, ASH	First Identified: July 2015	2017 Est. Medicare Utilization: 181,074	2007 Work RVU: 0.20 2018 Work RVU: 0.20 2007 NF PE RVU: 1.58 2018 NF PE RVU: 1.58 2007 Fac PE RVU: NA 2018 Fac PE RVU: NA Result: Maintain
RUC Recommendation: 0.20			Referred to CPT N/A Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
<hr/>					
96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug	Global: XXX	Issue: Chemotherapy Administration	Screen: Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: January 2013	Tab 29	Specialty Developing Recommendation: ACRh, ASCO, ASH, ASBMT	First Identified: February 2010	2017 Est. Medicare Utilization: 1,828,517	2007 Work RVU: 0.28 2018 Work RVU: 0.28 2007 NF PE RVU: 4.05 2018 NF PE RVU: 4.05 2007 Fac PE RVU: NA 2018 Fac PE RVU: NA Result: Maintain
RUC Recommendation: 0.28 and new PE inputs			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
<hr/>					
96415	Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Chemotherapy Administration	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: January 2013	Tab 29	Specialty Developing Recommendation: ACRh, ASCO, ASH, ASBMT	First Identified: January 2012	2017 Est. Medicare Utilization: 950,143	2007 Work RVU: 0.19 2018 Work RVU: 0.19 2007 NF PE RVU: 0.74 2018 NF PE RVU: 0.74 2007 Fac PE RVU: NA 2018 Fac PE RVU: NA Result: Maintain
RUC Recommendation: 0.19 and new PE inputs			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

96416 Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump **Global:** XXX **Issue:** Chemotherapy Administration **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab** 20 **Specialty Developing Recommendation:** ACRh, ASCO, ASH **First Identified:** February 2010 **2017 Est. Medicare Utilization:** 41,957 **2007 Work RVU:** 0.21 **2018 Work RVU:** 0.21 **2007 NF PE RVU:** 4.47 **2018 NF PE RVU:** 4.47 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** PE Only

RUC Recommendation: New PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96417 Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure) **Global:** ZZZ **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab** 29 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ASBMT **First Identified:** January 2012 **2017 Est. Medicare Utilization:** 393,194 **2007 Work RVU:** 0.21 **2018 Work RVU:** 0.21 **2007 NF PE RVU:** 1.89 **2018 NF PE RVU:** 1.89 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Maintain

RUC Recommendation: 0.21 and new PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96440 Chemotherapy administration into pleural cavity, requiring and including thoracentesis **Global:** 000 **Issue:** Chemotherapy Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab** R **Specialty Developing Recommendation:** **First Identified:** NA **2017 Est. Medicare Utilization:** 124 **2007 Work RVU:** 2.37 **2018 Work RVU:** 2.12 **2007 NF PE RVU:** 7.48 **2018 NF PE RVU:** 7.48 **2007 Fac PE RVU:** 1.17 **2018 Fac PE RVU:** 1.17 **Result:** PE Only

RUC Recommendation: New PE inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96567 Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day **Global:** XXX **Issue:** Photodynamic Therapy **Screen:** High Volume Growth1 / CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent **Tab** 16 **Specialty Developing** AAD
RUC Meeting: January 2017 **Recommendation:**

First Identified: February 2008 **2017 Est. Medicare Utilization:** 144,309

2007 Work RVU: 0.00 **2018 Work RVU:** 0.00
2007 NF PE RVU: 2.4 **2018 NF PE RVU:** 2.4
2007 Fac PE RVU: NA **2018 Fac PE RVU:** NA
Result: Maintain

RUC Recommendation: 0.00 PE Only

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

96573 Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day **Global:** 000 **Issue:** Photodynamic Therapy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent **Tab** 16 **Specialty Developing** AAD
RUC Meeting: January 2017 **Recommendation:**

First Identified: January 2017 **2017 Est. Medicare Utilization:**

2007 Work RVU: **2018 Work RVU:** 0.48
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU: **2018 Fac PE RVU:**
Result: Increase

RUC Recommendation: 0.48

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

96574 Debridement of premalignant hyperkeratotic lesion(s) (ie, targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day **Global:** 000 **Issue:** Photodynamic Therapy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent **Tab** 16 **Specialty Developing** AAD
RUC Meeting: January 2017 **Recommendation:**

First Identified: January 2017 **2017 Est. Medicare Utilization:**

2007 Work RVU: **2018 Work RVU:** 1.01
2007 NF PE RVU: **2018 NF PE RVU:**
2007 Fac PE RVU: **2018 Fac PE RVU:**
Result: Increase

RUC Recommendation: 1.01

Referred to CPT September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96910	Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B	Global: XXX	Issue: Photo-chemotherapy	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 44 Specialty Developing Recommendation: AAD	First Identified: July 2015	2017 Est. Medicare Utilization: 409,446	2007 Work RVU: 0.00 2007 NF PE RVU: 1.24 2007 Fac PE RVU NA Result: PE Only	2018 Work RVU: 0.00 2018 NF PE RVU: 1.24 2018 Fac PE RVU: NA
RUC Recommendation: PE Only		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
96920	Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm	Global: 000	Issue: Laser Treatment – Skin	Screen: CMS Fastest Growing / CPT Assistant Analysis / High Volume Growth3	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 19 Specialty Developing Recommendation: AAD	First Identified: October 2008	2017 Est. Medicare Utilization: 117,974	2007 Work RVU: 1.15 2007 NF PE RVU: 2.8 2007 Fac PE RVU 0.57 Result: Maintain	2018 Work RVU: 1.15 2018 NF PE RVU: 2.8 2018 Fac PE RVU: 0.57
RUC Recommendation: 1.15		Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Sep 2016		
<hr/>					
96921	Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm	Global: 000	Issue: Laser Treatment – Skin	Screen: High Volume Growth1 / CMS Fastest Growing / CPT Assistant Analysis / High Volume Growth3	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 19 Specialty Developing Recommendation: AAD	First Identified: February 2008	2017 Est. Medicare Utilization: 30,820	2007 Work RVU: 1.17 2007 NF PE RVU: 2.82 2007 Fac PE RVU 0.57 Result: Increase	2018 Work RVU: 1.30 2018 NF PE RVU: 2.82 2018 Fac PE RVU: 0.57
RUC Recommendation: 1.30		Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Sep 2016		

Status Report: CMS Requests and Relativity Assessment Issues

96922	Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm	Global: 000	Issue: Laser Treatment – Skin	Screen: High Volume Growth1 / CMS Fastest Growing / CPT Assistant Analysis	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 19 Specialty Developing Recommendation: AAD	First Identified: October 2008	2017 Est. Medicare Utilization: 18,518	2007 Work RVU: 2.10 2007 NF PE RVU: 3.77 2007 Fac PE RVU: 0.73 Result: Maintain	2018 Work RVU: 2.10 2018 NF PE RVU: 3.77 2018 Fac PE RVU: 0.73
RUC Recommendation: 2.10		Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Sep 2016		
<hr/>					
96X10		Global:	Issue: Psychological and Neuro-psychological Testing	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: October 2017	Tab 20 Specialty Developing Recommendation: APA (psychology), AAP, ASHA, AAN	First Identified: June 2017	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: New PE Inputs		Referred to CPT June 2017 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: PE Only	
<hr/>					
96X11	Psychological or neuropsychological test administration using single instrument, with interpretation and report by physician or other qualified health care professional and interactive feedback to the patient, family member(s), or caregivers(s), when performed	Global:	Issue: Psychological and Neuro-psychological Testing	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2018	Tab 19 Specialty Developing Recommendation: APA (psychology), AAP, ASHA, AAN	First Identified: June 2017	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: Rescind for CPT 2019		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	Result: Deleted from CPT	

Status Report: CMS Requests and Relativity Assessment Issues

96X12

Global:

Issue: Psychological and Neuro-psychological Testing

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent
RUC Meeting: October 2017

Tab 20

Specialty Developing
Recommendation: APA
(psychology),
AAP, ASHA,
AAN

First
Identified: June 2017

2017 Est.
Medicare
Utilization:

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU:
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: New PE Inputs

Referred to CPT June 2017

Referred to CPT Asst ☐ Published in CPT Asst:

Result: PE Only

97001 Physical therapy evaluation

Global: XXX

Issue: Physical Medicine and Rehabilitation Workgroup

Screen: CMS High Expenditure Procedural Codes1

Complete? Yes

Most Recent
RUC Meeting: October 2015

Tab 17

Specialty Developing
Recommendation:

First
Identified: September 2011

2017 Est.
Medicare
Utilization:

2007 Work RVU: 1.20
2007 NF PE RVU: 0.73
2007 Fac PE RVU NA

2018 Work RVU:
2018 NF PE RVU: 0.73
2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Referred to CPT Asst ☐ Published in CPT Asst:

Result: Deleted from CPT

97002 Physical therapy re-evaluation

Global: XXX

Issue: Physical Medicine and Rehabilitation Workgroup

Screen: CMS High Expenditure Procedural Codes1

Complete? Yes

Most Recent
RUC Meeting: October 2015

Tab 17

Specialty Developing
Recommendation:

First
Identified: February 2015

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.60
2007 NF PE RVU: 0.43
2007 Fac PE RVU NA

2018 Work RVU:
2018 NF PE RVU: 0.43
2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Referred to CPT Asst ☐ Published in CPT Asst:

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

97003 Occupational therapy evaluation

Global: XXX

Issue: Physical Medicine and Rehabilitation Workgroup

Screen: CMS High Expenditure Procedural Codes1

Complete? Yes

Most Recent
RUC Meeting: October 2015

Tab 17

Specialty Developing
Recommendation:

First
Identified: February 2015

2017 Est.
Medicare
Utilization:

2007 Work RVU: 1.20

2018 Work RVU:

2007 NF PE RVU: 0.86

2018 NF PE RVU: 0.86

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Referred to CPT Asst ☐ Published in CPT Asst:

Result: Deleted from CPT

97004 Occupational therapy re-evaluation

Global: XXX

Issue: Physical Medicine and Rehabilitation Workgroup

Screen: CMS High Expenditure Procedural Codes1

Complete? Yes

Most Recent
RUC Meeting: October 2015

Tab 17

Specialty Developing
Recommendation:

First
Identified: February 2015

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.60

2018 Work RVU:

2007 NF PE RVU: 0.64

2018 NF PE RVU: 0.64

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Deleted from CPT

Referred to CPT February 2015

Referred to CPT Asst ☐ Published in CPT Asst:

Result: Deleted from CPT

97010 Application of a modality to 1 or more areas; hot or cold packs

Global: XXX

Issue: Physical Medicine and Rehabilitation Services - Modalities

Screen: Physical Medicine and Rehabilitation Services

Complete? Yes

Most Recent
RUC Meeting: April 2017

Tab 41

Specialty Developing
Recommendation: No Interest

First
Identified:

2017 Est.
Medicare
Utilization:

2007 Work RVU: 0.06

2018 Work RVU: 0.06

2007 NF PE RVU: 0.06

2018 NF PE RVU: 0.06

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: No specialty society interest

Referred to CPT

Referred to CPT Asst ☐ Published in CPT Asst:

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

97012	Application of a modality to 1 or more areas; traction, mechanical	Global: XXX	Issue: Physical Medicine and Rehabilitation Services - Modalities	Screen: Physical Medicine and Rehabilitation Services	Complete? Yes
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Most Recent RUC Meeting: January 2017

Tab 29 **Specialty Developing Recommendation:** APTA

First Identified:

2017 Est. Medicare Utilization: 579,771

2007 Work RVU: 0.25

2018 Work RVU: 0.25

2007 NF PE RVU: 0.13

2018 NF PE RVU: 0.13

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.25

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)	Global: XXX	Issue: Physical Medicine and Rehabilitation Services - Modalities	Screen: Physical Medicine and Rehabilitation Services	Complete? Yes
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Most Recent RUC Meeting: January 2017

Tab 29 **Specialty Developing Recommendation:** APTA

First Identified:

2017 Est. Medicare Utilization:

2007 Work RVU: 0.18

2018 Work RVU: 0.18

2007 NF PE RVU: 0.19

2018 NF PE RVU: 0.19

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.18

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

97016	Application of a modality to 1 or more areas; vasopneumatic devices	Global: XXX	Issue: Physical Medicine and Rehabilitation Services - Modalities	Screen: Codes Reported Together 75% or More- Part1 / High Volume Growth2	Complete? Yes
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Most Recent RUC Meeting: January 2017

Tab 29 **Specialty Developing Recommendation:** APTA

First Identified: February 2010

2017 Est. Medicare Utilization: 652,867

2007 Work RVU: 0.18

2018 Work RVU: 0.18

2007 NF PE RVU: 0.2

2018 NF PE RVU: 0.2

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.18

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

97018 Application of a modality to 1 or more areas; paraffin bath

Global: XXX

Issue: Physical Medicine and Rehabilitation Services - Modalities

Screen: Codes Reported Together 75% or More-Part1

Complete? Yes

Most Recent RUC Meeting: January 2017

Tab 29

Specialty Developing Recommendation:

AOTA, APTA

First Identified: February 2010

2017 Est. Medicare Utilization: 147,040

2007 Work RVU: 0.06

2018 Work RVU: 0.06

2007 NF PE RVU: 0.12

2018 NF PE RVU: 0.12

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.06

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

97022 Application of a modality to 1 or more areas; whirlpool

Global: XXX

Issue: Physical Medicine and Rehabilitation Services - Modalities

Screen: Physical Medicine and Rehabilitation Services

Complete? Yes

Most Recent RUC Meeting: January 2017

Tab 29

Specialty Developing Recommendation:

APTA

First Identified:

2017 Est. Medicare Utilization: 185,160

2007 Work RVU: 0.17

2018 Work RVU: 0.17

2007 NF PE RVU: 0.24

2018 NF PE RVU: 0.24

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.17

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

97032 Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes

Global: XXX

Issue: Physical Medicine and Rehabilitation Services - Modalities

Screen: CMS High Expenditure Procedural Codes2

Complete? Yes

Most Recent RUC Meeting: January 2017

Tab 29

Specialty Developing Recommendation:

APTA

First Identified: July 2015

2017 Est. Medicare Utilization: 941,745

2007 Work RVU: 0.25

2018 Work RVU: 0.25

2007 NF PE RVU: 0.17

2018 NF PE RVU: 0.17

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.25

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes	Global: XXX	Issue: Physical Medicine and Rehabilitation Services - Modalities	Screen: Physical Medicine and Rehabilitation Services	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 29 Specialty Developing Recommendation: APTA	First Identified:	2017 Est. Medicare Utilization: 68,681	2007 Work RVU: 0.26 2007 NF PE RVU: 0.31 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 0.26 2018 NF PE RVU: 0.31 2018 Fac PE RVU: NA
RUC Recommendation: 0.26		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes	Global: XXX	Issue: Physical Medicine and Rehabilitation Services - Modalities	Screen: Physical Medicine and Rehabilitation Services	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 29 Specialty Developing Recommendation: APTA, AOTA	First Identified:	2017 Est. Medicare Utilization: 7,457	2007 Work RVU: 0.21 2007 NF PE RVU: 0.16 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 0.21 2018 NF PE RVU: 0.16 2018 Fac PE RVU: NA
RUC Recommendation: 0.21		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes	Global: XXX	Issue: Physical Medicine and Rehabilitation Services - Modalities	Screen: Low Value-High Volume / CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 29 Specialty Developing Recommendation: APTA	First Identified: October 2010	2017 Est. Medicare Utilization: 2,396,301	2007 Work RVU: 0.21 2007 NF PE RVU: 0.1 2007 Fac PE RVU NA Result: Maintain	2018 Work RVU: 0.21 2018 NF PE RVU: 0.1 2018 Fac PE RVU: NA
RUC Recommendation: 0.21		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	Global: XXX	Issue: Physical Medicine and Rehabilitation Services - Therapeutic	Screen: Codes Reported Together 75% or More- Part1 / MPC List / CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 29	Specialty Developing Recommendation: AOTA, APTA	First Identified: February 2010	2017 Est. Medicare Utilization: 56,112,641	2007 Work RVU: 0.45 2018 Work RVU: 0.45 2007 NF PE RVU: 0.28 2018 NF PE RVU: 0.28 2007 Fac PE RVU: NA 2018 Fac PE RVU: NA Result: Maintain
RUC Recommendation: 0.45			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
<hr/>					
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	Global: XXX	Issue: Physical Medicine and Rehabilitation Services - Therapeutic	Screen: CMS High Expenditure Procedural Codes1 / CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 29	Specialty Developing Recommendation: APTA, AOTA	First Identified: September 2011	2017 Est. Medicare Utilization: 12,646,457	2007 Work RVU: 0.45 2018 Work RVU: 0.50 2007 NF PE RVU: 0.32 2018 NF PE RVU: 0.32 2007 Fac PE RVU: NA 2018 Fac PE RVU: NA Result: Increase
RUC Recommendation: 0.50			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
<hr/>					
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises	Global: XXX	Issue: Physical Medicine and Rehabilitation Services - Therapeutic	Screen: CMS High Expenditure Procedural Codes2	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 29	Specialty Developing Recommendation: APTA	First Identified: July 2015	2017 Est. Medicare Utilization: 1,770,014	2007 Work RVU: 0.44 2018 Work RVU: 0.48 2007 NF PE RVU: 0.43 2018 NF PE RVU: 0.43 2007 Fac PE RVU: NA 2018 Fac PE RVU: NA Result: Increase
RUC Recommendation: 0.48			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

97116 Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing) **Global:** XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** Codes Reported Together 75% or More- Part1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA **First Identified:** February 2010 **2017 Est. Medicare Utilization:** 2,099,811 **2007 Work RVU:** 0.40 **2018 Work RVU:** 0.45 **2007 NF PE RVU:** 0.25 **2018 NF PE RVU:** 0.25 **2007 Fac PE RVU** NA **2018 Fac PE RVU:** NA **Result:** Increase

RUC Recommendation: 0.45 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

97127 Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact **Global:** XXX **Issue:** Cognitive Function Intervention **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA **First Identified:** January 2017 **2017 Est. Medicare Utilization:** **2007 Work RVU:** **2018 Work RVU:** 0.00 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU** **2018 Fac PE RVU:** **Result:** Decrease

RUC Recommendation: 1.50 **Referred to CPT** September 2016 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

97140 Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes **Global:** XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS High Expenditure Procedural Codes1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 27,038,922 **2007 Work RVU:** 0.43 **2018 Work RVU:** 0.43 **2007 NF PE RVU:** 0.26 **2018 NF PE RVU:** 0.26 **2007 Fac PE RVU** NA **2018 Fac PE RVU:** NA **Result:** Maintain

RUC Recommendation: 0.43 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97150	Therapeutic procedure(s), group (2 or more individuals)	Global: XXX	Issue: Physical Medicine and Rehabilitation Services - Therapeutic	Screen: CMS-Other - Utilization over 500,000	Complete? Yes
Most Recent RUC Meeting:	January 2012	Tab	Specialty Developing Recommendation: APTA	First Identified: April 2011	2017 Est. Medicare Utilization: 1,188,945
RUC Recommendation:	0.29			Referred to CPT	Referred to CPT Asst <input type="checkbox"/>
				Published in CPT Asst:	
				2007 Work RVU: 0.27	2018 Work RVU: 0.29
				2007 NF PE RVU: 0.19	2018 NF PE RVU: 0.19
				2007 Fac PE RVU NA	2018 Fac PE RVU: NA
				Result: Increase	

97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.	Global: XXX	Issue: Physical Medicine and Rehabilitation Services	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting:	October 2015	Tab 17	Specialty Developing Recommendation: AOTA, APTA	First Identified: February 2015	2017 Est. Medicare Utilization: 1,278,197
RUC Recommendation:	0.75			Referred to CPT February 2015	Referred to CPT Asst <input type="checkbox"/>
				Published in CPT Asst:	
				2007 Work RVU:	2018 Work RVU: 1.20
				2007 NF PE RVU:	2018 NF PE RVU:
				2007 Fac PE RVU	2018 Fac PE RVU:
				Result: Decrease	

Status Report: CMS Requests and Relativity Assessment Issues

97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.	Global: XXX	Issue: Physical Medicine and Rehabilitation Services	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes		
Most Recent RUC Meeting:	October 2015	Tab 17	Specialty Developing Recommendation: AOTA, APTA	First Identified: February 2015	2017 Est. Medicare Utilization: 1,286,521	2007 Work RVU:	2018 Work RVU: 1.20
RUC Recommendation:	1.18			Referred to CPT February 2015		2007 NF PE RVU:	2018 NF PE RVU:
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU	2018 Fac PE RVU:
						Result: Decrease	
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.	Global: XXX	Issue: Physical Medicine and Rehabilitation Services	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes		
Most Recent RUC Meeting:	October 2015	Tab 17	Specialty Developing Recommendation: AOTA, APTA	First Identified: February 2015	2017 Est. Medicare Utilization: 326,812	2007 Work RVU:	2018 Work RVU: 1.20
RUC Recommendation:	1.50			Referred to CPT February 2015		2007 NF PE RVU:	2018 NF PE RVU:
				Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU	2018 Fac PE RVU:
						Result: Maintain	

Status Report: CMS Requests and Relativity Assessment Issues

97164 Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015

Tab 17 Specialty Developing Recommendation: AOTA, APTA

First Identified: February 2015

2017 Est. Medicare Utilization: 525,044

2007 Work RVU:

2018 Work RVU: 0.75

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 0.75

Referred to CPT February 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

97165 Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015

Tab 17 Specialty Developing Recommendation: AOTA, APTA

First Identified: February 2015

2017 Est. Medicare Utilization: 113,821

2007 Work RVU:

2018 Work RVU: 1.20

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Decrease

RUC Recommendation: 0.88

Referred to CPT February 2015

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97166 Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.	Global: XXX	Issue: Physical Medicine and Rehabilitation Services	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 17 Specialty Developing Recommendation: AOTA, APTA	First Identified: February 2015	2017 Est. Medicare Utilization: 83,520	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Maintain 2018 Work RVU: 1.20 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.20	Referred to CPT February 2015	Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		

97167 Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.	Global: XXX	Issue: Physical Medicine and Rehabilitation Services	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 17 Specialty Developing Recommendation: AOTA, APTA	First Identified: February 2015	2017 Est. Medicare Utilization: 21,696	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Increase 2018 Work RVU: 1.20 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.70	Referred to CPT February 2015	Referred to CPT Asst <input type="checkbox"/> Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

97168 Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2017 Est. Medicare Utilization:** 32,205 **2007 Work RVU:** **2018 Work RVU:** 0.75 **2007 NF PE RVU:** **2018 NF PE RVU:** **2007 Fac PE RVU Result:** Increase **2018 Fac PE RVU:**

RUC Recommendation: 0.80 **Referred to CPT** February 2015 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

97530 Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS High Expenditure Procedural Codes1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 12,576,727 **2007 Work RVU:** 0.44 **2018 Work RVU:** 0.44 **2007 NF PE RVU:** 0.34 **2018 NF PE RVU:** 0.34 **2007 Fac PE RVU** NA **2018 Fac PE RVU:** NA **Result:** Maintain

RUC Recommendation: 0.44 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

97532 Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes

Global: XXX **Issue:** Cognitive Function Intervention **Screen:** High Volume Growth2 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 29 **Specialty Developing Recommendation:** APTA, AOTA, ASHA, APA (psychology) **First Identified:** April 2013 **2017 Est. Medicare Utilization:** 263,111 **2007 Work RVU:** 0.44 **2018 Work RVU:** **2007 NF PE RVU:** 0.21 **2018 NF PE RVU:** 0.21 **2007 Fac PE RVU** NA **2018 Fac PE RVU:** NA

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

97533 Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes **Global:** XXX **Issue:** Physical Medicine and Rehabilitation Services - ADL/IADL **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 29 Specialty Developing Recommendation: APTA, AOTA

First Identified:

2017 Est. Medicare Utilization: 9,567

2007 Work RVU: 0.44

2018 Work RVU: 0.48

2007 NF PE RVU: 0.25

2018 NF PE RVU: 0.25

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Increase

RUC Recommendation: 0.48

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: XXX

Issue: Physical Medicine and Rehabilitation Services - ADL/IADL

Screen: Codes Reported Together 75% or More-Part2

Complete? Yes

Most Recent RUC Meeting: January 2017

Tab 29 Specialty Developing Recommendation: APTA, AOTA

First Identified: October 2012

2017 Est. Medicare Utilization: 1,342,655

2007 Work RVU: 0.45

2018 Work RVU: 0.45

2007 NF PE RVU: 0.34

2018 NF PE RVU: 0.34

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Maintain

RUC Recommendation: 0.45

Referred to CPT

Referred to CPT Asst ☒ **Published in CPT Asst:** Article no longer necessary

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

Global: XXX

Issue: Physical Medicine and Rehabilitation Services - ADL/IADL

Screen: Physical Medicine and Rehabilitation Services

Complete? Yes

Most Recent RUC Meeting: January 2017

Tab 29 Specialty Developing Recommendation: APTA, AOTA

First Identified:

2017 Est. Medicare Utilization: 5,557

2007 Work RVU: 0.45

2018 Work RVU: 0.48

2007 NF PE RVU: 0.27

2018 NF PE RVU: 0.27

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Increase

RUC Recommendation: 0.48

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes	Global: XXX	Issue: Physical Medicine and Rehabilitation Services - Therapeutic	Screen: High Volume Growth2	Complete? Yes
Most Recent RUC Meeting: January 2017	Tab 29 Specialty Developing Recommendation: APTA, AOTA	First Identified: April 2013	2017 Est. Medicare Utilization: 41,481	2007 Work RVU: 0.45 2007 NF PE RVU: 0.28 2007 Fac PE RVU: NA Result: Increase	2018 Work RVU: 0.48 2018 NF PE RVU: 0.28 2018 Fac PE RVU: NA
RUC Recommendation: 0.48		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
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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	Global: 000	Issue: Open Wound Debridement	Screen: Site of Service Anomaly / High Volume Growth3	Complete? Yes
Most Recent RUC Meeting: October 2018	Tab 23 Specialty Developing Recommendation: AAFP, ACS, APMA	First Identified: September 2007	2017 Est. Medicare Utilization: 994,938	2007 Work RVU: 0.58 2007 NF PE RVU: 0.77 2007 Fac PE RVU: 0.53 Result: Increase	2018 Work RVU: 0.51 2018 NF PE RVU: 0.77 2018 Fac PE RVU: 0.53
RUC Recommendation: 0.88		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
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)	Global: ZZZ	Issue: Open Wound Debridement	Screen: Site of Service Anomaly / High Volume Growth3 / Different Performing Specialty from Survey	Complete? Yes
Most Recent RUC Meeting: October 2018	Tab 23 Specialty Developing Recommendation: AAFP, ACS, APMA	First Identified: September 2007	2017 Est. Medicare Utilization: 143,287	2007 Work RVU: 0.80 2007 NF PE RVU: 0.91 2007 Fac PE RVU: 0.64 Result: Increase	2018 Work RVU: 0.24 2018 NF PE RVU: 0.91 2018 Fac PE RVU: 0.64
RUC Recommendation: 0.50		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

97602	Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session	Global: XXX	Issue: Physical Medicine and Rehabilitation Services - Active Wound Care Management	Screen: Physical Medicine and Rehabilitation Services	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 47	Specialty Developing Recommendation: AAOS, ACS, APMA, ASPS	First Identified:	2017 Est. Medicare Utilization:	2007 Work RVU: 0.00 2007 NF PE RVU: 0 2007 Fac PE RVU: 0 2018 Work RVU: 0.00 2018 NF PE RVU: 0 2018 Fac PE RVU: 0
RUC Recommendation: Maintain			Referred to CPT	Published in CPT Asst:	Result: Maintain
			Referred to CPT Asst <input type="checkbox"/>		
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97605	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	Global: XXX	Issue: Negative Pressure Wound Therapy	Screen: High Volume Growth2	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 47	Specialty Developing Recommendation: AAOS, ACS, APMA, ASPS	First Identified: April 2013	2017 Est. Medicare Utilization: 49,713	2007 Work RVU: 0.55 2007 NF PE RVU: 0.36 2007 Fac PE RVU: 0.2 2018 Work RVU: 0.55 2018 NF PE RVU: 0.36 2018 Fac PE RVU: 0.2
RUC Recommendation: 0.55			Referred to CPT	Published in CPT Asst:	Result: Maintain
			Referred to CPT Asst <input type="checkbox"/>		
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97606	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	Global: XXX	Issue: Negative Pressure Wound Therapy	Screen: High Volume Growth2	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 47	Specialty Developing Recommendation: APMA, ACS, AAOS, ASPS	First Identified: April 2013	2017 Est. Medicare Utilization: 15,210	2007 Work RVU: 0.60 2007 NF PE RVU: 0.37 2007 Fac PE RVU: 0.21 2018 Work RVU: 0.60 2018 NF PE RVU: 0.37 2018 Fac PE RVU: 0.21
RUC Recommendation: 0.60			Referred to CPT	Published in CPT Asst:	Result: Maintain
			Referred to CPT Asst <input type="checkbox"/>		

Status Report: CMS Requests and Relativity Assessment Issues

97607 Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters **Global:** XXX **Issue:** Negative Pressure Wound Therapy **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 47 **Specialty Developing Recommendation:** APMA, ACS, AAOS, ASPS **First Identified:** May 2013 **2017 Est. Medicare Utilization:** 3,727 **2007 Work RVU:** **2007 NF PE RVU:** **2007 Fac PE RVU Result:** Decrease **2018 Work RVU:** 0.00 **2018 NF PE RVU:** **2018 Fac PE RVU:**

RUC Recommendation: 0.11 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

97608 Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters **Global:** XXX **Issue:** Negative Pressure Wound Therapy **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 47 **Specialty Developing Recommendation:** APMA, ACS, AAOS, ASPS **First Identified:** May 2013 **2017 Est. Medicare Utilization:** 834 **2007 Work RVU:** **2007 NF PE RVU:** **2007 Fac PE RVU Result:** Decrease **2018 Work RVU:** 0.00 **2018 NF PE RVU:** **2018 Fac PE RVU:**

RUC Recommendation: 0.46 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

97610 Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day **Global:** XXX **Issue:** Physical Medicine and Rehabilitation Services - Active Wound Care Management **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 47 **Specialty Developing Recommendation:** **First Identified:** **2017 Est. Medicare Utilization:** 5,011 **2007 Work RVU:** **2007 NF PE RVU:** **2007 Fac PE RVU Result:** Maintain **2018 Work RVU:** 0.35 **2018 NF PE RVU:** **2018 Fac PE RVU:**

RUC Recommendation: Maintain **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97755 Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes **Global:** XXX **Issue:** Physical Medicine and Rehabilitation Services - Tests and Measures **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent
RUC Meeting: April 2016

Tab 47 **Specialty Developing** APTA, AOTA
Recommendation:

First Identified: February 2008

2017 Est. Medicare Utilization: 2,063

2007 Work RVU: 0.62

2018 Work RVU: 0.62

2007 NF PE RVU: 0.28

2018 NF PE RVU: 0.28

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Remove from screen

RUC Recommendation: Remove from screen

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

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 **Global:** XXX **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent
RUC Meeting: January 2017

Tab 29 **Specialty Developing** APTA, AOTA
Recommendation:

First Identified: April 2016

2017 Est. Medicare Utilization: 67,499

2007 Work RVU: 0.45

2018 Work RVU: 0.50

2007 NF PE RVU: 0.36

2018 NF PE RVU: 0.36

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Increase

RUC Recommendation: 0.50

Referred to CPT September 2016

Referred to CPT Asst ☐

Published in CPT Asst:

97761 Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes **Global:** XXX **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent
RUC Meeting: January 2017

Tab 29 **Specialty Developing** APTA
Recommendation:

First Identified: April 2016

2017 Est. Medicare Utilization: 6,098

2007 Work RVU: 0.45

2018 Work RVU: 0.50

2007 NF PE RVU: 0.29

2018 NF PE RVU: 0.29

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

Result: Increase

RUC Recommendation: 0.50

Referred to CPT September 2016

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

97762 Checkout for orthotic/prosthetic use, established patient, each 15 minutes **Global:** XXX **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent **Tab** 29 **Specialty Developing** APTA
RUC Meeting: January 2017 **Recommendation:**

First
Identified: April 2016

2017 Est.
Medicare
Utilization: 17,888

2007 Work RVU: 0.25

2018 Work RVU:

2007 NF PE RVU: 0.5

2018 NF PE RVU: 0.5

2007 Fac PE RVU NA

2018 Fac PE RVU: NA

RUC Recommendation: Deleted from CPT

Referred to CPT September 2016

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

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 **Global:** XXX **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent **Tab** 29 **Specialty Developing** APTA, AOTA
RUC Meeting: January 2017 **Recommendation:**

First
Identified: April 2016

2017 Est.
Medicare
Utilization:

2007 Work RVU:

2018 Work RVU: 0.48

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

RUC Recommendation: 0.48

Referred to CPT

Result: Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97802 Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes **Global:** XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Request - Medical Nutrition Therapy **Complete?** Yes

Most Recent **Tab** 53 **Specialty Developing** ADA, AGA, AACE
RUC Meeting: April 2008 **Recommendation:**

First
Identified: NA

2017 Est.
Medicare
Utilization: 218,613

2007 Work RVU: 0.45

2018 Work RVU: 0.53

2007 NF PE RVU: 0.39

2018 NF PE RVU: 0.39

2007 Fac PE RVU 0.38

2018 Fac PE RVU: 0.38

RUC Recommendation: 0.53

Referred to CPT

Result: Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97803 Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes **Global:** XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Request - Medical Nutrition Therapy **Complete?** Yes

Most Recent RUC Meeting: April 2008

Tab 53 **Specialty Developing Recommendation:** ADA, AGA, AACE

First Identified: NA

2017 Est. Medicare Utilization: 199,738

2007 Work RVU: 0.37

2018 Work RVU: 0.45

2007 NF PE RVU: 0.38

2018 NF PE RVU: 0.38

2007 Fac PE RVU: 0.38

2018 Fac PE RVU: 0.38

Result: Increase

RUC Recommendation: 0.45

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

98925 Osteopathic manipulative treatment (OMT); 1-2 body regions involved

Global: 000

Issue: Osteopathic Manipulative Treatment

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: February 2011

Tab 34 **Specialty Developing Recommendation:** AOA

First Identified: February 2010

2017 Est. Medicare Utilization: 72,175

2007 Work RVU: 0.45

2018 Work RVU: 0.46

2007 NF PE RVU: 0.31

2018 NF PE RVU: 0.31

2007 Fac PE RVU: 0.14

2018 Fac PE RVU: 0.14

Result: Increase

RUC Recommendation: 0.50

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

98926 Osteopathic manipulative treatment (OMT); 3-4 body regions involved

Global: 000

Issue: Osteopathic Manipulative Treatment

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: February 2011

Tab 34 **Specialty Developing Recommendation:** AOA

First Identified: October 2009

2017 Est. Medicare Utilization: 113,235

2007 Work RVU: 0.65

2018 Work RVU: 0.71

2007 NF PE RVU: 0.4

2018 NF PE RVU: 0.4

2007 Fac PE RVU: 0.23

2018 Fac PE RVU: 0.23

Result: Increase

RUC Recommendation: 0.75

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

98927 Osteopathic manipulative treatment (OMT); 5-6 body regions involved

Global: 000

Issue: Osteopathic Manipulative Treatment

Screen: Harvard Valued - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: February 2011

Tab 34 **Specialty Developing Recommendation:** AOA

First Identified: October 2009

2017 Est. Medicare Utilization: 94,672

2007 Work RVU: 0.87

2018 Work RVU: 0.96

2007 NF PE RVU: 0.49

2018 NF PE RVU: 0.49

2007 Fac PE RVU: 0.28

2018 Fac PE RVU: 0.28

Result: Increase

RUC Recommendation: 1.00

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

98928	Osteopathic manipulative treatment (OMT); 7-8 body regions involved			Global: 000	Issue: Osteopathic Manipulative Treatment	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: February 2011	Tab 34	Specialty Developing Recommendation:	AOA	First Identified: February 2010	2017 Est. Medicare Utilization: 99,866	2007 Work RVU: 1.03 2007 NF PE RVU: 0.57 2007 Fac PE RVU: 0.32 Result: Increase	2018 Work RVU: 1.21 2018 NF PE RVU: 0.57 2018 Fac PE RVU: 0.32
RUC Recommendation: 1.25				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>							
98929	Osteopathic manipulative treatment (OMT); 9-10 body regions involved			Global: 000	Issue: Osteopathic Manipulative Treatment	Screen: Harvard Valued - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: February 2011	Tab 34	Specialty Developing Recommendation:	AOA	First Identified: February 2010	2017 Est. Medicare Utilization: 69,780	2007 Work RVU: 1.19 2007 NF PE RVU: 0.65 2007 Fac PE RVU: 0.35 Result: Increase	2018 Work RVU: 1.46 2018 NF PE RVU: 0.65 2018 Fac PE RVU: 0.35
RUC Recommendation: 1.50				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>							
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions			Global: 000	Issue: Chiropractic Manipulative Treatment	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: October 2012	Tab 25	Specialty Developing Recommendation:	ACA	First Identified: September 2011	2017 Est. Medicare Utilization: 6,191,404	2007 Work RVU: 0.45 2007 NF PE RVU: 0.23 2007 Fac PE RVU: 0.12 Result: Increase	2018 Work RVU: 0.46 2018 NF PE RVU: 0.23 2018 Fac PE RVU: 0.12
RUC Recommendation: 0.46				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>							
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions			Global: 000	Issue: Chiropractic Manipulative Treatment	Screen: CMS High Expenditure Procedural Codes1	Complete? Yes
Most Recent RUC Meeting: October 2012	Tab 25	Specialty Developing Recommendation:	ACA	First Identified: September 2011	2017 Est. Medicare Utilization: 13,263,702	2007 Work RVU: 0.65 2007 NF PE RVU: 0.29 2007 Fac PE RVU: 0.17 Result: Increase	2018 Work RVU: 0.71 2018 NF PE RVU: 0.29 2018 Fac PE RVU: 0.17
RUC Recommendation: 0.71				Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

98942 Chiropractic manipulative treatment (CMT); spinal, 5 regions **Global:** 000 **Issue:** Chiropractic Manipulative Treatment **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012

Tab 25 **Specialty Developing Recommendation:** ACA

First Identified: September 2011

2017 Est. Medicare Utilization: 858,674

2007 Work RVU: 0.87

2018 Work RVU: 0.96

2007 NF PE RVU: 0.36

2018 NF PE RVU: 0.36

2007 Fac PE RVU 0.23

2018 Fac PE RVU:0.23

Result: Increase

RUC Recommendation: 0.96

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

98943 Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions **Global:** XXX **Issue:** Chiropractic Manipulative Treatment **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012

Tab 25 **Specialty Developing Recommendation:** ACA

First Identified: September 2011

2017 Est. Medicare Utilization:

2007 Work RVU: 0.40

2018 Work RVU: 0.46

2007 NF PE RVU: 0.22

2018 NF PE RVU: 0.22

2007 Fac PE RVU 0.14

2018 Fac PE RVU:0.14

Result: Increase

RUC Recommendation: 0.46

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

99143 Deleted from CPT **Global:** XXX **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015

Tab 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI

First Identified: January 2014

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

99144 Deleted from CPT

Global: XXX

Issue: Moderate Sedation Services

Screen: Moderate Sedation Review

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 14

Specialty Developing Recommendation:

AAP,
AAOMS,
ACC,
CHEST,
ACEP, ACG,
ACR, AGA,
ASGE, ASA,
ATS, HRS,
SIR, SVS,
SCAI

First Identified: January 2014

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

99148 Deleted from CPT

Global: XXX

Issue: Moderate Sedation Services

Screen: Moderate Sedation Review

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 14

Specialty Developing Recommendation:

AAP,
AAOMS,
ACC,
CHEST,
ACEP, ACG,
ACR, AGA,
ASGE, ASA,
ATS, HRS,
SIR, SVS,
SCAI

First Identified: January 2014

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

99149 Deleted from CPT

Global: XXX

Issue: Moderate Sedation Services

Screen: Moderate Sedation Review

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 14

Specialty Developing Recommendation:

AAP,
AAOMS,
ACC,
CHEST,
ACEP, ACG,
ACR, AGA,
ASGE, ASA,
ATS, HRS,
SIR, SVS,
SCAI

First Identified: January 2014

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

99150 Deleted from CPT

Global: ZZZ

Issue: Moderate Sedation Services

Screen: Moderate Sedation Review

Complete? Yes

Most Recent RUC Meeting: October 2015

Tab 14

Specialty Developing Recommendation:

AAP,
AAOMS,
ACC,
CHEST,
ACEP, ACG,
ACR, AGA,
ASGE, ASA,
ATS, HRS,
SIR, SVS,
SCAI

First Identified: January 2014

2017 Est. Medicare Utilization:

2007 Work RVU: 0.00

2018 Work RVU:

2007 NF PE RVU: 0

2018 NF PE RVU: 0

2007 Fac PE RVU 0

2018 Fac PE RVU:0

RUC Recommendation: Deleted from CPT

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

99151 Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age

Global: XXX **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015

Tab 14

Specialty Developing Recommendation:

AAP,
AAOMS,
ACC,
CHEST,
ACEP, ACG,
ACR, AGA,
ASGE, ASA,
ATS, HRS,
SIR, SVS,
SCAI

First Identified: January 2014

2017 Est. Medicare Utilization: 211

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 0.50
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.50

Referred to CPT

Referred to CPT Asst

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Published in CPT Asst:

Result: Maintain

99152 Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older

Global: XXX **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015

Tab 14

Specialty Developing Recommendation:

AAP,
AAOMS,
ACC,
CHEST,
ACEP, ACG,
ACR, AGA,
ASGE, ASA,
ATS, HRS,
SIR, SVS,
SCAI

First Identified: January 2014

2017 Est. Medicare Utilization: 1,612,064

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 0.25
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 0.25

Referred to CPT

Referred to CPT Asst

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Published in CPT Asst:

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

99155 Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age

Global: XXX **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015

Tab 14

Specialty Developing Recommendation:

AAP,
AAOMS,
ACC,
CHEST,
ACEP, ACG,
ACR, AGA,
ASGE, ASA,
ATS, HRS,
SIR, SVS,
SCAI

First Identified: January 2014

2017 Est. Medicare Utilization: 66

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 1.90
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.90

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Maintain

99156 Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older

Global: XXX **Issue:** Moderate Sedation Services **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015

Tab 14

Specialty Developing Recommendation:

AAP,
AAOMS,
ACC,
CHEST,
ACEP, ACG,
ACR, AGA,
ASGE, ASA,
ATS, HRS,
SIR, SVS,
SCAI

First Identified: January 2014

2017 Est. Medicare Utilization: 9,454

2007 Work RVU:
2007 NF PE RVU:
2007 Fac PE RVU

2018 Work RVU: 1.65
2018 NF PE RVU:
2018 Fac PE RVU:

RUC Recommendation: 1.84

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

99174 Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with remote analysis and report **Global:** XXX **Issue:** Instrument-Based Ocular Screening (PE Only) **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: September 2014

Tab 09 Specialty Developing Recommendation: AAP, AAO

First Identified: NA

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU: 0.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: PE Only

RUC Recommendation: PE Only

Referred to CPT May 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

99177 Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with on-site analysis **Global:** XXX **Issue:** Instrument-Based Ocular Screening (PE Only) **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: September 2014

Tab 09 Specialty Developing Recommendation:

First Identified: May 2014

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU: 0.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: PE Only

RUC Recommendation: PE Only

Referred to CPT May 2014

Referred to CPT Asst ☐ **Published in CPT Asst:**

99183 Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session **Global:** XXX **Issue:** Hyperbaric Oxygen Therapy **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014

Tab 33 Specialty Developing Recommendation: ACEP, ACP, ACS, APMA

First Identified: April 2013

2017 Est. Medicare Utilization: 450,635

2007 Work RVU: 2.34

2018 Work RVU: 2.11

2007 NF PE RVU: 3.08

2018 NF PE RVU: 3.08

2007 Fac PE RVU 0.69

2018 Fac PE RVU: 0.69

Result: Decrease

RUC Recommendation: 2.11

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99281 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018

Tab 29 Specialty Developing Recommendation: AAP, ACEP

First Identified: June 2017

2017 Est. Medicare Utilization: 76,875

2007 Work RVU: 0.45

2018 Work RVU: 0.45

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 0.09

2018 Fac PE RVU:0.09

Result: Increase

RUC Recommendation: 0.48

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

99282 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018

Tab 29 Specialty Developing Recommendation: AAP, ACEP

First Identified: June 2017

2017 Est. Medicare Utilization: 381,387

2007 Work RVU: 0.88

2018 Work RVU: 0.88

2007 NF PE RVU: NA

2018 NF PE RVU: NA

2007 Fac PE RVU 0.15

2018 Fac PE RVU:0.15

Result: Increase

RUC Recommendation: 0.93

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99283	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.	Global: XXX	Issue: ED Visits	Screen: CMS Request - Final Rule for 2018	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 29	Specialty Developing Recommendation: AAP, ACEP	First Identified: June 2017	2017 Est. Medicare Utilization: 3,203,746	2007 Work RVU: 1.34 2018 Work RVU: 1.34 2007 NF PE RVU: NA 2018 NF PE RVU: NA 2007 Fac PE RVU: 0.3 2018 Fac PE RVU: 0.3 Result: Increase
RUC Recommendation: 1.42			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

99284	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.	Global: XXX	Issue: ED Visits	Screen: CMS Request - Final Rule for 2018	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 29	Specialty Developing Recommendation: AAP, ACEP	First Identified: June 2017	2017 Est. Medicare Utilization: 5,846,926	2007 Work RVU: 2.56 2018 Work RVU: 2.56 2007 NF PE RVU: NA 2018 NF PE RVU: NA 2007 Fac PE RVU: 0.47 2018 Fac PE RVU: 0.47 Result: Increase
RUC Recommendation: 2.60			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

99285 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2017 Est. Medicare Utilization:** 11,881,491

2007 Work RVU: 3.80 **2018 Work RVU:** 3.80
2007 NF PE RVU: NA **2018 NF PE RVU:** NA
2007 Fac PE RVU: 0.71 **2018 Fac PE RVU:** 0.71
Result: Maintain

RUC Recommendation: 3.80 **Referred to CPT**
Referred to CPT Asst ☐ **Published in CPT Asst:**

99363 Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)

Global: XXX **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 19 **Specialty Developing Recommendation:** **First Identified:** September 2016 **2017 Est. Medicare Utilization:**

2007 Work RVU: 1.65 **2018 Work RVU:**
2007 NF PE RVU: 1.29 **2018 NF PE RVU:** 1.29
2007 Fac PE RVU: 0.38 **2018 Fac PE RVU:** 0.38
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

99364 Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days of therapy (must include a minimum of 3 INR measurements)

Global: XXX **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 19 **Specialty Developing Recommendation:** **First Identified:** September 2016 **2017 Est. Medicare Utilization:**

2007 Work RVU: 0.63 **2018 Work RVU:**
2007 NF PE RVU: 0.38 **2018 NF PE RVU:** 0.38
2007 Fac PE RVU: 0.15 **2018 Fac PE RVU:** 0.15
Result: Deleted from CPT

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99375	Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	Global: XXX	Issue: Home Healthcare Supervision	Screen: CMS-Other - Utilization over 250,000	Complete? Yes		
Most Recent RUC Meeting:	Tab 47	Specialty Developing Recommendation:	No Interest	First Identified: April 2016	2017 Est. Medicare Utilization:	2007 Work RVU: 1.73	2018 Work RVU: 1.73
	April 2016					2007 NF PE RVU: 1.35	2018 NF PE RVU: 1.35
						2007 Fac PE RVU 1.26	2018 Fac PE RVU:1.26
RUC Recommendation:	RUC recommended to survey but no specialty society interest followed.			Referred to CPT		Result: Remove from screen	
				Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	

99378	Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	Global: XXX	Issue: Home Healthcare Supervision	Screen: CMS-Other - Utilization over 250,000	Complete? Yes		
Most Recent RUC Meeting:	Tab 47	Specialty Developing Recommendation:	No Interest	First Identified: April 2016	2017 Est. Medicare Utilization:	2007 Work RVU: 1.73	2018 Work RVU: 1.73
	April 2016					2007 NF PE RVU: 1.64	2018 NF PE RVU: 1.64
						2007 Fac PE RVU 1.56	2018 Fac PE RVU:1.56
RUC Recommendation:	RUC recommended to survey but no specialty society interest followed.			Referred to CPT		Result: Remove from screen	
				Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	Global: XXX	Issue: Advance Care Planning	Screen: RUC Referral to CPT Assistant	Complete? No
Most Recent RUC Meeting: October 2017	Tab 19	Specialty Developing Recommendation: AAFP, AAN, ACP, ACCP, AGS, ATS	First Identified: January 2014	2017 Est. Medicare Utilization: 1,079,946	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: 2018 Work RVU: 1.50 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: Review in 2 years			Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Dec 2014	
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)	Global: ZZZ	Issue: Advance Care Planning	Screen: RUC Referral to CPT Assistant	Complete? No
Most Recent RUC Meeting: October 2017	Tab 19	Specialty Developing Recommendation: AAFP, AAN, ACP, ACCP, AGS, ATS	First Identified: January 2014	2017 Est. Medicare Utilization: 31,525	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: 2018 Work RVU: 1.40 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: Review in 2 years			Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Dec 2014	
994X7	Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored	Global: XXX	Issue: Chronic Care Management Services	Screen: New and Revised Service (Not part of RAW)	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 09	Specialty Developing Recommendation: AAFP, AAN, ACP, AGS	First Identified: NA	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Not part of RAW 2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: 1.45. Refer to CPT Assistant			Referred to CPT Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Oct 2018	

Status Report: CMS Requests and Relativity Assessment Issues

G0101 Cervical or vaginal cancer screening; pelvic and clinical breast examination **Global:** XXX **Issue:** **Screen:** Low Value-High Volume / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab** 35 **Specialty Developing Recommendation:** ACOG **First Identified:** October 2010 **2017 Est. Medicare Utilization:** 983,754 **2007 Work RVU:** 0.45 **2018 Work RVU:** 0.45 **2007 NF PE RVU:** 0.51 **2018 NF PE RVU:** 0.51 **2007 Fac PE RVU:** NA **2018 Fac PE RVU:** NA **Result:** Remove from Screen

RUC Recommendation: Remove from screen **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

G0102 Prostate cancer screening; digital rectal examination **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab** 30 **Specialty Developing Recommendation:** **First Identified:** October 2016 **2017 Est. Medicare Utilization:** 41,636 **2007 Work RVU:** 0.17 **2018 Work RVU:** 0.17 **2007 NF PE RVU:** 0.37 **2018 NF PE RVU:** 0.37 **2007 Fac PE RVU:** 0.06 **2018 Fac PE RVU:** 0.06 **Result:** Remove from screen

RUC Recommendation: Remove from screen **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

G0104 Colorectal cancer screening; flexible sigmoidoscopy **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 09 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** January 2014 **2017 Est. Medicare Utilization:** 2,704 **2007 Work RVU:** 0.96 **2018 Work RVU:** 0.84 **2007 NF PE RVU:** 2.33 **2018 NF PE RVU:** 2.33 **2007 Fac PE RVU:** 0.53 **2018 Fac PE RVU:** 0.53 **Result:** Decrease

RUC Recommendation: 0.84 **Referred to CPT** October 2013 **Referred to CPT Asst** ☐ **Published in CPT Asst:**

G0105 Colorectal cancer screening; colonoscopy on individual at high risk **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2017 Est. Medicare Utilization:** 252,992 **2007 Work RVU:** 3.69 **2018 Work RVU:** 3.26 **2007 NF PE RVU:** 6.2 **2018 NF PE RVU:** 6.2 **2007 Fac PE RVU:** 1.57 **2018 Fac PE RVU:** 1.57 **Result:** Decrease

RUC Recommendation: 3.36 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	Global: XXX	Issue: Diabetes Management Training	Screen: CMS-Other - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 41iv Specialty Developing Recommendation: AND	First Identified: April 2016	2017 Est. Medicare Utilization: 154,648	2007 Work RVU: 0.00 2007 NF PE RVU: 0.77 2007 Fac PE RVU: NA Result: Maintain	2018 Work RVU: 0.90 2018 NF PE RVU: 0.77 2018 Fac PE RVU: NA
RUC Recommendation: 0.90		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes	Global: XXX	Issue: Diabetes Management Training	Screen: CMS-Other - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 41iv Specialty Developing Recommendation: AND	First Identified: April 2016	2017 Est. Medicare Utilization: 114,496	2007 Work RVU: 0.00 2007 NF PE RVU: 0.44 2007 Fac PE RVU: NA Result: Maintain	2018 Work RVU: 0.25 2018 NF PE RVU: 0.44 2018 Fac PE RVU: NA
RUC Recommendation: 0.25		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	Global: 000	Issue: Colonoscopy	Screen: MPC List	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 10 Specialty Developing Recommendation: AGA, ASGE, ACG, ASCRS, ACS, SAGES	First Identified: September 2011	2017 Est. Medicare Utilization: 252,278	2007 Work RVU: 3.69 2007 NF PE RVU: 6.2 2007 Fac PE RVU: 1.57 Result: Decrease	2018 Work RVU: 3.26 2018 NF PE RVU: 6.2 2018 Fac PE RVU: 1.57
RUC Recommendation: 3.36		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician	Global: XXX	Issue: Cytopathology Cervical/Vaginal	Screen: CMS-Other - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 26 Specialty Developing Recommendation: CAP	First Identified: October 2017	2017 Est. Medicare Utilization: 52,721	2007 Work RVU: 0.42 2007 NF PE RVU: 0.21 2007 Fac PE RVU: 0.21 Result: Maintain	2018 Work RVU: 0.42 2018 NF PE RVU: 0.21 2018 Fac PE RVU: 0.21
RUC Recommendation: 0.42		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
G0127	Trimming of dystrophic nails, any number	Global: 000	Issue:	Screen: CMS-Other - Utilization over 500,000	Complete? Yes
Most Recent RUC Meeting: September 2011	Tab 51 Specialty Developing Recommendation: APMA	First Identified: April 2011	2017 Est. Medicare Utilization: 975,294	2007 Work RVU: 0.17 2007 NF PE RVU: 0.28 2007 Fac PE RVU: 0.07 Result: Remove from Screen	2018 Work RVU: 0.17 2018 NF PE RVU: 0.28 2018 Fac PE RVU: 0.07
RUC Recommendation: Remove from screen		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	Global: XXX	Issue: Cytopathology Cervical/Vaginal	Screen: CMS-Other - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 26 Specialty Developing Recommendation: CAP	First Identified: April 2018	2017 Est. Medicare Utilization: 4,624	2007 Work RVU: 0.42 2007 NF PE RVU: 0.21 2007 Fac PE RVU: 0.21 Result: Maintain	2018 Work RVU: 0.42 2018 NF PE RVU: 0.21 2018 Fac PE RVU: 0.21
RUC Recommendation: 0.42		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

G0166	External counterpulsation, per treatment session	Global: XXX	Issue: External Counterpulsation	Screen: CMS-Other - Utilization over 100,000	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 33 Specialty Developing Recommendation: ACC	First Identified: April 2016	2017 Est. Medicare Utilization: 137,575	2007 Work RVU: 0.07 2007 NF PE RVU: 3.81 2007 Fac PE RVU: NA Result: Decrease	2018 Work RVU: 0.07 2018 NF PE RVU: 3.81 2018 Fac PE RVU: NA
RUC Recommendation: 0.00 (PE Only)		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
G0168	Wound closure utilizing tissue adhesive(s) only	Global: 000	Issue: Wound Closure by Adhesive	Screen: CMS 000-Day Global Typically Reported with an E/M	Complete? Yes
Most Recent RUC Meeting: April 2017	Tab 34 Specialty Developing Recommendation: ACEP, AAFP	First Identified: July 2016	2017 Est. Medicare Utilization: 41,653	2007 Work RVU: 0.45 2007 NF PE RVU: 1.84 2007 Fac PE RVU: 0.22 Result: Maintain	2018 Work RVU: 0.45 2018 NF PE RVU: 1.84 2018 Fac PE RVU: 0.22
RUC Recommendation: 0.45		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>					
G0179	Physician re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period	Global: XXX	Issue: Physician Recertification	Screen: CMS Fastest Growing / CMS-Other - Utilization over 250,000	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 47 Specialty Developing Recommendation: No Interest	First Identified: October 2008	2017 Est. Medicare Utilization: 939,129	2007 Work RVU: 0.45 2007 NF PE RVU: 0.89 2007 Fac PE RVU: NA Result: Remove from screen	2018 Work RVU: 0.45 2018 NF PE RVU: 0.89 2018 Fac PE RVU: NA
RUC Recommendation: RUC recommended to survey but no specialty society interest followed.		Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

G0180	Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period		Global: XXX	Issue: Physician Recertification	Screen: CMS Fastest Growing / CMS-Other - Utilization over 250,000	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 47	Specialty Developing Recommendation: No Interest	First Identified: October 2008	2017 Est. Medicare Utilization: 1,221,491	2007 Work RVU: 0.67 2007 NF PE RVU: 1.09 2007 Fac PE RVU: NA Result: Remove from screen	2018 Work RVU: 0.67 2018 NF PE RVU: 1.09 2018 Fac PE RVU: NA
RUC Recommendation: RUC recommended to survey but no specialty society interest followed.			Referred to CPT			
			Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	
<hr/>						
G0181	Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period		Global: XXX	Issue: Home Healthcare Supervision	Screen: CMS Fastest Growing / CMS-Other - Utilization over 250,000	Complete? Yes
Most Recent RUC Meeting: April 2016	Tab 47	Specialty Developing Recommendation: No Interest	First Identified: October 2008	2017 Est. Medicare Utilization: 361,673	2007 Work RVU: 1.73 2007 NF PE RVU: 1.32 2007 Fac PE RVU: NA Result: Remove from screen	2018 Work RVU: 1.73 2018 NF PE RVU: 1.32 2018 Fac PE RVU: NA
RUC Recommendation: Recommend deletion after review of 99375 and 99378. No specialty society interest followed.			Referred to CPT			
			Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	

Status Report: CMS Requests and Relativity Assessment Issues

G0182 Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more

Global: XXX **Issue:** Home Healthcare Supervision **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2016 **2017 Est. Medicare Utilization:** 24,643

2007 Work RVU: 1.73 **2018 Work RVU:** 1.73
2007 NF PE RVU: 1.46 **2018 NF PE RVU:** 1.46
2007 Fac PE RVU: NA **2018 Fac PE RVU:** NA
Result: Remove from screen

RUC Recommendation: Recommend deletion after review of 99375 and 99378. No specialty society interest followed.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0202 Screening mammography, producing direct digital image, bilateral, all views **Global:** XXX **Issue:** Mammography **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 20 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2017 Est. Medicare Utilization:** 6,028,631

2007 Work RVU: 0.70 **2018 Work RVU:**
2007 NF PE RVU: 2.74 **2018 NF PE RVU:** 2.74
2007 Fac PE RVU: NA **2018 Fac PE RVU:** NA
Result: Deleted from CPT

RUC Recommendation: Assume CMS will delete

Referred to CPT October 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0204 Diagnostic mammography, producing direct digital image, bilateral, all views **Global:** XXX **Issue:** Mammography **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab** 20 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2017 Est. Medicare Utilization:** 610,503

2007 Work RVU: 0.87 **2018 Work RVU:**
2007 NF PE RVU: 2.87 **2018 NF PE RVU:** 2.87
2007 Fac PE RVU: NA **2018 Fac PE RVU:** NA
Result: Deleted from CPT

RUC Recommendation: Assume CMS will delete

Referred to CPT October 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0206 Diagnostic mammography, producing direct digital image, unilateral, all views **Global:** XXX **Issue:** Mammography **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent **Tab** 20 **Specialty Developing** ACR
RUC Meeting: January 2016 **Recommendation:**

First Identified: February 2008 **2017 Est. Medicare Utilization:** 772,666

2007 Work RVU: 0.70 **2018 Work RVU:**
2007 NF PE RVU: 2.31 **2018 NF PE RVU:** 2.31
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Deleted from CPT

RUC Recommendation: Assume CMS will delete

Referred to CPT October 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0237 Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring) **Global:** XXX **Issue:** Respiratory Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent **Tab** 38 **Specialty Developing** ACCP/ATS
RUC Meeting: February 2009 **Recommendation:**

First Identified: February 2008 **2017 Est. Medicare Utilization:** 88,069

2007 Work RVU: 0.00 **2018 Work RVU:** 0.00
2007 NF PE RVU: 0.41 **2018 NF PE RVU:** 0.41
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Remove from Screen

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0238 Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring) **Global:** XXX **Issue:** Respiratory Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent **Tab** 38 **Specialty Developing** ACCP/ATS
RUC Meeting: February 2009 **Recommendation:**

First Identified: February 2008 **2017 Est. Medicare Utilization:** 84,339

2007 Work RVU: 0.00 **2018 Work RVU:** 0.00
2007 NF PE RVU: 0.43 **2018 NF PE RVU:** 0.43
2007 Fac PE RVU NA **2018 Fac PE RVU:**NA
Result: Remove from Screen

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0248 Demonstration, prior to initiation of home INR monitoring, for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient's ability to perform testing and report results

Global: XXX **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 19 Specialty Developing Recommendation: ACC

First Identified: January 2016

2017 Est. Medicare Utilization: 31,567

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: 5.8

2018 NF PE RVU: 5.8

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Created Category I code, recommend CMS delete G code

Referred to CPT September 2016

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0249 Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes: provision of materials for use in the home and reporting of test results to physician; testing not occurring more frequently than once a week; testing materials, billing units of service include 4 tests

Global: XXX **Issue:** Home INR Monitoring

Screen: CMS Fastest Growing / High Volume Growth3

Complete? Yes

Most Recent RUC Meeting: January 2017

Tab 19 Specialty Developing Recommendation: ACC

First Identified: February 2008

2017 Est. Medicare Utilization: 1,355,417

2007 Work RVU: 0.00

2018 Work RVU: 0.00

2007 NF PE RVU: 3.57

2018 NF PE RVU: 3.57

2007 Fac PE RVU NA

2018 Fac PE RVU:NA

RUC Recommendation: Created Category I code, recommend CMS delete G code

Referred to CPT September 2016

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0250 Physician review, interpretation, and patient management of home INR testing for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; testing not occurring more frequently than once a week; billing units of service include 4 tests **Global:** XXX **Issue:** Home INR Monitoring **Screen:** CMS Fastest Growing / High Volume Growth3 **Complete?** Yes

Most Recent **Tab** 19 **Specialty Developing** ACC **First** **2017 Est.** **2007 Work RVU:** 0.18 **2018 Work RVU:** 0.18
RUC Meeting: January 2017 **Recommendation:** **Identified:** February 2008 **Medicare** **2007 NF PE RVU:** 0.07 **2018 NF PE RVU:** 0.07
Utilization: 224,045 **2007 Fac PE RVU** NA **2018 Fac PE RVU:** NA
RUC Recommendation: Created Category I code, recommend CMS delete G code **Referred to CPT** September 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0268 Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing **Global:** 000 **Issue:** Removal of Impacted Cerumen **Screen:** CMS Fastest Growing / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent **Tab** 35 **Specialty Developing** AAO-HNS **First** **2017 Est.** **2007 Work RVU:** 0.61 **2018 Work RVU:** 0.61
RUC Meeting: April 2017 **Recommendation:** **Identified:** October 2008 **Medicare** **2007 NF PE RVU:** 0.63 **2018 NF PE RVU:** 0.63
Utilization: 157,027 **2007 Fac PE RVU** 0.23 **2018 Fac PE RVU:** 0.23
RUC Recommendation: 0.61 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0270 Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes **Global:** XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Fastest Growing **Complete?** No

Most Recent **Tab** S **Specialty Developing** ADA **First** **2017 Est.** **2007 Work RVU:** 0.37 **2018 Work RVU:** 0.45
RUC Meeting: February 2008 **Recommendation:** **Identified:** February 2008 **Medicare** **2007 NF PE RVU:** 0.38 **2018 NF PE RVU:** 0.38
Utilization: 56,518 **2007 Fac PE RVU** 0.38 **2018 Fac PE RVU:** 0.38
RUC Recommendation: Review action plan **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0279 Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to g0204 or g0206) **Global:** ZZZ **Issue:** RAW **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2018

Tab 31 **Specialty Developing Recommendation:**

First Identified: October 2017

2017 Est. Medicare Utilization: 481,612

2007 Work RVU: **2018 Work RVU:** 0.60

2007 NF PE RVU: **2018 NF PE RVU:**

2007 Fac PE RVU **2018 Fac PE RVU:**

Result: Remove from Screen

RUC Recommendation: Recommend CMS delete

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0283 Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care **Global:** XXX **Issue:** Physical Medicine and Rehabilitation Services - Electrical Stimulation Other than Wound **Screen:** Low Value-High Volume / CMS-Other - Utilization over 250,000 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017

Tab 29 **Specialty Developing Recommendation:** APTA

First Identified: October 2010

2017 Est. Medicare Utilization: 7,492,634

2007 Work RVU: 0.18 **2018 Work RVU:** 0.18

2007 NF PE RVU: 0.12 **2018 NF PE RVU:** 0.12

2007 Fac PE RVU NA **2018 Fac PE RVU:**NA

Result: Maintain

RUC Recommendation: 0.18

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0297 Low dose ct scan (ldct) for lung cancer screening **Global:** XXX **Issue:** **Screen:** CMS-Other - Utilization over 30,000 **Complete?** No

Most Recent RUC Meeting: October 2018

Tab 27 **Specialty Developing Recommendation:**

First Identified: October 2018

2017 Est. Medicare Utilization: 131,971

2007 Work RVU: 0.00 **2018 Work RVU:** 1.02

2007 NF PE RVU: 0 **2018 NF PE RVU:** 0

2007 Fac PE RVU 0 **2018 Fac PE RVU:**0

Result:

RUC Recommendation: Review action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0364	Bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service			Global: ZZZ	Issue: RAW	Screen: CMS-Other - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: January 2018	Tab 31	Specialty Developing Recommendation:		First Identified: October 2017	2017 Est. Medicare Utilization: 90,253	2007 Work RVU: 0.16 2007 NF PE RVU: 0.15 2007 Fac PE RVU: 0.06 Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 0.15 2018 Fac PE RVU: 0.06
RUC Recommendation: Deleted				Referred to CPT	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
<hr/>							
G0365	Vessel mapping of vessels for hemodialysis access (services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow)			Global: XXX	Issue: Duplex Scan Arterial Inflow-Venous Outflow Upper Extremity	Screen: CMS-Other - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: January 2018	Tab 31	Specialty Developing Recommendation:	ACR, SIR, SVS	First Identified: October 2017	2017 Est. Medicare Utilization: 39,141	2007 Work RVU: 0.25 2007 NF PE RVU: 4.28 2007 Fac PE RVU: NA Result: Deleted from CPT	2018 Work RVU: 0.25 2018 NF PE RVU: 4.28 2018 Fac PE RVU: NA
RUC Recommendation: Deleted from CPT				Referred to CPT September 2018	Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:	
<hr/>							
G0389	Ultrasound b-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening			Global: XXX	Issue: Abdominal Aorta Ultrasound Screening	Screen: Final Rule for 2015 / High Volume Growth4	Complete? Yes
Most Recent RUC Meeting: October 2015	Tab 12	Specialty Developing Recommendation:	ACC, ACP, ACR, SCAI, SVS	First Identified: July 2014	2017 Est. Medicare Utilization:	2007 Work RVU: 0.58 2007 NF PE RVU: 1.81 2007 Fac PE RVU: NA Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 1.81 2018 Fac PE RVU: NA
RUC Recommendation: CPT Assistant article published				Referred to CPT May 2015	Referred to CPT Asst <input checked="" type="checkbox"/>	Published in CPT Asst: Jan 2017	

Status Report: CMS Requests and Relativity Assessment Issues

G0396 Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes **Global:** XXX **Issue:** **Screen:** CMS-Other - Utilization over 30,000 **Complete?** No

Most Recent RUC Meeting: January 2018

Tab 31

Specialty Developing Recommendation: AAFP, ASA, ASAM

First Identified: October 2017

2017 Est. Medicare Utilization: 37,902

2007 Work RVU:

2018 Work RVU: 0.65

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result:

RUC Recommendation: Refer to CPT

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

G0399 Home sleep test (hst) with type iii portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ecg/heart rate and 1 oxygen saturation

Global: XXX

Issue:

Screen: High Volume Growth5

Complete? No

Most Recent RUC Meeting:

Tab

Specialty Developing Recommendation:

First Identified: October 2018

2017 Est. Medicare Utilization: 88,657

2007 Work RVU:

2018 Work RVU: 0.00

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result:

RUC Recommendation: Review action plan

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

G0402 Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment

Global: XXX

Issue: Initial Preventive Exam

Screen: CMS-Other - Utilization over 100,000

Complete? Yes

Most Recent RUC Meeting: October 2016

Tab 35

Specialty Developing Recommendation: No Specialty Society Interest

First Identified: April 2016

2017 Est. Medicare Utilization: 468,951

2007 Work RVU:

2018 Work RVU: 2.43

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Referred to CPT Asst ☐

Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

G0403 Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report **Global:** XXX **Issue:** EKG for Initial Preventive Exam **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016

Tab 35

Specialty Developing Recommendation: No Specialty Society Interest

First Identified: April 2016

2017 Est. Medicare Utilization: 129,796

2007 Work RVU:

2018 Work RVU: 0.17

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0416 Surgical pathology, gross and microscopic examinations, for prostate needle biopsy, any method **Global:** XXX **Issue:** Prostate Biopsy - Pathology **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015

Tab 16

Specialty Developing Recommendation: ASC, CAP

First Identified: July 2014

2017 Est. Medicare Utilization: 125,040

2007 Work RVU:

2018 Work RVU: 3.60

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Increase

RUC Recommendation: 4.00

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0436 Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes **Global:** XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016

Tab 35

Specialty Developing Recommendation:

First Identified: April 2016

2017 Est. Medicare Utilization:

2007 Work RVU:

2018 Work RVU:

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Deleted from CPT

RUC Recommendation: Deleted

Referred to CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit				Global: XXX	Issue: RAW	Screen: CMS-Other - Utilization over 250,000	Complete? Yes			
Most Recent RUC Meeting:	April 2016	Tab 47	Specialty Developing Recommendation:	No Interest	First Identified:	April 2013	2017 Est. Medicare Utilization:	1,207,169	2007 Work RVU:	2018 Work RVU:	2.43
RUC Recommendation:				RUC recommended to survey but no specialty society interest followed.		Referred to CPT			2007 NF PE RVU:	2018 NF PE RVU:	
						Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU	2018 Fac PE RVU:	
								Result: Remove from screen			
<hr/>											
G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit				Global: XXX	Issue: RAW	Screen: CMS-Other - Utilization over 250,000	Complete? Yes			
Most Recent RUC Meeting:	April 2016	Tab 47	Specialty Developing Recommendation:	No Interest	First Identified:	April 2013	2017 Est. Medicare Utilization:	6,614,650	2007 Work RVU:	2018 Work RVU:	1.50
RUC Recommendation:				RUC recommended to survey but no specialty society interest followed.		Referred to CPT			2007 NF PE RVU:	2018 NF PE RVU:	
						Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU	2018 Fac PE RVU:	
								Result: Remove from screen			
<hr/>											
G0442	Annual alcohol misuse screening, 15 minutes				Global: XXX	Issue: Annual Alcohol Screening	Screen: CMS-Other - Utilization over 100,000	Complete? Yes			
Most Recent RUC Meeting:	October 2016	Tab 35	Specialty Developing Recommendation:	No Specialty Society Interest	First Identified:	April 2016	2017 Est. Medicare Utilization:	589,986	2007 Work RVU:	2018 Work RVU:	0.18
RUC Recommendation:				RUC recommended to survey but no specialty society interest followed.		Referred to CPT			2007 NF PE RVU:	2018 NF PE RVU:	
						Referred to CPT Asst	<input type="checkbox"/>	Published in CPT Asst:	2007 Fac PE RVU	2018 Fac PE RVU:	
								Result: Maintain			
<hr/>											

Status Report: CMS Requests and Relativity Assessment Issues

G0444 Annual depression screening, 15 minutes

Global: XXX

Issue: Annual Depression Screening

Screen: CMS-Other - Utilization over 100,000

Complete? Yes

Most Recent
RUC Meeting: October 2016

Tab 35

Specialty Developing
Recommendation: No Specialty
Society
Interest

First
Identified: April 2016

2017 Est.
Medicare
Utilization: 1,408,918

2007 Work RVU:

2018 Work RVU: 0.18

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Referred to CPT Asst ☐ Published in CPT Asst:

G0446 Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes

Global: XXX

Issue: Intensive Behavioral Therapy for Cardiovascular Disease

Screen: CMS-Other - Utilization over 30,000

Complete? Yes

Most Recent
RUC Meeting: January 2018

Tab

Specialty Developing
Recommendation: No Specialty
Society
Interest

First
Identified: October 2017

2017 Est.
Medicare
Utilization: 188,161

2007 Work RVU:

2018 Work RVU: 0.45

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: Survey, but no specialty interest, so no recommendation.

Referred to CPT

Referred to CPT Asst ☐ Published in CPT Asst:

G0447 Face-to-face behavioral counseling for obesity, 15 minutes

Global: XXX

Issue: Behavioral Counseling for Obesity

Screen: CMS-Other - Utilization over 100,000

Complete? Yes

Most Recent
RUC Meeting: October 2016

Tab 35

Specialty Developing
Recommendation: No Specialty
Society
Interest

First
Identified: April 2016

2017 Est.
Medicare
Utilization: 279,863

2007 Work RVU:

2018 Work RVU: 0.45

2007 NF PE RVU:

2018 NF PE RVU:

2007 Fac PE RVU

2018 Fac PE RVU:

Result: Maintain

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Referred to CPT Asst ☐ Published in CPT Asst:

Status Report: CMS Requests and Relativity Assessment Issues

G0452	Molecular pathology procedure; physician interpretation and report	Global:	Issue:	Screen: CMS-Other - Utilization over 30,000	Complete? No	
Most Recent RUC Meeting: October 2018	Tab 27	Specialty Developing Recommendation:	First Identified: October 2018	2017 Est. Medicare Utilization: 89,737	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result:	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: Review action plan			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>						
G0453	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)	Global: XXX	Issue: RAW	Screen: CMS-Other - Utilization over 100,000	Complete? Yes	
Most Recent RUC Meeting: October 2016	Tab 35	Specialty Developing Recommendation:	First Identified: April 2016	2017 Est. Medicare Utilization: 364,743	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Remove from screen	2018 Work RVU: 0.60 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: Remove from screen			Referred to CPT Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
<hr/>						
G0456	Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters	Global: XXX	Issue: Negative Pressure Wound Therapy	Screen: CMS Request - Final Rule for 2013	Complete? Yes	
Most Recent RUC Meeting: January 2014	Tab 17	Specialty Developing Recommendation:	First Identified: November 2012	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: RUC recommended to survey but no specialty society interest followed. CMS deleted.			Referred to CPT May 2013 Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

G0457	Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters		Global: XXX	Issue: Negative Pressure Wound Therapy	Screen: CMS Request - Final Rule for 2013	Complete? Yes
Most Recent RUC Meeting: January 2014	Tab 17	Specialty Developing Recommendation:	First Identified: November 2012	2017 Est. Medicare Utilization:	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Deleted from CPT	2018 Work RVU: 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: RUC recommended to survey but no specialty society interest followed. CMS deleted.			Referred to CPT May 2013			
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
G6002	Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy		Global: XXX	Issue:	Screen: CMS-Other - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: January 2018	Tab 31	Specialty Developing Recommendation:	First Identified: October 2017	2017 Est. Medicare Utilization: 1,377,083	2007 Work RVU: 2007 NF PE RVU: 2007 Fac PE RVU Result: Remove from screen	2018 Work RVU: 0.39 2018 NF PE RVU: 2018 Fac PE RVU:
RUC Recommendation: Remove from screen			Referred to CPT			
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		
P3001	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician		Global: XXX	Issue: Cytopathology Cervical/Vaginal	Screen: CMS-Other - Utilization over 30,000	Complete? Yes
Most Recent RUC Meeting: April 2018	Tab 26	Specialty Developing Recommendation: CAP	First Identified: April 2018	2017 Est. Medicare Utilization: 1,735	2007 Work RVU: 0.42 2007 NF PE RVU: 0.21 2007 Fac PE RVU 0.21 Result: Maintain	2018 Work RVU: 0.42 2018 NF PE RVU: 0.21 2018 Fac PE RVU: 0.21
RUC Recommendation: 0.42			Referred to CPT			
			Referred to CPT Asst <input type="checkbox"/>	Published in CPT Asst:		

Status Report: CMS Requests and Relativity Assessment Issues

Q0091 Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory		Global: XXX	Issue:	Screen: CMS-Other - Utilization over 30,000	Complete? No
Most Recent RUC Meeting: October 2018	Tab 27	Specialty Developing Recommendation:	First Identified: October 2018	2017 Est. Medicare Utilization: 606,043	2007 Work RVU: 0.37 2018 Work RVU: 0.37 2007 NF PE RVU: 0.69 2018 NF PE RVU: 0.69 2007 Fac PE RVU: 0.13 2018 Fac PE RVU: 0.13
RUC Recommendation: Review action plan		Referred to CPT Referred to CPT Asst <input type="checkbox"/>		Published in CPT Asst:	Result:

RUC Referrals to CPT Editorial Panel - Outstanding Issues

32405	Biopsy, lung or mediastinum, percutaneous needle	Screen	RUC Meeting	Specialty Society:	CPT Meeting
		Codes Reported Together 75%or More-Part4	January 2018	ACR, SIR	February 2019

Background: In October 2017, maintaining the consistency with previous iterations, AMA staff used the 2016 estimated Medicare 5% sample claims data to determine when a code pair is reported on the same day, same patient and same NPI number at or more than 75% of the time. Only groups that totaled allowed charges of \$5 million or more were included. As with previous iterations, any code pairs in which one of the codes was either below 1,000 in Medicare claims data and/or contained at least one ZZZ global service were removed. Based on these criteria 32405/77012 were identified. In January 2018, the RUC recommended to refer to CPT to bundle with 32405 with 77012 for CPT 2020.

64415	Injection, anesthetic agent; brachial plexus, single	Screen	RUC Meeting	Specialty Society:	CPT Meeting
		CMS Fastest Growing	October 2018	AAPM, ASA	May 2019

Background: During the October 2018 RUC presentation of the Somatic Nerve Injection 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.

64416	Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)	Screen	RUC Meeting	Specialty Society:	CPT Meeting
		Site of Service Anomaly / High Volume Growth2	October 2018	ASA	May 2019

Background: During the October 2018 RUC presentation of the Somatic Nerve Injection 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.

64417	Injection, anesthetic agent; axillary nerve	Screen	RUC Meeting	Specialty Society:	CPT Meeting
		part of New/Revised Review	October 2018		May 2019

Background: During the October 2018 RUC presentation of the Somatic Nerve Injection 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.

RUC Referrals to CPT Editorial Panel - Outstanding Issues

64446	Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement)	<u>Screen</u> Site of Service Anomaly / High Volume Growth1	<u>RUC Meeting</u> October 2018	<u>Specialty Society:</u> ASA	<u>CPT Meeting</u> May 2019
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Background: During the October 2018 RUC presentation of the Somatic Nerve Injection 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.

64447	Injection, anesthetic agent; femoral nerve, single	<u>Screen</u> CMS Fastest Growing	<u>RUC Meeting</u> October 2018	<u>Specialty Society:</u> AAPM, ASA	<u>CPT Meeting</u> May 2019
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Background: During the October 2018 RUC presentation of the Somatic Nerve Injection 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.

64448	Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)	<u>Screen</u> Site of Service Anomaly / High Volume Growth1 / CMS Fastest Growing / High Volume Growth2	<u>RUC Meeting</u> October 2018	<u>Specialty Society:</u> ASA	<u>CPT Meeting</u> May 2019
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Background: During the October 2018 RUC presentation of the Somatic Nerve Injection 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.

74425	Urography, antegrade (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation	<u>Screen</u> Codes Reported Together 75% or More-Part2	<u>RUC Meeting</u> October 2018	<u>Specialty Society:</u> ACR, AUA, SIR	<u>CPT Meeting</u> May 2019
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Background: CPT code 74425 was bundled with 50398 at the October 2014 CPT/January 2015 meetings for CPT 2016. . While this code is not being deleted, it was unclear what the typical vignette will 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 recommends a delay to the survey of CPT code 74425 until at least two years of Medicare claims data is available (October 2018). In October 2018, the RUC referred CPT code 74425 to CPT for editorial changes to the descriptor and vignette to clarify between pyelostogram, nephrostogram, and loopogram.

RUC Referrals to CPT Editorial Panel - Outstanding Issues

76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	<u>Screen</u> CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 / High Volume Growth3	<u>RUC Meeting</u> April 2014	<u>Specialty Society:</u> AAACE, AAOS, AAPMR, ACR, ACRrh, APMA, ASA, ASBS, ASIPP, AUA, SIR, TES	<u>CPT Meeting</u> May 2019
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Background: During the October 2018 RUC presentation of the Somatic Nerve Injection 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.

77012	Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation	<u>Screen</u> CMS-Other - Utilization over 100,000 / Codes Reported Together 75%or More- Part4	<u>RUC Meeting</u> January 2018	<u>Specialty Society:</u> ACR, SIR	<u>CPT Meeting</u> February 2019
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Background: In October 2017, maintaining the consistency with previous iterations, AMA staff used the 2016 estimated Medicare 5% sample claims data to determine when a code pair is reported on the same day, same patient and same NPI number at or more than 75% of the time. Only groups that totaled allowed charges of \$5 million or more were included. As with previous iterations, any code pairs in which one of the codes was either below 1,000 in Medicare claims data and/or contained at least one ZZZ global service were removed. Based on these criteria 32405/77012 were identified. In January 2018, the RUC recommended to refer to CPT to bundle with 32405 with 77012 for CPT 2020.

77014	Computed tomography guidance for placement of radiation therapy fields	<u>Screen</u> CMS Request - Practice Expense Review / CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 / High Volume Growth3	<u>RUC Meeting</u> January 2016	<u>Specialty Society:</u> ASTRO, ACR	<u>CPT Meeting</u>
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Background: Revise based on CMS input regarding the radiation oncology services. CMS maintains G codes at this time. Specialty society will revise once CMS makes final determinations on the radiation oncology CPT codes. TBD.

92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive	<u>Screen</u> CMS-Other - Utilization over 30,000	<u>RUC Meeting</u> January 2018	<u>Specialty Society:</u> AAA, AANEM, ACNS, ASHA	<u>CPT Meeting</u> February 2019
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Background: In October 2017, the RAW requested that AMA staff compile a list of CMS/Other codes with Medicare utilization of 30,000 or more. This list resulted in 34 services and the RAW requested action plans to be reviewed at the January 2018 meeting. In January 2018, the RUC recommended to refer to Feb 2019 CPT meeting to clarify the code descriptors to better define limited/comprehensive and develop a new related procedure, Vestibular Evoked Myogenic Potentials (VEMP), has recently been approved by the FDA. A VEMP specific code should be developed and will replace some use of CPT code 92585.

RUC Referrals to CPT Editorial Panel - Outstanding Issues

93299	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Screen CMS High Expenditure Procedural Codes2 / Contractor Priced High Volume	RUC Meeting October 2018	Specialty Society: ACC, HRS	CPT Meeting May 2019
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Background: In October 2018, the RUC recommended new practice expense inputs for practice expense only code. The specialty society indicated that they intend 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.

G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes	Screen CMS-Other - Utilization over 30,000	RUC Meeting January 2018	Specialty Society: AAFP, ASA, ASAM	CPT Meeting
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Background: In October 2017, the RAW requested that AMA staff compile a list of CMS/Other codes with Medicare utilization of 30,000 or more. This list resulted in 34 services and the RAW requested action plans to be reviewed at the January 2018 meeting. In January 2018, the RUC recommended to maintain the physician work and refer to CPT to editorially remove "screening" from 99408 and 99409 to "assessment" to mirror G0396. At the February 2018 CPT meeting, the Panel postponed until time uncertain this request to revise codes 99408-99409 to identify assessment of alcohol and/or substance abuse. As a rationale for postponement, the Panel said that the service described in this application did not meet the General Criteria for Category I because the proposed service is not unique or well defined, and does not describe a service that is clearly identified and distinguished from existing services already described in CPT by other codes. The Panel's additional rationale for postponement of this item was to allow the relevant specialty societies an opportunity to submit a new code change application to address the differences between assessment and screening services.

RUC Recommendations to Develop CPT Assistant Articles - Outstanding Issues

958X3	<u>Screen:</u> High Volume Growth2 / CMS Request - Final Rule for 2016	<u>RUC Meeting:</u> October 2017	<u>RUC Rec:</u> 0.95 and Refer to CPT Assistant	<u>Specialty Society:</u> AAN, AANS/CNS, ACNS	<u>CPT Asst Status:</u> Specialty societies are drafting the article for the February 2019 publication.
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Background: In June 2017, the CPT Editorial Panel revised codes 95970, 95971, and 95972, deleted codes 95974, 95975, 95978, and 95979 and created four new codes for analysis and programming of implanted cranial nerve neurostimulator pulse generator, analysis, and programming of brain neurostimulator pulse generator systems and analysis of stored neurophysiology recording data. Introductory guidelines were also revised extensively. In October 2017, the RUC noted code 95X83 is defined as simple programming of cranial nerve neurostimulator (adjustment of 1-3 parameters) versus deleted code 95974 which was time based and defined as the first hour of programming and 95X84 is defined as complex programming of cranial nerve neurostimulator (adjustment of more than 3 parameters) versus deleted code 95975, which was a time-based add-on code defined as each additional 30 minutes of programming. The RUC recommends that the specialty societies develop a CPT Assistant article to direct providers on when to report simple versus complex cranial nerve neurostimulator services. The specialty societies indicated they will submit an article to be published in the January or February 2018 CPT Assistant.

958X4	<u>Screen:</u> High Volume Growth2 / CMS Request - Final Rule for 2016	<u>RUC Meeting:</u> October 2017	<u>RUC Rec:</u> 1.19 and Refer to CPT Assistant	<u>Specialty Society:</u> AAN, AANS/CNS, ACNS	<u>CPT Asst Status:</u> Specialty societies are drafting the article for the February 2019 publication.
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Background: In June 2017, the CPT Editorial Panel revised codes 95970, 95971, and 95972, deleted codes 95974, 95975, 95978, and 95979 and created four new codes for analysis and programming of implanted cranial nerve neurostimulator pulse generator, analysis, and programming of brain neurostimulator pulse generator systems and analysis of stored neurophysiology recording data. Introductory guidelines were also revised extensively. In October 2017, the RUC noted code 95X83 is defined as simple programming of cranial nerve neurostimulator (adjustment of 1-3 parameters) versus deleted code 95974 which was time based and defined as the first hour of programming and 95X84 is defined as complex programming of cranial nerve neurostimulator (adjustment of more than 3 parameters) versus deleted code 95975, which was a time-based add-on code defined as each additional 30 minutes of programming. The RUC recommends that the specialty societies develop a CPT Assistant article to direct providers on when to report simple versus complex cranial nerve neurostimulator services. The specialty societies indicated they will submit an article to be published in the January or February 2018 CPT Assistant.

958X5	<u>Screen:</u> High Volume Growth2 / CMS Request - Final Rule for 2016	<u>RUC Meeting:</u> October 2017	<u>RUC Rec:</u> 1.25 and Refer to CPT Assistant	<u>Specialty Society:</u> AAN, AANS/CNS, ACNS	<u>CPT Asst Status:</u> Specialty societies are drafting the article for the February 2019 publication.
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Background: In June 2017, the CPT Editorial Panel revised codes 95970, 95971, and 95972, deleted codes 95974, 95975, 95978, and 95979 and created four new codes for analysis and programming of implanted cranial nerve neurostimulator pulse generator, analysis, and programming of brain neurostimulator pulse generator systems and analysis of stored neurophysiology recording data. Introductory guidelines were also revised extensively. In October 2017, the RUC noted code 95X83 is defined as simple programming of cranial nerve neurostimulator (adjustment of 1-3 parameters) versus deleted code 95974 which was time based and defined as the first hour of programming and 95X84 is defined as complex programming of cranial nerve neurostimulator (adjustment of more than 3 parameters) versus deleted code 95975, which was a time-based add-on code defined as each additional 30 minutes of programming. The RUC recommends that the specialty societies develop a CPT Assistant article to direct providers on when to report simple versus complex cranial nerve neurostimulator services. The specialty societies indicated they will submit an article to be published in the January or February 2018 CPT Assistant.

RUC Recommendations to Develop CPT Assistant Articles - Outstanding Issues

958X6	<u>Screen:</u> High Volume Growth2 / CMS Request - Final Rule for 2016	<u>RUC Meeting:</u> October 2017	<u>RUC Rec:</u> 1.00 and Refer to CPT Assistant	<u>Specialty Society:</u> AAN, AANS/CNS, ACNS	<u>CPT Asst Status:</u> Specialty societies are drafting the article for the February 2019 publication.
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Background: In June 2017, the CPT Editorial Panel revised codes 95970, 95971, and 95972, deleted codes 95974, 95975, 95978, and 95979 and created four new codes for analysis and programming of implanted cranial nerve neurostimulator pulse generator, analysis, and programming of brain neurostimulator pulse generator systems and analysis of stored neurophysiology recording data. Introductory guidelines were also revised extensively. In October 2017, the RUC noted code 95X83 is defined as simple programming of cranial nerve neurostimulator (adjustment of 1-3 parameters) versus deleted code 95974 which was time based and defined as the first hour of programming and 95X84 is defined as complex programming of cranial nerve neurostimulator (adjustment of more than 3 parameters) versus deleted code 95975, which was a time-based add-on code defined as each additional 30 minutes of programming. The RUC recommends that the specialty societies develop a CPT Assistant article to direct providers on when to report simple versus complex cranial nerve neurostimulator services. The specialty societies indicated they will submit an article to be published in the January or February 2018 CPT Assistant.

New Technology/New Services List

<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
10X18		Jan 2018	Fine Needle Aspiration	04	CPT 2019	October 2022		<input type="checkbox"/>
10X19		Jan 2018	Fine Needle Aspiration	04	CPT 2019	October 2022		<input type="checkbox"/>
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)	Apr 2009	Adjacent Tissue Transfer	4	CPT 2010	October 2015	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (List separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
15X00		Oct 2018	Tissue Grafting Procedures	04	CPT 2020	CPT 2023		<input type="checkbox"/>
15X01		Oct 2018	Tissue Grafting Procedures	04	CPT 2020	CPT 2023		<input type="checkbox"/>

<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
15X02		Oct 2018	Tissue Grafting Procedures	04	CPT 2020	CPT 2023		<input type="checkbox"/>
15X03		Oct 2018	Tissue Grafting Procedures	04	CPT 2020	CPT 2023		<input type="checkbox"/>
15X04		Oct 2018	Tissue Grafting Procedures	04	CPT 2020	CPT 2023		<input type="checkbox"/>
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	Apr 2006	Fibroadenoma Cryoablation	11	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
19294	Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with partial mastectomy (List separately in addition to code for primary procedure)	Oct 2016	Intraoperative Radiation Therapy Applicator Procedures	07	CPT 2018	October 2021		<input type="checkbox"/>
20696	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s)	Apr 2008	Computer Dependent External Fixation	6	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>

<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
20697	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement) of strut, each	Apr 2008	Computer Dependent External Fixation	6	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
206X0		Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	CPT 2023		<input type="checkbox"/>
206X1		Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	CPT 2023		<input type="checkbox"/>
206X2		Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	CPT 2023		<input type="checkbox"/>
206X3		Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	CPT 2023		<input type="checkbox"/>
206X4		Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	CPT 2023		<input type="checkbox"/>
206X5		Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	CPT 2023		<input type="checkbox"/>
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation	Apr 2014	Cryoablation Treatment of the Bone Tumors	04	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)	Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Resurvey for January 2012	<input checked="" type="checkbox"/>
20986	Code Deleted CPT 2009	Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Code Deleted CPT 2009	<input checked="" type="checkbox"/>
20987	Code Deleted CPT 2009	Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Code Deleted CPT 2009	<input checked="" type="checkbox"/>

<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>CPT Tab</i>	<i>Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
21011	Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
21012	Excision, tumor, soft tissue of face or scalp, subcutaneous; 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
21013	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>

<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
21014	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
21015	Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
21016	Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
21552	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
21554	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
21555	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
21556	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
21557	Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
21558	Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
21811	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs	Apr 2014	Internal Fixation of Rib Fracture	05	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
21812	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 4-6 ribs	Apr 2014	Internal Fixation of Rib Fracture	05	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
21813	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs	Apr 2014	Internal Fixation of Rib Fracture	05	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
21930	Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
21931	Excision, tumor, soft tissue of back or flank, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
21932	Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
21933	Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
21935	Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
21936	Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	Apr 2006	Percutaneous Intradiscal Annuloplast	13	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)	Apr 2006	Percutaneous Intradiscal Annuloplast	13	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>

<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophylectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)	Apr 2014	Total Disc Arthroplasty Additional Cervical Level Add-On Code	07	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	October 2020		<input type="checkbox"/>

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22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (List separately in addition to code for primary procedure)	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	October 2020		<input type="checkbox"/>
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	October 2020		<input type="checkbox"/>
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	October 2020		<input type="checkbox"/>
22900	Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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22901	Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
22902	Excision, tumor, soft tissue of abdominal wall, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
22903	Excision, tumor, soft tissue of abdominal wall, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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22904	Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
22905	Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
23071	Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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23073	Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
23075	Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
23076	Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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23077	Radical resection of tumor (eg, sarcoma), soft tissue of shoulder area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
23078	Radical resection of tumor (eg, sarcoma), soft tissue of shoulder area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
23200	Radical resection of tumor; clavicle	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
23210	Radical resection of tumor; scapula	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>

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23220	Radical resection of tumor, proximal humerus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
24073	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
24075	Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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24076	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
24077	Radical resection of tumor (eg, sarcoma), soft tissue of upper arm or elbow area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
24079	Radical resection of tumor (eg, sarcoma), soft tissue of upper arm or elbow area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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24150	Radical resection of tumor, shaft or distal humerus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
24152	Radical resection of tumor, radial head or neck	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
25071	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
25073	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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25075	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
25076	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
25077	Radical resection of tumor (eg, sarcoma), soft tissue of forearm and/or wrist area; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>

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25078	Radical resection of tumor (eg, sarcoma), soft tissue of forearm and/or wrist area; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
25170	Radical resection of tumor, radius or ulna	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
26111	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>

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26113	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
26115	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
26116	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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26117	Radical resection of tumor (eg, sarcoma), soft tissue of hand or finger; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
26118	Radical resection of tumor (eg, sarcoma), soft tissue of hand or finger; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
26250	Radical resection of tumor, metacarpal	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
26260	Radical resection of tumor, proximal or middle phalanx of finger	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>

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26262	Radical resection of tumor, distal phalanx of finger	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
27043	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
27045	Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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27047	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
27048	Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
27049	Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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27059	Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
27075	Radical resection of tumor; wing of ilium, 1 pubic or ischial ramus or symphysis pubis	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
27076	Radical resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
27077	Radical resection of tumor; innominate bone, total	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
27078	Radical resection of tumor; ischial tuberosity and greater trochanter of femur	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>

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27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device	Apr 2014	Sacroiliac Joint Fusion	08	CPT 2015	October 2018	Surveyed in April 2018 for a CMS Request in the Final Rule for 2018	<input checked="" type="checkbox"/>
27280	Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed	Sep 2014	Sacroiliac Joint Fusion	06	CPT 2016	October 2019		<input type="checkbox"/>
27327	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
27328	Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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27329	Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
27337	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
27339	Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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27364	Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
27365	Radical resection of tumor, femur or knee	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
27615	Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>

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27616	Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
27618	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
27619	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>

<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>CPT Tab</i>	<i>Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
27632	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
27634	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
27645	Radical resection of tumor; tibia	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
27646	Radical resection of tumor; fibula	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>

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27647	Radical resection of tumor; talus or calcaneus	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
28039	Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>
28041	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors	CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.		<input checked="" type="checkbox"/>

<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
28043	Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
28045	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
28046	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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28047	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28171	Radical resection of tumor; tarsal (except talus or calcaneus)	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28173	Radical resection of tumor; metatarsal	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28175	Radical resection of tumor; phalanx of toe	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
29582	Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	October 2018	Specialty societies develop a CPT Assistant article to specify which bandage application should be reported based on what is being treated and review in 3 years (2018). Code Deleted for CPT 2018.	☑

<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
29583	Application of multi-layer compression system; upper arm and forearm	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	October 2018	Specialty societies develop a CPT Assistant article to specify which bandage application should be reported based on what is being treated and review in 3 years (2018). Code Deleted for CPT 2018.	<input checked="" type="checkbox"/>
29584	Application of multi-layer compression system; upper arm, forearm, hand, and fingers	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	October 2021	Specialty societies develop a CPT Assistant article to specify which bandage application should be reported based on what is being treated and review in 3 years (2018). In October 2018, RUC recommended to review again after 3 more years of data (2021).	<input type="checkbox"/>
29828	Arthroscopy, shoulder, surgical; biceps tenodesis	Apr 2007	Arthroscopic Biceps Tenodesis	17	CPT 2008	September 2011	Resurvey for January 2012	<input checked="" type="checkbox"/>
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	<input checked="" type="checkbox"/>
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	<input checked="" type="checkbox"/>

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29916	Arthroscopy, hip, surgical; with labral repair	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	October 2016	Surveying for January 2017 as part of bundling	☑
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	October 2016	Surveying for January 2017 as part of bundling	☑
31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	October 2016	Surveying for January 2017 as part of bundling	☑
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s])	Feb 2009	Navigational Bronchoscopy	9	CPT 2010	October 2016	Review practice expense January 2014. Review data again in 3 years (Sept 2016).	☑
31634	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed	Feb 2010	Bronchoscopy with Balloon Occlusion	7	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
31647	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

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31648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure)	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
31651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure[s])	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
31652	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures	Jan 2015	Endobronchial Ultrasound (EBUS)	05	CPT 2016	October 2019		<input type="checkbox"/>
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	Jan 2015	Endobronchial Ultrasound (EBUS)	05	CPT 2016	October 2019		<input type="checkbox"/>
31654	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (List separately in addition to code for primary procedure[s])	Jan 2015	Endobronchial Ultrasound (EBUS)	05	CPT 2016	October 2019		<input type="checkbox"/>

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32553	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
32701	Thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment	Jan 2012	Stereotactic Body Radiation	07	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
32994	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation	Jan 2017	Cryoablation of Pulmonary Tumors	08	CPT 2018	October 2021		<input type="checkbox"/>
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral	Apr 2006	Percutaneous RF Pulmonary Tumor Ablation	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
33254	Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
33255	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
33256	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
33257	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure) (List separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>

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33258	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass (List separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
33259	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass (List separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
33265	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
33266	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
33270	Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	<input type="checkbox"/>
33271	Insertion of subcutaneous implantable defibrillator electrode	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	<input type="checkbox"/>
33272	Removal of subcutaneous implantable defibrillator electrode	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	<input type="checkbox"/>

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33273	Repositioning of previously implanted subcutaneous implantable defibrillator electrode	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	<input type="checkbox"/>
332X0		Jan 2018	Pulmonary Wireless Pressure Sensor Services	08	CPT 2019	October 2022		<input type="checkbox"/>
332X5		Apr 2017	Cardiac Event Recorder Procedures	07	CPT 2019	October 2022		<input type="checkbox"/>
332X6		Apr 2017	Cardiac Event Recorder Procedures	07	CPT 2019	October 2022		<input type="checkbox"/>
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation	Jan 2016	Closure Left Atrial Appendage with Endocardial Implant	10	CPT 2017	October 2020		<input type="checkbox"/>
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2023	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	<input type="checkbox"/>

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33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2023	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	<input type="checkbox"/>
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2023	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	<input type="checkbox"/>
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2023	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	<input type="checkbox"/>

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33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2023	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	<input type="checkbox"/>
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2023	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	<input type="checkbox"/>
33367	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2016	The Workgroup did not believe there would be a change in physician work or practice expense for the add-on services and recommends that 33367, 33368 and 33369 be removed from the new technology list as there is no demonstrated diffusion.	<input checked="" type="checkbox"/>

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33368	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2016	The Workgroup did not believe there would be a change in physician work or practice expense for the add-on services and recommends that 33367, 33368 and 33369 be removed from the new technology list as there is no demonstrated diffusion.	<input checked="" type="checkbox"/>
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)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2016	The Workgroup did not believe there would be a change in physician work or practice expense for the add-on services and recommends that 33367, 33368 and 33369 be removed from the new technology list as there is no demonstrated diffusion.	<input checked="" type="checkbox"/>
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)	Jan 2018	Aortoventriculoplasty with Pulmonary Autograft	05	CPT 2019	October 2022	In the NPRM for 2019 CMS requested that codes 33412 and 33413 should be reviewed when the new code is reviewed for new technology.	<input type="checkbox"/>

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33413	Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (Ross procedure)	Jan 2018	Aortoventriculoplasty with Pulmonary Autograft	05	CPT 2019	October 2022	In the NPRM for 2019 CMS requested that codes 33412 and 33413 should be reviewed when the new code is reviewed for new technology.	<input type="checkbox"/>
33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	Apr 2014	Transcatheter Mitral Valve Repair	10	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	<input type="checkbox"/>
33419	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure)	Apr 2014	Transcatheter Mitral Valve Repair	10	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	<input type="checkbox"/>
33477	Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed	Jan 2015	Transcatheter Pulmonary Valve Implantation	06	CPT 2016	October 2019		<input type="checkbox"/>
335X1		Jan 2018	Aortoventriculoplasty with Pulmonary Autograft	05	CPT 2019	October 2022		<input type="checkbox"/>
33620	Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014	Develop CPT Assitant article to clarify who should report these services. The STS noted and the RUC agreed that only pediatric cardiac surgeons perform 33620 and 33622.	<input checked="" type="checkbox"/>

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33621	Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014	Develop CPT Assitant article to clarify who should report these services. The STS noted and the RUC agreed that only pediatric cardiac surgeons perform 33620 and 33622.	<input checked="" type="checkbox"/>
33622	Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014	Develop CPT Assitant article to clarify who should report these services. The STS noted and the RUC agreed that only pediatric cardiac surgeons perform 33620 and 33622.	<input checked="" type="checkbox"/>
33864	Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub Procedure)	Apr 2007	Valve Sparing Aortic Annulus Reconstruction	24	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
33927	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy	Jan 2017	Artificial Heart System Procedure	09	CPT 2018	October 2021		<input type="checkbox"/>
33928	Removal and replacement of total replacement heart system (artificial heart)	Jan 2017	Artificial Heart System Procedure	09	CPT 2018	October 2021		<input type="checkbox"/>
33929	Removal of a total replacement heart system (artificial heart) for heart transplantation (List separately in addition to code for primary procedure)	Jan 2017	Artificial Heart System Procedure	09	CPT 2018	October 2021		<input type="checkbox"/>
33946	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-venous	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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33947	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; initiation, veno-arterial	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33948	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-venous	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33949	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; daily management, each day, veno-arterial	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33951	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33952	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33953	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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33954	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33955	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33956	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33957	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33958	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33959	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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33962	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33963	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33964	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; reposition central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33965	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33966	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33969	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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33984	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33985	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33986	Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33987	Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33988	Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33989	Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
33X01		Jan 2018	Hemi-Aortic Arch Replacement	06	CPT 2019	October 2022		<input type="checkbox"/>
33X01		Oct 2018	Aortic Graft Procedures	06	CPT 2020	CPT 2023		<input type="checkbox"/>

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33X05		Jan 2018	Leadless Pacemaker Procedures	07	CPT 2019	October 2022		<input type="checkbox"/>
33X06		Jan 2018	Leadless Pacemaker Procedures	07	CPT 2019	October 2022		<input type="checkbox"/>
34806	Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration, and collection of pressure data (List separately in addition to code for primary procedure)	Apr 2007	Wireless Pressure Sensor Implantation	25	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	October 2021		<input type="checkbox"/>
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	October 2021		<input type="checkbox"/>
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	Jan 2016	Mechanochemical (MOCA) Vein Ablation	13	CPT 2017	October 2020		<input type="checkbox"/>
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Jan 2016	Mechanochemical (MOCA) Vein Ablation	13	CPT 2017	October 2020		<input type="checkbox"/>

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36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	Apr 2014	Endovenous Ablation	38	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	<input type="checkbox"/>
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Apr 2014	Endovenous Ablation	38	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	<input type="checkbox"/>
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	Apr 2014	Endovenous Ablation	38	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	<input type="checkbox"/>
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Apr 2014	Endovenous Ablation	38	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	<input type="checkbox"/>
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	October 2021		<input type="checkbox"/>

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36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	October 2021		<input type="checkbox"/>
37192	Repositioning 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	Apr 2011	IVC Transcatheter Procedure	12	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
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	Apr 2011	IVC Transcatheter Procedure	12	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
37218	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation	Apr 2014	Transcatheter Placement of Carotid Stents	12	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
38220	Diagnostic bone marrow; aspiration(s)	Apr 2016	Diagnostic Bone Marrow Aspiration and Bone Biopsy	06	CPT 2018	October 2021		<input type="checkbox"/>
38221	Diagnostic bone marrow; biopsy(ies),	Apr 2016	Diagnostic Bone Marrow Aspiration and Bone Biopsy	06	CPT 2018	October 2021		<input type="checkbox"/>
38222	Diagnostic bone marrow; biopsy(ies) and aspiration(s)	Apr 2016	Diagnostic Bone Marrow Aspiration and Bone Biopsy	06	CPT 2018	October 2021		<input type="checkbox"/>

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38900	Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)	Apr 2010	Sentinel Lymph Node Mapping	8	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	<input checked="" type="checkbox"/>
43180	Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, Zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed	Jan 2014	Endoscopic Hypopharyngeal Diverticulotomy	7	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	Apr 2015	Esophagogatric Fundoplasty Trans-Oral Approach	05	CPT 2016	October 2019		<input type="checkbox"/>
43273	Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)	Apr 2008	Cholangioscopy-Pancreatascopy	13	CPT 2009	September 2012	Specialty to survey Feb 2013 with family of services	<input checked="" type="checkbox"/>
43279	Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed	Apr 2008	Laparoscopic Heller Myotomy	12	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	Apr 2009	Laparoscopic Paraesophageal Hernia Repair	12	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	Apr 2009	Laparoscopic Paraesophageal Hernia Repair	12	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	Jan 2016	Esophageal Sphincter Augmentation	17	CPT 2017	October 2020		<input type="checkbox"/>
43285	Removal of esophageal sphincter augmentation device	Jan 2016	Esophageal Sphincter Augmentation	17	CPT 2017	October 2020		<input type="checkbox"/>
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	Apr 2009	Laparoscopic Longitudinal Gastrectomy	14	CPT 2010	September 2013	Remove from list, carrier priced.	<input checked="" type="checkbox"/>
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>

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44705	Preparation of fecal microbiota for instillation, including assessment of donor specimen	Apr 2012	Fecal Bacteriotherapy	18	CPT 2013	October 2018	The specialty societies indicated that they tried to develop a category I code to replace 44705 which is not currently covered by Medicare, but the CPT Editorial Panel did not accept the coding change proposal due to a lack in literature provided. The Workgroup recommended that these services be reviewed in 2 year after additional utilization data is available (October 2018). In October 2018, the RUC recommended to remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
46601	Anoscopy; diagnostic, with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed	Apr 2014	High Resolution Anoscopy	14	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data and to determine what specialties are performing this service (2021).	<input type="checkbox"/>

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46607	Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple	Apr 2014	High Resolution Anoscopy	14	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data and to determine what specialties are performing this service (2021).	<input type="checkbox"/>
46707	Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [SIS])	Apr 2009	Fistula Plug	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
46X48		Oct 2018	Transanal Hemorrhoidal Dearterialization	07	CPT 2020	CPT 2023		<input type="checkbox"/>
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation	Apr 2014	Cryoablation of Liver Tumor	15	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
49327	Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple (List separately in addition to code for primary procedure)	Apr 2010	Fiducial Marker Placement	10	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	<input checked="" type="checkbox"/>
49411	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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49412	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)	Apr 2010	Fiducial Marker Placement	10	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	<input checked="" type="checkbox"/>
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2009	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2009	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2009	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
50430	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019		<input type="checkbox"/>

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50431	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019		<input type="checkbox"/>
50432	Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019		<input type="checkbox"/>
50433	Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019		<input type="checkbox"/>
50434	Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019		<input type="checkbox"/>
50435	Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019		<input type="checkbox"/>
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	Apr 2007	Percutaneous Renal Tumor Cryotherapy	A	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>

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50606	Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019		<input type="checkbox"/>
50693	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; pre-existing nephrostomy tract	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019		<input type="checkbox"/>
50694	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, without separate nephrostomy catheter	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019		<input type="checkbox"/>
50695	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, with separate nephrostomy catheter	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019		<input type="checkbox"/>
50705	Ureteral embolization or occlusion, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019		<input type="checkbox"/>
50706	Balloon dilation, ureteral stricture, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019		<input type="checkbox"/>

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52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	Apr 2014	Cystourethroscopy Insertion Transprostatic Implant	16	CPT 2015	October 2018	Survey for January 2019	<input type="checkbox"/>
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	Apr 2014	Cystourethroscopy Insertion Transprostatic Implant	16	CPT 2015	October 2018	Survey for January 2019	<input type="checkbox"/>
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	Feb 2009	Temporary Prostatic Urethral Stent Insertion	12	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	Apr 2010	Transurethral Radiofrequency Bladder Neck and Urethra	12	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	<input checked="" type="checkbox"/>
538X3		Jan 2018	Transurethral Destruction of Prostate Tissue	13	CPT 2019	October 2022		<input type="checkbox"/>
55706	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance	Apr 2008	Saturation Biopsies	15	CPT 2009	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	<input checked="" type="checkbox"/>
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	Oct 2009	Laparoscopic Radical Prostatectomy	14	CPT 2011	September 2014	Survey for April 2015. Specialty society should consider surveying 55845 and 55866 at the same time.	<input checked="" type="checkbox"/>
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	Jan 2017	Peri-Prostatic Implantation of Biodegradable Material	13	CPT 2018	October 2021		<input type="checkbox"/>

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57423	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach	Apr 2007	Laparoscopic Paravaginal Defect Repair	C	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)	Oct 2008	Laparoscopic Revision of Prosthetic Vaginal Graft	7	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach	Oct 2008	Laparoscopic Revision of Prosthetic Vaginal Graft	7	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	<input checked="" type="checkbox"/>
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	<input checked="" type="checkbox"/>
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	<input checked="" type="checkbox"/>
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	<input checked="" type="checkbox"/>
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	<input checked="" type="checkbox"/>
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	<input checked="" type="checkbox"/>
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	<input checked="" type="checkbox"/>

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58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	<input checked="" type="checkbox"/>
58674	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency	Jan 2016	Laparoscopic Radiofrequency Ablation of Uterine Fibroids	18	CPT 2017	October 2020		<input type="checkbox"/>
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	Apr 2015	Intracranial Endovascular Intervention	09	CPT 2016	October 2019		<input type="checkbox"/>
61650	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory	Apr 2015	Intracranial Endovascular Intervention	09	CPT 2016	October 2019		<input type="checkbox"/>
61651	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; each additional vascular territory (List separately in addition to code for primary procedure)	Apr 2015	Intracranial Endovascular Intervention	09	CPT 2016	October 2019		<input type="checkbox"/>
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar	Jan 2016	Endoscopic Decompression of Spinal Cord Nerve	19	CPT 2017	October 2020		<input type="checkbox"/>
63620	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion	Apr 2008	Stereotactic Radiosurgery	16	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
63621	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)	Apr 2008	Stereotactic Radiosurgery	16	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>

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64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	Apr 2010	Posterior Tibial Nerve Stimulation	13	CPT 2011	October 2019	Surveyed for April 2015, RUC recommended to review utilization again in 2 years (September 2019).	<input checked="" type="checkbox"/>
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	Feb 2010	Vagus Nerve Stimulator	14	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	<input checked="" type="checkbox"/>
64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Feb 2010	Vagus Nerve Stimulator	14	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	<input checked="" type="checkbox"/>
65756	Keratoplasty (corneal transplant); endothelial	Apr 2008	Endothelial Keratoplasty	20	CPT 2009	September 2012	Remove, code does not need to be re-evaluated. Though volume grew faster than expected, there was a decrease in other services of similar magnitude, that were previously reported and had similar work RVUs. All remained work neutral.	<input checked="" type="checkbox"/>
65757	Backbench preparation of corneal endothelial allograft prior to transplantation (List separately in addition to code for primary procedure)	Apr 2008	Endothelial Keratoplasty	20	CPT 2009	September 2012	Remove, code does not need to be re-evaluated.	<input checked="" type="checkbox"/>
65778	Placement of amniotic membrane on the ocular surface; without sutures	Feb 2010	Amniotic Membrane Placement	15	CPT 2011	September 2014	Survey for April 2015.	<input checked="" type="checkbox"/>
65779	Placement of amniotic membrane on the ocular surface; single layer, sutured	Feb 2010	Amniotic Membrane Placement	15	CPT 2011	September 2014	Survey for April 2015.	<input checked="" type="checkbox"/>

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65780	Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	Oct 2011	Relativity Assessment Workgroup	51	CPT 2011	September 2014	Survey for April 2015.	<input checked="" type="checkbox"/>
65785	Implantation of intrastomal corneal ring segments	Jan 2015	Intrastomal Corneal Ring Implantation	11	CPT 2016	October 2019		<input type="checkbox"/>
66174	Transluminal dilation of aqueous outflow canal; without retention of device or stent	Apr 2010	Open Angle Glaucoma Procedures	15	CPT 2011	October 2019	Review utilization in 3 years (Sept 2019) and flag in the RUC database not to use to validate physician work.	<input type="checkbox"/>
66175	Transluminal dilation of aqueous outflow canal; with retention of device or stent	Apr 2010	Open Angle Glaucoma Procedures	15	CPT 2011	October 2019	Review utilization in 3 years (Sept 2019) and flag in the RUC database not to use to validate physician work.	<input type="checkbox"/>
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	Apr 2013	Insertion of Anterior Segment	14	CPT 2014	October 2017	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
68816	Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation	Apr 2007	Nasolacrimal Duct Balloon Catheter Dilation	E	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
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	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
70555	Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>

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74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material	Apr 2009	CT Colonography	19	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	Apr 2009	CT Colonography	19	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
74263	Computed tomographic (CT) colonography, screening, including image postprocessing	Apr 2009	CT Colonography	19	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, as utilization is appropriate due to shift of utilization for deleted code which included "with flow/velocity quantification", code 75558.	<input checked="" type="checkbox"/>
75558	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	<input checked="" type="checkbox"/>
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
75560	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	<input checked="" type="checkbox"/>

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75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, as utilization is appropriate due to shift of utilization for deleted code which included "with flow/velocity quantification", code 75560.	<input checked="" type="checkbox"/>
75562	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	<input checked="" type="checkbox"/>
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
75564	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	<input checked="" type="checkbox"/>
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
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)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
767X1		Jan 2018	Ultrasound Elastography	14	CPT 2019	October 2022		<input type="checkbox"/>
767X2		Jan 2018	Ultrasound Elastography	14	CPT 2019	October 2022		<input type="checkbox"/>
767X3		Jan 2018	Ultrasound Elastography	14	CPT 2019	October 2022		<input type="checkbox"/>

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76881	Ultrasound, extremity, nonvascular, real-time with image documentation; complete	Apr 2010	Ultrasound of Extremity	17	CPT 2011	October 2019	The specialty society noted and the Workgroup agreed that the dominant specialties providing the complete versus the limited ultrasound of extremity services are different. Thus, causing variation in what the typical practice expense inputs. The Workgroup recommends to 1) Refer CPT codes 76881 and 76882 to the Practice Expense Subcommittee for review of the direct practice expense inputs; 2) Refer to the CPT Editorial Panel to clarify the introductory language regarding the reference to one joint in the complete ultrasound; and 3) Review again in 3 years (October 2019).	<input type="checkbox"/>

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76882	Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific	Apr 2010	Ultrasound of Extremity	17	CPT 2011	October 2019	The specialty society noted and the Workgroup agreed that the dominant specialties providing the complete versus the limited ultrasound of extremity services are different. Thus, causing variation in what the typical practice expense inputs. The Workgroup recommends to 1) Refer CPT codes 76881 and 76882 to the Practice Expense Subcommittee for review of the direct practice expense inputs; 2) Refer to the CPT Editorial Panel to clarify the introductory language regarding the reference to one joint in the complete ultrasound; and 3) Review again in 3 years (October 2019).	<input type="checkbox"/>
76X01		Jan 2018	Magnetic Resonance Elastography	16	CPT 2019	October 2022		<input type="checkbox"/>
76X0X		Jan 2018	Contrast-Enhanced Ultrasound	15	CPT 2019	October 2022		<input type="checkbox"/>
76X1X		Jan 2018	Contrast-Enhanced Ultrasound	15	CPT 2019	October 2022		<input type="checkbox"/>

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77021	Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	Jan 2018	Fine Needle Aspiration	04	CPT 2019	October 2022		<input type="checkbox"/>
77061	Digital breast tomosynthesis; unilateral	Apr 2014	Breast Tomosynthesis	19	CPT 2015	October 2021	In October 2018, the RUC recommended that CMS delete G0279 and ise codes 77061, 77062 and 77063 as created by CPT and valued by the RUC. Review again in 3 years (2021).	<input type="checkbox"/>
77062	Digital breast tomosynthesis; bilateral	Apr 2014	Breast Tomosynthesis	19	CPT 2015	October 2021	In October 2018, the RUC recommended that CMS delete G0279 amd ise codes 77061, 77062 and 77063 as created by CPT and valued by the RUC. Review again in 3 years (2021).	<input type="checkbox"/>
77063	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	Apr 2014	Breast Tomosynthesis	19	CPT 2015	October 2021	In October 2018, the RUC recommended that CMS delete G0279 amd ise codes 77061, 77062 and 77063 as created by CPT and valued by the RUC. Review again in 3 years (2021).	<input type="checkbox"/>
77293	Respiratory motion management simulation (List separately in addition to code for primary procedure)	Jan 2013	Respiratory Motion Management Simulation	14	CPT 2014	October 2020	Review in 3 years (October 2020)	<input type="checkbox"/>

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77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	Sep 2005	Stereotactic Radiation Tx Delivery	7	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	Sep 2005	Stereotactic Radiation Tx Delivery	7	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Apr 2006	Stereotactic Body Radiation Therapy	B	CPT 2007	September 2010	Practice expense review (Feb 2011).	<input checked="" type="checkbox"/>
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Feb 2011	Stereotactic Body Radiation Delivery	32	CPT 2012	October 2015	Practice expense review (Feb 2011).	<input checked="" type="checkbox"/>
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Apr 2006	Stereotactic Body Radiation Therapy	B	CPT 2007	September 2010	Survey (work) and PE review (Feb 2011).	<input checked="" type="checkbox"/>
77X49		Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	October 2022		<input type="checkbox"/>
77X50		Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	October 2022		<input type="checkbox"/>
77X51		Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	October 2022		<input type="checkbox"/>
77X52		Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	October 2022		<input type="checkbox"/>

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78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)	Apr 2012	Parathyroid Imaging	23	CPT 2013	October 2018	In April 2011, CPT Code 78007, Thyroid imaging, with uptake; multiple determinations was identified in the Harvard Valued-Utilization over 30,000 screen. As part of the review of the entire endocrine family, the specialty societies determined that revisions to the parathyroid imaging procedures were necessary to reflect current bundling policies, guideline changes and new technology. AMA Staff reviewed the work neutrality impacts for codes reviewed in the CPT 2013 cycle. It appeared that was only one issue where there was a large growth in utilization in the first year. For CPT 2013 the Parathyroid Imaging codes were not work neutral, and it was initially estimated as a savings overall. It appears that there was 40% increase from what was projected. The specialty societies submitted an action plan indicating that literature supporting	<input checked="" type="checkbox"/>

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							<p>parathyroid scintigraphy as an effective diagnostic study for parathyroid disease has recently emerged and supports the clinical utility thus increasing utilization. Secondly, the availability of SPECT/CT cameras has increased and is greater than initially predicted, allowing for a higher utilization. The Workgroup agreed and also noted that these services are conducted on patients who are referred to the radiologists or nuclear medicine physicians. The physicians providing these services do not control the number of patients referred to them who receive these services. The Workgroup recommends that the specialty societies develop a CPT Assistant article to address potential current use of 78803 rather than the new codes 78071 and 78072. The Workgroup noted that these services are on the new technology list for review later this year and should be</p>	

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							postponed and reviewed in 2 years after the CPT Assistant article is published. In October 2018, the RUC recommended to remove from list , no demonstrated technology diffusion that impacts work or practice expense.	

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78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization	Apr 2012	Parathyroid Imaging	23	CPT 2013	October 2018	In April 2011, CPT Code 78007, Thyroid imaging, with uptake; multiple determinations was identified in the Harvard Valued-Utilization over 30,000 screen. As part of the review of the entire endocrine family, the specialty societies determined that revisions to the parathyroid imaging procedures were necessary to reflect current bundling policies, guideline changes and new technology. AMA Staff reviewed the work neutrality impacts for codes reviewed in the CPT 2013 cycle. It appeared that was only one issue where there was a large growth in utilization in the first year. For CPT 2013 the Parathyroid Imaging codes were not work neutral, and it was initially estimated as a savings overall. It appears that there was 40% increase from what was projected. The specialty societies submitted an action plan indicating that literature supporting	<input checked="" type="checkbox"/>

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							<p>parathyroid scintigraphy as an effective diagnostic study for parathyroid disease has recently emerged and supports the clinical utility thus increasing utilization. Secondly, the availability of SPECT/CT cameras has increased and is greater than initially predicted, allowing for a higher utilization. The Workgroup agreed and also noted that these services are conducted on patients who are referred to the radiologists or nuclear medicine physicians. The physicians providing these services do not control the number of patients referred to them who receive these services. The Workgroup recommends that the specialty societies develop a CPT Assistant article to address potential current use of 78803 rather than the new codes 78071 and 78072. The Workgroup noted that these services are on the new technology list for review later this year and should be</p>	

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							postponed and reviewed in 2 years after the CPT Assistant article is published. In October 2018, the RUC recommended to remove from list , no demonstrated technology diffusion that impacts work or practice expense.	
78265	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit	Apr 2015	Colon Transit Imaging	18	CPT 2016	October 2019		<input type="checkbox"/>
78266	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days	Apr 2015	Colon Transit Imaging	18	CPT 2016	October 2019		<input type="checkbox"/>
78811	Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
78812	Positron emission tomography (PET) imaging; skull base to mid-thigh	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
78813	Positron emission tomography (PET) imaging; whole body	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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78814	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78815	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78816	Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
81161	DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	Oct 2012	Molecular Pathology -Tier 1	11	CPT 2014	October 2017	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81201	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence	Apr 2012	Molecular Pathology-Adenomatous Polyposis Coli	24	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81202	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants	Apr 2012	Molecular Pathology-Adenomatous Polyposis Coli	24	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

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81203	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants	Apr 2012	Molecular Pathology- Adenomatous Polyposis Coli	24	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81206	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81207	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81208	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81210	BRAF (B-Raf proto-oncogene, serine/threonine kinase) (eg, colon cancer, melanoma), gene analysis, V600 variant(s)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81216	BRCA2 (breast cancer 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

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81217	BRCA2 (breast cancer 2) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81220	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81221	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81222	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81223	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81224	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

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81225	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81227	CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81235	EGFR (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81240	F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis, 20210G>A variant	Apr 2011	Molecular Pathology Test - Tier 1	15	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81241	F5 (coagulation factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant	Apr 2011	Molecular Pathology Test - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81243	FMR1 (fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

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81244	FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and methylation status)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81245	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; internal tandem duplication (ITD) variants (ie, exons 14, 15)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81252	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81253	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81254	GJB6 (gap junction protein, beta 6, 30kDa, connexin 30) (eg, nonsyndromic hearing loss) gene analysis, common variants (eg, 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81256	HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis, common variants (eg, C282Y, H63D)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

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81257	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis, for common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, and Constant Spring)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81261	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplified methodology (eg, polymerase chain reaction)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81262	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, Southern blot)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81263	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81264	IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

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81265	Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81266	Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81267	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; without cell selection	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81268	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; with cell selection (eg, CD3, CD33), each cell type	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81270	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, p.Val617Phe (V617F) variant	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

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81275	KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; variants in exon 2 (eg, codons 12 and 13)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81291	MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81292	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81293	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81294	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81295	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

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81296	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81297	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81298	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81299	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81300	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81301	Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

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81302	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81303	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variant	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81304	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81315	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81316	PML/RARalpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81317	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

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81318	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81319	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81321	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81322	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81323	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81331	SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

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81332	SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81340	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81341	TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (eg, Southern blot)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81342	TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81350	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81355	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variant(s) (eg, -1639G>A, c.173+1000C>T)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

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81370	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81371	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, and -DRB1 (eg, verification typing)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81372	HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81373	HLA Class I typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-A, -B, or -C), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81374	HLA Class I typing, low resolution (eg, antigen equivalents); one antigen equivalent (eg, B*27), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81375	HLA Class II typing, low resolution (eg, antigen equivalents); HLA-DRB1/3/4/5 and -DQB1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

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81376	HLA Class II typing, low resolution (eg, antigen equivalents); one locus (eg, HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81377	HLA Class II typing, low resolution (eg, antigen equivalents); one antigen equivalent, each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81378	HLA Class I and II typing, high resolution (ie, alleles or allele groups), HLA-A, -B, -C, and -DRB1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81379	HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B, and -C)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81380	HLA Class I typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-A, -B, or -C), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81381	HLA Class I typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, B*57:01P), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

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81382	HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-DRB1, -DRB3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>
81383	HLA Class II typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, HLA-DQB1*06:02P), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

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81400	Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis) ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD) (eg, medium chain acyl dehydrogenase deficiency), K304E variant ACE (angiotensin converting enzyme) (eg, hereditary blood pressure regulation), insertion/deletion variant AGTR1 (angiotensin II receptor, type 1) (eg, essential hypertension), 1166A>C variant BCKDHA (branched chain keto acid dehydrogenase E1, alpha polypeptide) (eg, maple syrup urine disease, type 1A), Y438N variant CCR5 (chemokine C-C motif receptor 5) (eg, HIV resistance), 32-bp deletion mutation/794 825del32 deletion CLRN1 (clarin 1) (eg, Usher syndrome, type 3), N48K variant DPYD (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism), IVS14+1G>A variant F2 (coagulation factor 2) (eg, hereditary hypercoagulability), 1199G>A variant F5 (coagulation factor V) (eg, hereditary hypercoagulability), HR2 variant F7 (coagulation factor VII [serum prothrombin conversion accelerator]) (eg, hereditary hypercoagulability), R353Q variant F13B (coagulation factor XIII, B polypeptide) (eg, hereditary hypercoagulability), V34L variant FGB (fibrinogen beta chain) (eg, hereditary ischemic heart disease), -455G>A variant FGFR1 (fibroblast growth factor receptor 1) (eg, Pfeiffer syndrome type 1, craniosynostosis), P252R variant FGFR3 (fibroblast growth factor receptor 3) (eg, Muenke syndrome), P250R variant FKTN (fukutin) (eg, Fukuyama congenital muscular dystrophy), retrotransposon insertion variant GNE (glucosamine [UDP-N-acetyl]-2-epimerase/N-acetylmannosamine kinase) (eg, inclusion body myopathy 2 [IBM2], Nonaka myopathy), M712T variant Human Platelet Antigen 1 genotyping	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

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	(HPA-1), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-1a/b (L33P) Human Platelet Antigen 2 genotyping (HPA-2), GP1BA (glycoprotein Ib [platelet], alpha polypeptide [GPIba]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-2a/b (T145M) Human Platelet Antigen 3 genotyping (HPA-3), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex], antigen CD41 [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-3a/b (I843S) Human Platelet Antigen 4 genotyping (HPA-4), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-4a/b (R143Q) Human Platelet Antigen 5 genotyping (HPA-5), ITGA2 (integrin, alpha 2 [CD49B, alpha 2 subunit of VLA-2 receptor] [GPIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-5a/b (K505E) Human Platelet Antigen 6 genotyping (HPA-6w), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa, antigen CD61] [GPIIIa]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-6a/b (R489Q) Human Platelet Antigen 9 genotyping (HPA-9w), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex, antigen CD41] [GPIIb]) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-9a/b (V837M) Human Platelet Antigen 15 genotyping (HPA-15), CD109 (CD109 molecule) (eg, neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), HPA-15a/b (S682Y) IL28B (interleukin 28B [interferon, lambda 3]) (eg, drug response), rs12979860 variant IVD (isovaleryl-CoA dehydrogenase) (eg, isovaleric acidemia), A282V variant LCT (lactase-phlorizin hydrolase) (eg, lactose intolerance), 13910 C>T variant NEB							

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	(nebulin) (eg, nemaline myopathy 2), exon 55 deletion variant PCDH15 (protocadherin-related 15) (eg, Usher syndrome type 1F), R245X variant SERPINE1 (serpine peptidase inhibitor clade E, member 1, plasminogen activator inhibitor -1, PAI-1) (eg, thrombophilia), 4G variant SHOC2 (soc-2 suppressor of clear homolog) (eg, Noonan-like syndrome with loose anagen hair), S2G variant SLCO1B1 (solute carrier organic anion transporter family, member 1B1) (eg, adverse drug reaction), V174A variant SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy), exon 7 deletion SRY (sex determining region Y) (eg, 46,XX testicular disorder of sex development, gonadal dysgenesis), gene analysis TOR1A (torsin family 1, member A [torsin A]) (eg, early-onset primary dystonia [DYT1]), 907_909delGAG (904_906delGAG) variant							

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81401	Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat) ABCC8 (ATP-binding cassette, sub-family C [CFTR/MRP], member 8) (eg, familial hyperinsulinism), common variants (eg, c.3898-9G>A [c.3992-9G>A], F1388del) ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (eg, acquired imatinib resistance), T315I variant ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD) (eg, medium chain acyl dehydrogenase deficiency), commons variants (eg, K304E, Y42H) ADRB2 (adrenergic beta-2 receptor surface) (eg, drug metabolism), common variants (eg, G16R, Q27E) AFF2 (AF4/FMR2 family, member 2 [FMR2]) (eg, fragile X mental retardation 2 [FRAXE]), evaluation to detect abnormal (eg, expanded) alleles APOB (apolipoprotein B) (eg, familial hypercholesterolemia type B), common variants (eg, R3500Q, R3500W) APOE (apolipoprotein E) (eg, hyperlipoproteinemia type III, cardiovascular disease, Alzheimer disease), common variants (eg, *2, *3, *4) AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation), characterization of alleles (eg, expanded size or methylation status) ATN1 (atrophin 1) (eg, dentatorubral-pallidoluysian atrophy), evaluation to detect abnormal (eg, expanded) alleles ATXN1 (ataxin 1) (eg, spinocerebellar ataxia), evaluation to detect abnormal (eg, expanded) alleles ATXN2 (ataxin 2) (eg, spinocerebellar ataxia), evaluation to detect abnormal (eg, expanded) alleles ATXN3 (ataxin 3) (eg, spinocerebellar ataxia, Machado-Joseph disease), evaluation to detect abnormal (eg, expanded) alleles ATXN7 (ataxin 7) (eg, spinocerebellar ataxia), evaluation to detect abnormal (eg, expanded) alleles ATXN8OS (ATXN8 opposite strand [non-protein coding]) (eg,	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

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	spinocerebellar ataxia), evaluation to detect abnormal (eg, expanded) alleles ATXN10 (ataxin 10) (eg, spinocerebellar ataxia), evaluation to detect abnormal (eg, expanded) alleles CACNA1A (calcium channel, voltage-dependent, P/Q type, alpha 1A subunit) (eg, spinocerebellar ataxia), evaluation to detect abnormal (eg, expanded) alleles CBFB/MYH11 (inv(16)) (eg, acute myeloid leukemia), qualitative, and quantitative, if performed CBS (cystathionine-beta-synthase) (eg, homocystinuria, cystathionine beta-synthase deficiency), common variants (eg, I278T, G307S) CCND1/IGH (BCL1/IgH, t(11;14)) (eg, mantle cell lymphoma) translocation analysis, major breakpoint, qualitative, and quantitative, if performed CFH/ARMS2 (complement factor H/age-related maculopathy susceptibility 2) (eg, macular degeneration), common variants (eg, Y402H [CFH], A69S [ARMS2]) CNBP (CCHC-type zinc finger, nucleic acid binding protein) (eg, myotonic dystrophy type 2), evaluation to detect abnormal (eg, expanded) alleles CSTB (cystatin B [stefin B]) (eg, Unverricht-Lundborg disease), evaluation to detect abnormal (eg, expanded) alleles CYP3A4 (cytochrome P450, family 3, subfamily A, polypeptide 4) (eg, drug metabolism), common variants (eg, *2, *3, *4, *5, *6) CYP3A5 (cytochrome P450, family 3, subfamily A, polypeptide 5) (eg, drug metabolism), common variants (eg, *2, *3, *4, *5, *6) DEK/NUP214 (t(6;9)) (eg, acute myeloid leukemia), translocation analysis, qualitative, and quantitative, if performed DMPK (dystrophin myotonia-protein kinase) (eg, myotonic dystrophy, type 1), evaluation to detect abnormal (eg, expanded) alleles E2A/PBX1 (t(1;19)) (eg, acute lymphocytic leukemia), translocation analysis, qualitative, and quantitative, if performed EML4/ALK (inv(2)) (eg, non-small cell lung cancer), translocation or inversion analysis ETV6/NTRK3 (t(12;15)) (eg, congenital/infantile fibrosarcoma), translocation analysis, qualitative,							

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	and quantitative, if performed ETV6/RUNX1 (t(12;21)) (eg, acute lymphocytic leukemia), translocation analysis, qualitative, and quantitative, if performed EWSR1/ATF1 (t(12;22)) (eg, clear cell sarcoma), translocation analysis, qualitative, and quantitative, if performed EWSR1/ERG (t(21;22)) (eg, Ewing sarcoma/peripheral neuroectodermal tumor), translocation analysis, qualitative, and quantitative, if performed EWSR1/FLI1 (t(11;22)) (eg, Ewing sarcoma/peripheral neuroectodermal tumor), translocation analysis, qualitative, and quantitative, if performed EWSR1/WT1 (t(11;22)) (eg, desmoplastic small round cell tumor), translocation analysis, qualitative, and quantitative, if performed F11 (coagulation factor XI) (eg, coagulation disorder), common variants (eg, E117X [Type II], F283L [Type III], IVS14del14, and IVS14+1G>A [Type I]) FGFR3 (fibroblast growth factor receptor 3) (eg, achondroplasia, hypochondroplasia), common variants (eg, 1138G>A, 1138G>C, 1620C>A, 1620C>G) FIP1L1/PDGFR4 (del[4q12]) (eg, imatinib-sensitive chronic eosinophilic leukemia), qualitative, and quantitative, if performed FLG (filaggrin) (eg, ichthyosis vulgaris), common variants (eg, R501X, 2282del4, R2447X, S3247X, 3702delG) FOXO1/PAX3 (t(2;13)) (eg, alveolar rhabdomyosarcoma), translocation analysis, qualitative, and quantitative, if performed FOXO1/PAX7 (t(1;13)) (eg, alveolar rhabdomyosarcoma), translocation analysis, qualitative, and quantitative, if performed FUS/DDIT3 (t(12;16)) (eg, myxoid liposarcoma), translocation analysis, qualitative, and quantitative, if performed FXN (frataxin) (eg, Friedreich ataxia), evaluation to detect abnormal (expanded) alleles GALC (galactosylceramidase) (eg, Krabbe disease), common variants (eg, c.857G>A, 30-kb deletion) GALT (galactose-1-phosphate uridylyltransferase) (eg, galactosemia), common variants (eg, Q188R, S135L, K285N, T138M, L195P, Y209C, IVS2-							

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	<p>2A>G, P171S, del5kb, N314D, L218L/N314D) H19 (imprinted maternally expressed transcript [non-protein coding]) (eg, Beckwith-Wiedemann syndrome), methylation analysis HBB (hemoglobin, beta) (eg, sickle cell anemia, hemoglobin C, hemoglobin E), common variants (eg, HbS, HbC, HbE) HTT (huntingtin) (eg, Huntington disease), evaluation to detect abnormal (eg, expanded) alleles IGH@/BCL2 (t(14;18)) (eg, follicular lymphoma), translocation analysis; single breakpoint (eg, major breakpoint region [MBR] or minor cluster region [mcr]), qualitative or quantitative (When both MBR and mcr breakpoints are performed, use 81402) KCNQ1OT1 (KCNQ1 overlapping transcript 1 [non-protein coding]) (eg, Beckwith-Wiedemann syndrome), methylation analysis LRRK2 (leucine-rich repeat kinase 2) (eg, Parkinson disease), common variants (eg, R1441G, G2019S, I2020T) MED12 (mediator complex subunit 12) (eg, FG syndrome type 1, Lujan syndrome), common variants (eg, R961W, N1007S) MEG3/DLK1 (maternally expressed 3 [non-protein coding]/delta-like 1 homolog [Drosophila]) (eg, intrauterine growth retardation), methylation analysis MLL/AFF1 (t(4;11)) (eg, acute lymphoblastic leukemia), translocation analysis, qualitative, and quantitative, if performed MLL/MLLT3 (t(9;11)) (eg, acute myeloid leukemia), translocation analysis, qualitative, and quantitative, if performed MT-ATP6 (mitochondrially encoded ATP synthase 6) (eg, neuropathy with ataxia and retinitis pigmentosa [NARP], Leigh syndrome), common variants (eg, m.8993T>G, m.8993T>C) MT-ND4, MT-ND6 (mitochondrially encoded NADH dehydrogenase 4, mitochondrially encoded NADH dehydrogenase 6) (eg, Leber hereditary optic neuropathy [LHON]), common variants (eg, m.11778G>A, m.3460G>A, m.14484T>C) MT-ND5 (mitochondrially encoded tRNA leucine 1 [UUA/G], mitochondrially encoded NADH dehydrogenase 5) (eg, mitochondrial</p>							

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	encephalopathy with lactic acidosis and stroke-like episodes [MELAS]), common variants (eg, m.3243A>G, m.3271T>C, m.3252A>G, m.13513G>A) MT-RNR1 (mitochondrially encoded 12S RNA) (eg, nonsyndromic hearing loss), common variants (eg, m.1555A>G, m.1494C>T) MT-TK (mitochondrially encoded tRNA lysine) (eg, myoclonic epilepsy with ragged-red fibers [MERRF]), common variants (eg, m.8344A>G, m.8356T>C) MT-TL1 (mitochondrially encoded tRNA leucine 1 [UUA/G]) (eg, diabetes and hearing loss), common variants (eg, m.3243A>G, m.14709 T>C) MT-TL1 MT-TS1, MT-RNR1 (mitochondrially encoded tRNA serine 1 [UCN], mitochondrially encoded 12S RNA) (eg, nonsyndromic sensorineural deafness [including aminoglycoside-induced nonsyndromic deafness]), common variants (eg, m.7445A>G, m.1555A>G) MUTYH (mutY homolog [E. coli]) (eg, MYH-associated polyposis), common variants (eg, Y165C, G382D) NOD2 (nucleotide-binding oligomerization domain containing 2) (eg, Crohn's disease, Blau syndrome), common variants (eg, SNP 8, SNP 12, SNP 13) NPM1/ALK (t(2;5)) (eg, anaplastic large cell lymphoma), translocation analysis PABPN1 (poly[A] binding protein, nuclear 1) (eg, oculopharyngeal muscular dystrophy), evaluation to detect abnormal (eg, expanded) alleles PAX8/PPARG (t(2;3) (q13;p25)) (eg, follicular thyroid carcinoma), translocation analysis PPP2R2B (protein phosphatase 2, regulatory subunit B, beta) (eg, spinocerebellar ataxia), evaluation to detect abnormal (eg, expanded) alleles PRSS1 (protease, serine, 1 [trypsin 1]) (eg, hereditary pancreatitis), common variants (eg, N29I, A16V, R122H) PYGM (phosphorylase, glycogen, muscle) (eg, glycogen storage disease type V, McArdle disease), common variants (eg, R50X, G205S) RUNX1/RUNX1T1 (t(8;21)) (eg, acute myeloid leukemia) translocation analysis, qualitative, and quantitative, if performed SEPT9							

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	(septin 9) (eg, colon cancer), methylation analysis SMN1/SMN2 (survival of motor neuron 1, telomeric/survival of motor neuron 2, centromeric) (eg, spinal muscular atrophy), dosage analysis (eg, carrier testing) (For duplication/deletion analysis of SMN1/SMN2, use 81401) SS18/SSX1 (t(X;18)) (eg, synovial sarcoma), translocation analysis, qualitative, and quantitative, if performed SS18/SSX2 (t(X;18)) (eg, synovial sarcoma), translocation analysis, qualitative, and quantitative, if performed TBP (TATA box binding protein) (eg, spinocerebellar ataxia), evaluation to detect abnormal (eg, expanded) alleles TPMT (thiopurine S-methyltransferase) (eg, drug metabolism), common variants (eg, *2, *3) TYMS (thymidylate synthetase) (eg, 5-fluorouracil/5-FU drug metabolism), tandem repeat variant VWF (von Willebrand factor) (eg, von Willebrand disease type 2N), common variants (eg, T791M, R816W, R854Q)							

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81402	Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants of 1 exon, loss of heterozygosity [LOH], uniparental disomy [UPD]) Chromosome 1p-/19q- (eg, glial tumors), deletion analysis Chromosome 18q- (eg, D18S55, D18S58, D18S61, D18S64, and D18S69) (eg, colon cancer), allelic imbalance assessment (ie, loss of heterozygosity) COL1A1/PDGFB (t(17;22)) (eg, dermatofibrosarcoma protuberans), translocation analysis, multiple breakpoints, qualitative, and quantitative, if performed CYP21A2 (cytochrome P450, family 21, subfamily A, polypeptide 2) (eg, congenital adrenal hyperplasia, 21-hydroxylase deficiency), common variants (eg, IVS2-13G, P30L, I172N, exon 6 mutation cluster [I235N, V236E, M238K], V281L, L307FfsX6, Q318X, R356W, P453S, G110VfsX21, 30-kb deletion variant) ESR1/PGR (receptor 1/progesterone receptor) ratio (eg, breast cancer) IGH@/BCL2 (t(14;18)) (eg, follicular lymphoma), translocation analysis; major breakpoint region (MBR) and minor cluster region (mcr) breakpoints, qualitative or quantitative MEFV (Mediterranean fever) (eg, familial Mediterranean fever), common variants (eg, E148Q, P369S, F479L, M680I, I692del, M694V, M694I, K695R, V726A, A744S, R761H) MPL (myeloproliferative leukemia virus oncogene, thrombopoietin receptor, TPOR) (eg, myeloproliferative disorder), common variants (eg, W515A, W515K, W515L, W515R) TRD@ (T cell antigen receptor, delta) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population Uniparental disomy (UPD) (eg, Russell-Silver syndrome, Prader-Willi/Angelman syndrome), short tandem repeat (STR) analysis	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

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81403	Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons) ANG (angiogenin, ribonuclease, RNase A family, 5) (eg, amyotrophic lateral sclerosis), full gene sequence ARX (aristaless-related homeobox) (eg, X-linked lissencephaly with ambiguous genitalia, X-linked mental retardation), duplication/deletion analysis CEL (carboxyl ester lipase [bile salt-stimulated lipase]) (eg, maturity-onset diabetes of the young [MODY]), targeted sequence analysis of exon 11 (eg, c.1785delC, c.1686delT) CTNNB1 (catenin [cadherin-associated protein], beta 1, 88kDa) (eg, desmoid tumors), targeted sequence analysis (eg, exon 3) DAZ/SRY (deleted in azoospermia and sex determining region Y) (eg, male infertility), common deletions (eg, AZFa, AZFb, AZFc, AZFd) DNMT3A (DNA [cytosine-5-]-methyltransferase 3 alpha) (eg, acute myeloid leukemia), targeted sequence analysis (eg, exon 23) EPCAM (epithelial cell adhesion molecule) (eg, Lynch syndrome), duplication/deletion analysis F8 (coagulation factor VIII) (eg, hemophilia A), inversion analysis, intron 1 and intron 22A F12 (coagulation factor XII [Hageman factor]) (eg, angioedema, hereditary, type III; factor XII deficiency), targeted sequence analysis of exon 9 FGFR3 (fibroblast growth factor receptor 3) (eg, isolated craniosynostosis), targeted sequence analysis (eg, exon 7) (For targeted sequence analysis of multiple FGFR3 exons, use 81404) GJB1 (gap junction protein, beta 1) (eg, Charcot-Marie-Tooth X-linked), full gene sequence GNAQ (guanine nucleotide-binding protein G[q] subunit alpha) (eg, uveal melanoma), common variants (eg, R183, Q209) HBB (hemoglobin, beta, beta-globin) (eg, beta thalassemia), duplication/deletion analysis Human erythrocyte antigen gene analyses (eg,	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

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	SLC14A1 [Kidd blood group], BCAM [Lutheran blood group], ICAM4 [Landsteiner-Wiener blood group], SLC4A1 [Diego blood group], AQP1 [Colton blood group], ERMAP [Scianna blood group], RHCE [Rh blood group, CcEe antigens], KEL [Kell blood group], DARC [Duffy blood group], GYPA, GYPB, GYPE [MNS blood group], ART4 [Dombrock blood group]) (eg, sickle-cell disease, thalassemia, hemolytic transfusion reactions, hemolytic disease of the fetus or newborn), common variants HRAS (v-Ha-ras Harvey rat sarcoma viral oncogene homolog) (eg, Costello syndrome), exon 2 sequence IDH1 (isocitrate dehydrogenase 1 [NADP+], soluble) (eg, glioma), common exon 4 variants (eg, R132H, R132C) IDH2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial) (eg, glioma), common exon 4 variants (eg, R140W, R172M) JAK2 (Janus kinase 2) (eg, myeloproliferative disorder), exon 12 sequence and exon 13 sequence, if performed KCNC3 (potassium voltage-gated channel, Shaw-related subfamily, member 3) (eg, spinocerebellar ataxia), targeted sequence analysis (eg, exon 2) KCNJ2 (potassium inwardly-rectifying channel, subfamily J, member 2) (eg, Andersen-Tawil syndrome), full gene sequence KCNJ11 (potassium inwardly-rectifying channel, subfamily J, member 11) (eg, familial hyperinsulinism), full gene sequence Killer cell immunoglobulin-like receptor (KIR) gene family (eg, hematopoietic stem cell transplantation), genotyping of KIR family genes Known familial variant not otherwise specified, for gene listed in Tier 1 or Tier 2, DNA sequence analysis, each variant exon (For a known familial variant that is considered a common variant, use specific common variant Tier 1 or Tier 2 code) MC4R (melanocortin 4 receptor) (eg, obesity), full gene sequence MICA (MHC class I polypeptide-related sequence A) (eg, solid organ transplantation), common variants (eg, *001, *002) MPL (myeloproliferative leukemia virus oncogene, thrombopoietin receptor, TPOR) (eg,							

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	myeloproliferative disorder), exon 10 sequence MT-RNR1 (mitochondrially encoded 12S RNA) (eg, nonsyndromic hearing loss), full gene sequence MT-TS1 (mitochondrially encoded tRNA serine 1) (eg, nonsyndromic hearing loss), full gene sequence NDP (Norrie disease [pseudoglioma]) (eg, Norrie disease), duplication/deletion analysis NHLRC1 (NHL repeat containing 1) (eg, progressive myoclonus epilepsy), full gene sequence PHOX2B (paired-like homeobox 2b) (eg, congenital central hypoventilation syndrome), duplication/deletion analysis PLN (phospholamban) (eg, dilated cardiomyopathy, hypertrophic cardiomyopathy), full gene sequence RHD (Rh blood group, D antigen) (eg, hemolytic disease of the fetus and newborn, Rh maternal/fetal compatibility), deletion analysis (eg, exons 4, 5, and 7, pseudogene) RHD (Rh blood group, D antigen) (eg, hemolytic disease of the fetus and newborn, Rh maternal/fetal compatibility), deletion analysis (eg, exons 4, 5, and 7, pseudogene), performed on cell-free fetal DNA in maternal blood (For human erythrocyte gene analysis of RHD, use a separate unit of 81403) SH2D1A (SH2 domain containing 1A) (eg, X-linked lymphoproliferative syndrome), duplication/deletion analysis SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy), known familial sequence variant(s) TWIST1 (twist homolog 1 [Drosophila]) (eg, Saethre-Chotzen syndrome), duplication/deletion analysis UBA1 (ubiquitin-like modifier activating enzyme 1) (eg, spinal muscular atrophy, X-linked), targeted sequence analysis (eg, exon 15) VHL (von Hippel-Lindau tumor suppressor) (eg, von Hippel-Lindau familial cancer syndrome), deletion/duplication analysis VWF (von Willebrand factor) (eg, von Willebrand disease types 2A, 2B, 2M), targeted sequence analysis (eg, exon 28)							

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81404	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis) ACADS (acyl-CoA dehydrogenase, C-2 to C-3 short chain) (eg, short chain acyl-CoA dehydrogenase deficiency), targeted sequence analysis (eg, exons 5 and 6) AFF2 (AF4/FMR2 family, member 2 [FMR2]) (eg, fragile X mental retardation 2 [FRAXE]), characterization of alleles (eg, expanded size and methylation status) AQP2 (aquaporin 2 [collecting duct]) (eg, nephrogenic diabetes insipidus), full gene sequence ARX (aristaless related homeobox) (eg, X-linked lissencephaly with ambiguous genitalia, X-linked mental retardation), full gene sequence AVPR2 (arginine vasopressin receptor 2) (eg, nephrogenic diabetes insipidus), full gene sequence BBS10 (Bardet-Biedl syndrome 10) (eg, Bardet-Biedl syndrome), full gene sequence BTM (biotinidase) (eg, biotinidase deficiency), full gene sequence C10orf2 (chromosome 10 open reading frame 2) (eg, mitochondrial DNA depletion syndrome), full gene sequence CAV3 (caveolin 3) (eg, CAV3-related distal myopathy, limb-girdle muscular dystrophy type 1C), full gene sequence CD40LG (CD40 ligand) (eg, X-linked hyper IgM syndrome), full gene sequence CDKN2A (cyclin-dependent kinase inhibitor 2A) (eg, CDKN2A-related cutaneous malignant melanoma, familial atypical mole-malignant melanoma syndrome), full gene sequence CLRN1 (clarin 1) (eg, Usher syndrome, type 3), full gene sequence COX6B1 (cytochrome c oxidase subunit VIb polypeptide 1) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence CPT2 (carnitine palmitoyltransferase 2) (eg, carnitine palmitoyltransferase II deficiency), full gene sequence CRX (cone-rod homeobox) (eg, cone-rod dystrophy 2, Leber congenital amaurosis), full	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

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	gene sequence CSTB (cystatin B [stefin B]) (eg, Unverricht-Lundborg disease), full gene sequence CYP1B1 (cytochrome P450, family 1, subfamily B, polypeptide 1) (eg, primary congenital glaucoma), full gene sequence DMPK (dystrophia myotonica-protein kinase) (eg, myotonic dystrophy type 1), characterization of abnormal (eg, expanded) alleles EGR2 (early growth response 2) (eg, Charcot-Marie-Tooth), full gene sequence EMD (emerin) (eg, Emery-Dreifuss muscular dystrophy), duplication/deletion analysis EPM2A (epilepsy, progressive myoclonus type 2A, Lafora disease [laforin]) (eg, progressive myoclonus epilepsy), full gene sequence FGF23 (fibroblast growth factor 23) (eg, hypophosphatemic rickets), full gene sequence FGFR2 (fibroblast growth factor receptor 2) (eg, craniosynostosis, Apert syndrome, Crouzon syndrome), targeted sequence analysis (eg, exons 8, 10) FGFR3 (fibroblast growth factor receptor 3) (eg, achondroplasia, hypochondroplasia), targeted sequence analysis (eg, exons 8, 11, 12, 13) FHL1 (four and a half LIM domains 1) (eg, Emery-Dreifuss muscular dystrophy), full gene sequence FKRP (fukutin related protein) (eg, congenital muscular dystrophy type 1C [MDC1C], limb-girdle muscular dystrophy [LGMD] type 2I), full gene sequence FOXP1 (forkhead box G1) (eg, Rett syndrome), full gene sequence FSHMD1A (facioscapulohumeral muscular dystrophy 1A) (eg, facioscapulohumeral muscular dystrophy), evaluation to detect abnormal (eg, deleted) alleles FSHMD1A (facioscapulohumeral muscular dystrophy 1A) (eg, facioscapulohumeral muscular dystrophy), characterization of haplotype(s) (ie, chromosome 4A and 4B haplotypes) FXN (frataxin) (eg, Friedreich ataxia), full gene sequence GH1 (growth hormone 1) (eg, growth hormone deficiency), full gene sequence GP1BB (glycoprotein Ib [platelet], beta polypeptide) (eg, Bernard-Soulier syndrome type B), full gene sequence HBA1/HBA2 (alpha globin 1 and alpha							

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	<p>globin 2) (eg, alpha thalassemia), duplication/deletion analysis (For common deletion variants of alpha globin 1 and alpha globin 2 genes, use 81257) HBB (hemoglobin, beta, Beta-Globin) (eg, thalassemia), full gene sequence HNF1B (HNF1 homeobox B) (eg, maturity-onset diabetes of the young [MODY]), duplication/deletion analysis HRAS (v-Ha-ras Harvey rat sarcoma viral oncogene homolog) (eg, Costello syndrome), full gene sequence HSD3B2 (hydroxy-delta-5-steroid dehydrogenase, 3 beta-and steroid delta-isomerase 2) (eg, 3-beta-hydroxysteroid dehydrogenase type II deficiency), full gene sequence HSD11B2 (hydroxysteroid [11-beta] dehydrogenase 2) (eg, mineralocorticoid excess syndrome), full gene sequence HSPB1 (heat shock 27kDa protein 1) (eg, Charcot-Marie-Tooth disease), full gene sequence INS (insulin) (eg, diabetes mellitus), full gene sequence KCNJ1 (potassium inwardly-rectifying channel, subfamily J, member 1) (eg, Bartter syndrome), full gene sequence KCNJ10 (potassium inwardly-rectifying channel, subfamily J, member 10) (eg, SeSAME syndrome, EAST syndrome, sensorineural hearing loss), full gene sequence LITAF (lipopolysaccharide-induced TNF factor) (eg, Charcot-Marie-Tooth), full gene sequence MEFV (Mediterranean fever) (eg, familial Mediterranean fever), full gene sequence MEN1 (multiple endocrine neoplasia I) (eg, multiple endocrine neoplasia type 1, Wermer syndrome), duplication/deletion analysis MMACHC (methylmalonic aciduria [cobalamin deficiency] cblC type, with homocystinuria) (eg, methylmalonic acidemia and homocystinuria), full gene sequence MPV17 (MpV17 mitochondrial inner membrane protein) (eg, mitochondrial DNA depletion syndrome), duplication/deletion analysis NDP (Norrie disease [pseudoglioma]) (eg, Norrie disease), full gene sequence NDUFA1 (NADH dehydrogenase [ubiquinone] 1 alpha subcomplex, 1, 7.5kDa) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence</p>							

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	NDUFAF2 (NADH dehydrogenase [ubiquinone] 1 alpha subcomplex, assembly factor 2) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NDUFS4 (NADH dehydrogenase [ubiquinone] Fe-S protein 4, 18kDa [NADH-coenzyme Q reductase]) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NIPA1 (non-imprinted in Prader-Willi/Angelman syndrome 1) (eg, spastic paraplegia), full gene sequence NLGN4X (neuroligin 4, X-linked) (eg, autism spectrum disorders), duplication/deletion analysis NPC2 (Niemann-Pick disease, type C2 [epididymal secretory protein E1]) (eg, Niemann-Pick disease type C2), full gene sequence NR0B1 (nuclear receptor subfamily 0, group B, member 1) (eg, congenital adrenal hypoplasia), full gene sequence PDX1 (pancreatic and duodenal homeobox 1) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence PHOX2B (paired-like homeobox 2b) (eg, congenital central hypoventilation syndrome), full gene sequence PIK3CA (phosphatidylinositol-4,5-bisphosphate 3-kinase, catalytic subunit alpha) (eg, colorectal cancer), targeted sequence analysis (eg, exons 9 and 20) PLP1 (proteolipid protein 1) (eg, Pelizaeus-Merzbacher disease, spastic paraplegia), duplication/deletion analysis PQBP1 (polyglutamine binding protein 1) (eg, Renpenning syndrome), duplication/deletion analysis PRNP (prion protein) (eg, genetic prion disease), full gene sequence PROP1 (PROP paired-like homeobox 1) (eg, combined pituitary hormone deficiency), full gene sequence PRPH2 (peripherin 2 [retinal degeneration, slow]) (eg, retinitis pigmentosa), full gene sequence PRSS1 (protease, serine, 1 [trypsin 1]) (eg, hereditary pancreatitis), full gene sequence RAF1 (v-raf-1 murine leukemia viral oncogene homolog 1) (eg, LEOPARD syndrome), targeted sequence analysis (eg, exons 7, 12, 14, 17) RET (ret proto-oncogene) (eg, multiple endocrine neoplasia, type 2B and familial medullary thyroid carcinoma),							

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	common variants (eg, M918T, 2647_2648delinsTT, A883F) RHO (rhodopsin) (eg, retinitis pigmentosa), full gene sequence RP1 (retinitis pigmentosa 1) (eg, retinitis pigmentosa), full gene sequence SCN1B (sodium channel, voltage-gated, type I, beta) (eg, Brugada syndrome), full gene sequence SCO2 (SCO cytochrome oxidase deficient homolog 2 [SCO1L]) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence SDHC (succinate dehydrogenase complex, subunit C, integral membrane protein, 15kDa) (eg, hereditary paraganglioma-pheochromocytoma syndrome), duplication/deletion analysis SDHD (succinate dehydrogenase complex, subunit D, integral membrane protein) (eg, hereditary paraganglioma), full gene sequence SGCG (sarcoglycan, gamma [35kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), duplication/deletion analysis SH2D1A (SH2 domain containing 1A) (eg, X-linked lymphoproliferative syndrome), full gene sequence SLC16A2 (solute carrier family 16, member 2 [thyroid hormone transporter]) (eg, specific thyroid hormone cell transporter deficiency, Allan-Herndon-Dudley syndrome), duplication/deletion analysis SLC25A20 (solute carrier family 25 [carnitine/acylcarnitine translocase], member 20) (eg, carnitine-acylcarnitine translocase deficiency), duplication/deletion analysis SLC25A4 (solute carrier family 25 [mitochondrial carrier; adenine nucleotide translocator], member 4) (eg, progressive external ophthalmoplegia), full gene sequence SOD1 (superoxide dismutase 1, soluble) (eg, amyotrophic lateral sclerosis), full gene sequence SPINK1 (serine peptidase inhibitor, Kazal type 1) (eg, hereditary pancreatitis), full gene sequence STK11 (serine/threonine kinase 11) (eg, Peutz-Jeghers syndrome), duplication/deletion analysis TACO1 (translational activator of mitochondrial encoded cytochrome c oxidase I) (eg, mitochondrial							

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	respiratory chain complex IV deficiency), full gene sequence THAP1 (THAP domain containing, apoptosis associated protein 1) (eg, torsion dystonia), full gene sequence TOR1A (torsin family 1, member A [torsin A]) (eg, torsion dystonia), full gene sequence TP53 (tumor protein 53) (eg, tumor samples), targeted sequence analysis of 2-5 exons TTPA (tocopherol [alpha] transfer protein) (eg, ataxia), full gene sequence TTR (transthyretin) (eg, familial transthyretin amyloidosis), full gene sequence TWIST1 (twist homolog 1 [Drosophila]) (eg, Saethre-Chotzen syndrome), full gene sequence TYR (tyrosinase [oculocutaneous albinism IA]) (eg, oculocutaneous albinism IA), full gene sequence USH1G (Usher syndrome 1G [autosomal recessive]) (eg, Usher syndrome, type 1), full gene sequence VHL (von Hippel-Lindau tumor suppressor) (eg, von Hippel-Lindau familial cancer syndrome), full gene sequence VWF (von Willebrand factor) (eg, von Willebrand disease type 1C), targeted sequence analysis (eg, exons 26, 27, 37) ZEB2 (zinc finger E-box binding homeobox 2) (eg, Mowat-Wilson syndrome), duplication/deletion analysis ZNF41 (zinc finger protein 41) (eg, X-linked mental retardation 89), full gene sequence							

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81405	Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons, regionally targeted cytogenomic array analysis) ABCD1 (ATP-binding cassette, sub-family D [ALD], member 1) (eg, adrenoleukodystrophy), full gene sequence ACADS (acyl-CoA dehydrogenase, C-2 to C-3 short chain) (eg, short chain acyl-CoA dehydrogenase deficiency), full gene sequence ACTA2 (actin, alpha 2, smooth muscle, aorta) (eg, thoracic aortic aneurysms and aortic dissections), full gene sequence ACTC1 (actin, alpha, cardiac muscle 1) (eg, familial hypertrophic cardiomyopathy), full gene sequence ANKRD1 (ankyrin repeat domain 1) (eg, dilated cardiomyopathy), full gene sequence APTX (aprataxin) (eg, ataxia with oculomotor apraxia 1), full gene sequence AR (androgen receptor) (eg, androgen insensitivity syndrome), full gene sequence ARSA (arylsulfatase A) (eg, arylsulfatase A deficiency), full gene sequence BCKDHA (branched chain keto acid dehydrogenase E1, alpha polypeptide) (eg, maple syrup urine disease, type 1A), full gene sequence BCS1L (BCS1-like [S. cerevisiae]) (eg, Leigh syndrome, mitochondrial complex III deficiency, GRACILE syndrome), full gene sequence BMPR2 (bone morphogenetic protein receptor, type II [serine/threonine kinase]) (eg, heritable pulmonary arterial hypertension), duplication/deletion analysis CASQ2 (calsequestrin 2 [cardiac muscle]) (eg, catecholaminergic polymorphic ventricular tachycardia), full gene sequence CASR (calcium-sensing receptor) (eg, hypocalcemia), full gene sequence CDKL5 (cyclin-dependent kinase-like 5) (eg, early infantile epileptic encephalopathy), duplication/deletion analysis CHRNA4 (cholinergic receptor, nicotinic, alpha 4) (eg, nocturnal frontal lobe epilepsy), full gene sequence CHRNB2 (cholinergic receptor,	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

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	<p>nicotinic, beta 2 [neuronal]) (eg, nocturnal frontal lobe epilepsy), full gene sequence COX10 (COX10 homolog, cytochrome c oxidase assembly protein) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence COX15 (COX15 homolog, cytochrome c oxidase assembly protein) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence CYP11B1 (cytochrome P450, family 11, subfamily B, polypeptide 1) (eg, congenital adrenal hyperplasia), full gene sequence CYP17A1 (cytochrome P450, family 17, subfamily A, polypeptide 1) (eg, congenital adrenal hyperplasia), full gene sequence CYP21A2 (cytochrome P450, family 21, subfamily A, polypeptide2) (eg, steroid 21-hydroxylase isoform, congenital adrenal hyperplasia), full gene sequence Cytogenomic constitutional targeted microarray analysis of chromosome 22q13 by interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities (When performing genome-wide cytogenomic constitutional microarray analysis, see 81228, 81229) (Do not report analyte-specific molecular pathology procedures separately when the specific analytes are included as part of the microarray analysis of chromosome 22q13) (Do not report 88271 when performing cytogenomic microarray analysis) DBT (dihydrolipoamide branched chain transacylase E2) (eg, maple syrup urine disease, type 2), duplication/deletion analysis DCX (doublecortin) (eg, X-linked lissencephaly), full gene sequence DES (desmin) (eg, myofibrillar myopathy), full gene sequence DFNB59 (deafness, autosomal recessive 59) (eg, autosomal recessive nonsyndromic hearing impairment), full gene sequence DGUOK (deoxyguanosine kinase) (eg, hepatocerebral mitochondrial DNA depletion syndrome), full gene sequence DHCR7 (7-dehydrocholesterol reductase) (eg, Smith-Lemli-Opitz syndrome), full gene sequence EIF2B2 (eukaryotic translation</p>							

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	initiation factor 2B, subunit 2 beta, 39kDa) (eg, leukoencephalopathy with vanishing white matter), full gene sequence EMD (emerin) (eg, Emery-Dreifuss muscular dystrophy), full gene sequence ENG (endoglin) (eg, hereditary hemorrhagic telangiectasia, type 1), duplication/deletion analysis EYA1 (eyes absent homolog 1 [Drosophila]) (eg, branchio-oto-renal [BOR] spectrum disorders), duplication/deletion analysis F9 (coagulation factor IX) (eg, hemophilia B), full gene sequence FGFR1 (fibroblast growth factor receptor 1) (eg, Kallmann syndrome 2), full gene sequence FH (fumarate hydratase) (eg, fumarate hydratase deficiency, hereditary leiomyomatosis with renal cell cancer), full gene sequence FKTN (fukutin) (eg, limb-girdle muscular dystrophy [LGMD] type 2M or 2L), full gene sequence FTSJ1 (FtsJ RNA methyltransferase homolog 1 [E. coli]) (eg, X-linked mental retardation 9), duplication/deletion analysis GABRG2 (gamma-aminobutyric acid [GABA] A receptor, gamma 2) (eg, generalized epilepsy with febrile seizures), full gene sequence GCH1 (GTP cyclohydrolase 1) (eg, autosomal dominant dopa-responsive dystonia), full gene sequence GDAP1 (ganglioside-induced differentiation-associated protein 1) (eg, Charcot-Marie-Tooth disease), full gene sequence GFAP (glial fibrillary acidic protein) (eg, Alexander disease), full gene sequence GHR (growth hormone receptor) (eg, Laron syndrome), full gene sequence GHRHR (growth hormone releasing hormone receptor) (eg, growth hormone deficiency), full gene sequence GLA (galactosidase, alpha) (eg, Fabry disease), full gene sequence HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, thalassemia), full gene sequence HNF1A (HNF1 homeobox A) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence HNF1B (HNF1 homeobox B) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence HTRA1 (Htra serine peptidase 1) (eg, macular degeneration), full gene							

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	sequence IDS (iduronate 2-sulfatase) (eg, mucopolysaccharidosis, type II), full gene sequence IL2RG (interleukin 2 receptor, gamma) (eg, X-linked severe combined immunodeficiency), full gene sequence ISPD (isoprenoid synthase domain containing) (eg, muscle-eye-brain disease, Walker-Warburg syndrome), full gene sequence KRAS (Kirsten rat sarcoma viral oncogene homolog) (eg, Noonan syndrome), full gene sequence LAMP2 (lysosomal-associated membrane protein 2) (eg, Danon disease), full gene sequence LDLR (low density lipoprotein receptor) (eg, familial hypercholesterolemia), duplication/deletion analysis MEN1 (multiple endocrine neoplasia I) (eg, multiple endocrine neoplasia type 1, Wermer syndrome), full gene sequence MMAA (methylmalonic aciduria [cobalamine deficiency] type A) (eg, MMAA-related methylmalonic acidemia), full gene sequence MMAB (methylmalonic aciduria [cobalamine deficiency] type B) (eg, MMAA-related methylmalonic acidemia), full gene sequence MPI (mannose phosphate isomerase) (eg, congenital disorder of glycosylation 1b), full gene sequence MPV17 (MpV17 mitochondrial inner membrane protein) (eg, mitochondrial DNA depletion syndrome), full gene sequence MPZ (myelin protein zero) (eg, Charcot-Marie-Tooth), full gene sequence MTM1 (myotubularin 1) (eg, X-linked centronuclear myopathy), duplication/deletion analysis MYL2 (myosin, light chain 2, regulatory, cardiac, slow) (eg, familial hypertrophic cardiomyopathy), full gene sequence MYL3 (myosin, light chain 3, alkali, ventricular, skeletal, slow) (eg, familial hypertrophic cardiomyopathy), full gene sequence MYOT (myotilin) (eg, limb-girdle muscular dystrophy), full gene sequence NDUFS7 (NADH dehydrogenase [ubiquinone] Fe-S protein 7, 20kDa [NADH-coenzyme Q reductase]) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NDUFS8 (NADH dehydrogenase [ubiquinone] Fe-S protein 8,							

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	23kDa [NADH-coenzyme Q reductase]) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NDUFV1 (NADH dehydrogenase [ubiquinone] flavoprotein 1, 51kDa) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NEFL (neurofilament, light polypeptide) (eg, Charcot-Marie-Tooth), full gene sequence NF2 (neurofibromin 2 [merlin]) (eg, neurofibromatosis, type 2), duplication/deletion analysis NLGN3 (neuroligin 3) (eg, autism spectrum disorders), full gene sequence NLGN4X (neuroligin 4, X-linked) (eg, autism spectrum disorders), full gene sequence NPHP1 (nephronophthisis 1 [juvenile]) (eg, Joubert syndrome), deletion analysis, and duplication analysis, if performed NPHS2 (nephrosis 2, idiopathic, steroid-resistant [podocin]) (eg, steroid-resistant nephrotic syndrome), full gene sequence NSD1 (nuclear receptor binding SET domain protein 1) (eg, Sotos syndrome), duplication/deletion analysis OTC (ornithine carbamoyltransferase) (eg, ornithine transcarbamylase deficiency), full gene sequence PAFAH1B1 (platelet-activating factor acetylhydrolase 1b, regulatory subunit 1 [45kDa]) (eg, lissencephaly, Miller-Dieker syndrome), duplication/deletion analysis PARK2 (Parkinson protein 2, E3 ubiquitin protein ligase [parkin]) (eg, Parkinson disease), duplication/deletion analysis PCCA (propionyl CoA carboxylase, alpha polypeptide) (eg, propionic acidemia, type 1), duplication/deletion analysis PCDH19 (protocadherin 19) (eg, epileptic encephalopathy), full gene sequence PDHA1 (pyruvate dehydrogenase [lipoamide] alpha 1) (eg, lactic acidosis), duplication/deletion analysis PDHB (pyruvate dehydrogenase [lipoamide] beta) (eg, lactic acidosis), full gene sequence PINK1 (PTEN induced putative kinase 1) (eg, Parkinson disease), full gene sequence PLP1 (proteolipid protein 1) (eg, Pelizaeus-Merzbacher disease, spastic paraplegia), full gene sequence POU1F1 (POU class 1 homeobox 1) (eg, combined							

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	<p>pituitary hormone deficiency), full gene sequence PRX (periaxin) (eg, Charcot-Marie-Tooth disease), full gene sequence PQBP1 (polyglutamine binding protein 1) (eg, Renpenning syndrome), full gene sequence PSEN1 (presenilin 1) (eg, Alzheimer disease), full gene sequence RAB7A (RAB7A, member RAS oncogene family) (eg, Charcot-Marie-Tooth disease), full gene sequence RAI1 (retinoic acid induced 1) (eg, Smith-Magenis syndrome), full gene sequence REEP1 (receptor accessory protein 1) (eg, spastic paraplegia), full gene sequence RET (ret proto-oncogene) (eg, multiple endocrine neoplasia, type 2A and familial medullary thyroid carcinoma), targeted sequence analysis (eg, exons 10, 11, 13-16) RPS19 (ribosomal protein S19) (eg, Diamond-Blackfan anemia), full gene sequence RRM2B (ribonucleotide reductase M2 B [TP53 inducible]) (eg, mitochondrial DNA depletion), full gene sequence SCO1 (SCO cytochrome oxidase deficient homolog 1) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence SDHB (succinate dehydrogenase complex, subunit B, iron sulfur) (eg, hereditary paraganglioma), full gene sequence SDHC (succinate dehydrogenase complex, subunit C, integral membrane protein, 15kDa) (eg, hereditary paraganglioma-pheochromocytoma syndrome), full gene sequence SGCA (sarcoglycan, alpha [50kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SGCB (sarcoglycan, beta [43kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SGCD (sarcoglycan, delta [35kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SGCE (sarcoglycan, epsilon) (eg, myoclonic dystonia), duplication/deletion analysis SGCG (sarcoglycan, gamma [35kDa dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence SHOC2 (soc-2</p>							

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	<p>suppressor of clear homolog) (eg, Noonan-like syndrome with loose anagen hair), full gene sequence SHOX (short stature homeobox) (eg, Langer mesomelic dysplasia), full gene sequence SIL1 (SIL1 homolog, endoplasmic reticulum chaperone [<i>S. cerevisiae</i>]) (eg, ataxia), full gene sequence SLC2A1 (solute carrier family 2 [facilitated glucose transporter], member 1) (eg, glucose transporter type 1 [GLUT 1] deficiency syndrome), full gene sequence SLC16A2 (solute carrier family 16, member 2 [thyroid hormone transporter]) (eg, specific thyroid hormone cell transporter deficiency, Allan-Herndon-Dudley syndrome), full gene sequence SLC22A5 (solute carrier family 22 [organic cation/carnitine transporter], member 5) (eg, systemic primary carnitine deficiency), full gene sequence SLC25A20 (solute carrier family 25 [carnitine/acylcarnitine translocase], member 20) (eg, carnitine-acylcarnitine translocase deficiency), full gene sequence SMAD4 (SMAD family member 4) (eg, hemorrhagic telangiectasia syndrome, juvenile polyposis), duplication/deletion analysis SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy), full gene sequence SPAST (spastin) (eg, spastic paraplegia), duplication/deletion analysis SPG7 (spastic paraplegia 7 [pure and complicated autosomal recessive]) (eg, spastic paraplegia), duplication/deletion analysis SPRED1 (sprouty-related, EVH1 domain containing 1) (eg, Legius syndrome), full gene sequence STAT3 (signal transducer and activator of transcription 3 [acute-phase response factor]) (eg, autosomal dominant hyper-IgE syndrome), targeted sequence analysis (eg, exons 12, 13, 14, 16, 17, 20, 21) STK11 (serine/threonine kinase 11) (eg, Peutz-Jeghers syndrome), full gene sequence SURF1 (surfeit 1) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence TARDBP (TAR DNA binding protein) (eg, amyotrophic lateral sclerosis), full gene sequence TBX5 (T-box 5) (eg, Holt-Oram</p>							

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	syndrome), full gene sequence TCF4 (transcription factor 4) (eg, Pitt-Hopkins syndrome), duplication/deletion analysis TGFBR1 (transforming growth factor, beta receptor 1) (eg, Marfan syndrome), full gene sequence TGFBR2 (transforming growth factor, beta receptor 2) (eg, Marfan syndrome), full gene sequence THRB (thyroid hormone receptor, beta) (eg, thyroid hormone resistance, thyroid hormone beta receptor deficiency), full gene sequence or targeted sequence analysis of >5 exons TK2 (thymidine kinase 2, mitochondrial) (eg, mitochondrial DNA depletion syndrome), full gene sequence TNNC1 (troponin C type 1 [slow]) (eg, hypertrophic cardiomyopathy or dilated cardiomyopathy), full gene sequence TNNI3 (troponin I, type 3 [cardiac]) (eg, familial hypertrophic cardiomyopathy), full gene sequence TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome, tumor samples), full gene sequence or targeted sequence analysis of >5 exons TPM1 (tropomyosin 1 [alpha]) (eg, familial hypertrophic cardiomyopathy), full gene sequence TSC1 (tuberous sclerosis 1) (eg, tuberous sclerosis), duplication/deletion analysis TYMP (thymidine phosphorylase) (eg, mitochondrial DNA depletion syndrome), full gene sequence VWF (von Willebrand factor) (eg, von Willebrand disease type 2N), targeted sequence analysis (eg, exons 18-20, 23-25) WT1 (Wilms tumor 1) (eg, Denys-Drash syndrome, familial Wilms tumor), full gene sequence ZEB2 (zinc finger E-box binding homeobox 2) (eg, Mowat-Wilson syndrome), full gene sequence							

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81406	Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia) ACADVL (acyl-CoA dehydrogenase, very long chain) (eg, very long chain acyl-coenzyme A dehydrogenase deficiency), full gene sequence ACTN4 (actinin, alpha 4) (eg, focal segmental glomerulosclerosis), full gene sequence AFG3L2 (AFG3 ATPase family gene 3-like 2 [S. cerevisiae]) (eg, spinocerebellar ataxia), full gene sequence AIRE (autoimmune regulator) (eg, autoimmune polyendocrinopathy syndrome type 1), full gene sequence ALDH7A1 (aldehyde dehydrogenase 7 family, member A1) (eg, pyridoxine-dependent epilepsy), full gene sequence ANO5 (anoctamin 5) (eg, limb-girdle muscular dystrophy), full gene sequence APP (amyloid beta [A4] precursor protein) (eg, Alzheimer disease), full gene sequence ASS1 (argininosuccinate synthase 1) (eg, citrullinemia type I), full gene sequence ATL1 (atlastin GTPase 1) (eg, spastic paraplegia), full gene sequence ATP1A2 (ATPase, Na ⁺ /K ⁺ transporting, alpha 2 polypeptide) (eg, familial hemiplegic migraine), full gene sequence ATP7B (ATPase, Cu ⁺⁺ transporting, beta polypeptide) (eg, Wilson disease), full gene sequence BBS1 (Bardet-Biedl syndrome 1) (eg, Bardet-Biedl syndrome), full gene sequence BBS2 (Bardet-Biedl syndrome 2) (eg, Bardet-Biedl syndrome), full gene sequence BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (eg, maple syrup urine disease, type 1B), full gene sequence BEST1 (bestrophin 1) (eg, vitelliform macular dystrophy), full gene sequence BMPR2 (bone morphogenetic protein receptor, type II [serine/threonine kinase]) (eg, heritable pulmonary arterial hypertension), full gene sequence BRAF (B-Raf proto-oncogene, serine/threonine kinase) (eg, Noonan syndrome),	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

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	full gene sequence BSCL2 (Berardinelli-Seip congenital lipodystrophy 2 [seipin]) (eg, Berardinelli-Seip congenital lipodystrophy), full gene sequence BTK (Bruton agammaglobulinemia tyrosine kinase) (eg, X-linked agammaglobulinemia), full gene sequence CACNB2 (calcium channel, voltage-dependent, beta 2 subunit) (eg, Brugada syndrome), full gene sequence CAPN3 (calpain 3) (eg, limb-girdle muscular dystrophy [LGMD] type 2A, calpainopathy), full gene sequence CBS (cystathionine-beta-synthase) (eg, homocystinuria, cystathionine beta-synthase deficiency), full gene sequence CDH1 (cadherin 1, type 1, E-cadherin [epithelial]) (eg, hereditary diffuse gastric cancer), full gene sequence CDKL5 (cyclin-dependent kinase-like 5) (eg, early infantile epileptic encephalopathy), full gene sequence CLCN1 (chloride channel 1, skeletal muscle) (eg, myotonia congenita), full gene sequence CLCNKB (chloride channel, voltage-sensitive Kb) (eg, Bartter syndrome 3 and 4b), full gene sequence CNTNAP2 (contactin-associated protein-like 2) (eg, Pitt-Hopkins-like syndrome 1), full gene sequence COL6A2 (collagen, type VI, alpha 2) (eg, collagen type VI-related disorders), duplication/deletion analysis CPT1A (carnitine palmitoyltransferase 1A [liver]) (eg, carnitine palmitoyltransferase 1A [CPT1A] deficiency), full gene sequence CRB1 (crumbs homolog 1 [Drosophila]) (eg, Leber congenital amaurosis), full gene sequence CREBBP (CREB binding protein) (eg, Rubinstein-Taybi syndrome), duplication/deletion analysis Cytogenomic microarray analysis, neoplasia (eg, interrogation of copy number, and loss-of-heterozygosity via single nucleotide polymorphism [SNP]-based comparative genomic hybridization [CGH] microarray analysis) (Do not report analyte-specific molecular pathology procedures separately when the specific analytes are included as part of the cytogenomic microarray analysis for neoplasia) (Do not report 88271 when							

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	performing cytogenomic microarray analysis) DBT (dihydrolipoamide branched chain transacylase E2) (eg, maple syrup urine disease, type 2), full gene sequence DLAT (dihydrolipoamide S-acetyltransferase) (eg, pyruvate dehydrogenase E2 deficiency), full gene sequence DLD (dihydrolipoamide dehydrogenase) (eg, maple syrup urine disease, type III), full gene sequence DSC2 (desmocollin) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 11), full gene sequence DSG2 (desmoglein 2) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 10), full gene sequence DSP (desmoplakin) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 8), full gene sequence EFHC1 (EF-hand domain [C-terminal] containing 1) (eg, juvenile myoclonic epilepsy), full gene sequence EIF2B3 (eukaryotic translation initiation factor 2B, subunit 3 gamma, 58kDa) (eg, leukoencephalopathy with vanishing white matter), full gene sequence EIF2B4 (eukaryotic translation initiation factor 2B, subunit 4 delta, 67kDa) (eg, leukoencephalopathy with vanishing white matter), full gene sequence EIF2B5 (eukaryotic translation initiation factor 2B, subunit 5 epsilon, 82kDa) (eg, childhood ataxia with central nervous system hypomyelination/vanishing white matter), full gene sequence ENG (endoglin) (eg, hereditary hemorrhagic telangiectasia, type 1), full gene sequence EYA1 (eyes absent homolog 1 [Drosophila]) (eg, branchio-oto-renal [BOR] spectrum disorders), full gene sequence F8 (coagulation factor VIII) (eg, hemophilia A), duplication/deletion analysis FAH (fumarylacetoacetate hydrolase [fumarylacetoacetase]) (eg, tyrosinemia, type 1), full gene sequence FASTKD2 (FAST kinase domains 2) (eg, mitochondrial respiratory chain complex IV deficiency), full gene sequence FIG4 (FIG4 homolog, SAC1 lipid phosphatase domain							

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	containing [<i>S. cerevisiae</i>]) (eg, Charcot-Marie-Tooth disease), full gene sequence FTSJ1 (FtsJ RNA methyltransferase homolog 1 [<i>E. coli</i>]) (eg, X-linked mental retardation 9), full gene sequence FUS (fused in sarcoma) (eg, amyotrophic lateral sclerosis), full gene sequence GAA (glucosidase, alpha; acid) (eg, glycogen storage disease type II [Pompe disease]), full gene sequence GALC (galactosylceramidase) (eg, Krabbe disease), full gene sequence GALT (galactose-1-phosphate uridylyltransferase) (eg, galactosemia), full gene sequence GARS (glycyl-tRNA synthetase) (eg, Charcot-Marie-Tooth disease), full gene sequence GCDH (glutaryl-CoA dehydrogenase) (eg, glutaricacidemia type 1), full gene sequence GCK (glucokinase [hexokinase 4]) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence GLUD1 (glutamate dehydrogenase 1) (eg, familial hyperinsulinism), full gene sequence GNE (glucosamine [UDP-N-acetyl]-2-epimerase/N-acetylmannosamine kinase) (eg, inclusion body myopathy 2 [IBM2], Nonaka myopathy), full gene sequence GRN (granulin) (eg, frontotemporal dementia), full gene sequence HADHA (hydroxyacyl-CoA dehydrogenase/3-ketoacyl-CoA thiolase/enoyl-CoA hydratase [trifunctional protein] alpha subunit) (eg, long chain acyl-coenzyme A dehydrogenase deficiency), full gene sequence HADHB (hydroxyacyl-CoA dehydrogenase/3-ketoacyl-CoA thiolase/enoyl-CoA hydratase [trifunctional protein], beta subunit) (eg, trifunctional protein deficiency), full gene sequence HEXA (hexosaminidase A, alpha polypeptide) (eg, Tay-Sachs disease), full gene sequence HLCS (HLCS holocarboxylase synthetase) (eg, holocarboxylase synthetase deficiency), full gene sequence HNF4A (hepatocyte nuclear factor 4, alpha) (eg, maturity-onset diabetes of the young [MODY]), full gene sequence IDUA (iduronidase, alpha-L-) (eg, mucopolysaccharidosis type I), full gene sequence INF2 (inverted formin, FH2 and WH2							

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	domain containing) (eg, focal segmental glomerulosclerosis), full gene sequence IVD (isovaleryl-CoA dehydrogenase) (eg, isovaleric acidemia), full gene sequence JAG1 (jagged 1) (eg, Alagille syndrome), duplication/deletion analysis JUP (junction plakoglobin) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 11), full gene sequence KAL1 (Kallmann syndrome 1 sequence) (eg, Kallmann syndrome), full gene sequence KCNH2 (potassium voltage-gated channel, subfamily H [eag-related], member 2) (eg, short QT syndrome, long QT syndrome), full gene sequence (Do not report 81406 for KCNH2 full gene sequence in conjunction with 81280) KCNQ1 (potassium voltage-gated channel, KQT-like subfamily, member 1) (eg, short QT syndrome, long QT syndrome), full gene sequence (Do not report 81406 for KCNQ1 full gene sequence with 81280) KCNQ2 (potassium voltage-gated channel, KQT-like subfamily, member 2) (eg, epileptic encephalopathy), full gene sequence LDB3 (LIM domain binding 3) (eg, familial dilated cardiomyopathy, myofibrillar myopathy), full gene sequence LDLR (low density lipoprotein receptor) (eg, familial hypercholesterolemia), full gene sequence LEPR (leptin receptor) (eg, obesity with hypogonadism), full gene sequence LHCGR (luteinizing hormone/choriogonadotropin receptor) (eg, precocious male puberty), full gene sequence LMNA (lamin A/C) (eg, Emery-Dreifuss muscular dystrophy [EDMD1, 2 and 3] limb-girdle muscular dystrophy [LGMD] type 1B, dilated cardiomyopathy [CMD1A], familial partial lipodystrophy [FPLD2]), full gene sequence LRP5 (low density lipoprotein receptor-related protein 5) (eg, osteopetrosis), full gene sequence MAP2K1 (mitogen-activated protein kinase 1) (eg, cardiofaciocutaneous syndrome), full gene sequence MAP2K2 (mitogen-activated protein kinase 2) (eg, cardiofaciocutaneous syndrome), full gene sequence MAPT (microtubule-							

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	associated protein tau) (eg, frontotemporal dementia), full gene sequence MCCC1 (methylcrotonoyl-CoA carboxylase 1 [alpha]) (eg, 3-methylcrotonyl-CoA carboxylase deficiency), full gene sequence MCCC2 (methylcrotonoyl-CoA carboxylase 2 [beta]) (eg, 3-methylcrotonyl carboxylase deficiency), full gene sequence MFN2 (mitofusin 2) (eg, Charcot-Marie-Tooth disease), full gene sequence MTM1 (myotubularin 1) (eg, X-linked centronuclear myopathy), full gene sequence MUT (methylmalonyl CoA mutase) (eg, methylmalonic acidemia), full gene sequence MUTYH (mutY homolog [E. coli]) (eg, MYH-associated polyposis), full gene sequence NDUFS1 (NADH dehydrogenase [ubiquinone] Fe-S protein 1, 75kDa [NADH-coenzyme Q reductase]) (eg, Leigh syndrome, mitochondrial complex I deficiency), full gene sequence NF2 (neurofibromin 2 [merlin]) (eg, neurofibromatosis, type 2), full gene sequence NOTCH3 (notch 3) (eg, cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy [CADASIL]), targeted sequence analysis (eg, exons 1-23) NPC1 (Niemann-Pick disease, type C1) (eg, Niemann-Pick disease), full gene sequence NPHP1 (nephronophthisis 1 [juvenile]) (eg, Joubert syndrome), full gene sequence NSD1 (nuclear receptor binding SET domain protein 1) (eg, Sotos syndrome), full gene sequence OPA1 (optic atrophy 1) (eg, optic atrophy), duplication/deletion analysis OPTN (optineurin) (eg, amyotrophic lateral sclerosis), full gene sequence PAFAH1B1 (platelet-activating factor acetylhydrolase 1b, regulatory subunit 1 [45kDa]) (eg, lissencephaly, Miller-Dieker syndrome), full gene sequence PAH (phenylalanine hydroxylase) (eg, phenylketonuria), full gene sequence PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer), full gene sequence PARK2 (Parkinson protein 2, E3 ubiquitin protein ligase [parkin]) (eg, Parkinson disease), full gene							

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	sequence PAX2 (paired box 2) (eg, renal coloboma syndrome), full gene sequence PC (pyruvate carboxylase) (eg, pyruvate carboxylase deficiency), full gene sequence PCCA (propionyl CoA carboxylase, alpha polypeptide) (eg, propionic acidemia, type 1), full gene sequence PCCB (propionyl CoA carboxylase, beta polypeptide) (eg, propionic acidemia), full gene sequence PCDH15 (protocadherin-related 15) (eg, Usher syndrome type 1F), duplication/deletion analysis PCSK9 (proprotein convertase subtilisin/kexin type 9) (eg, familial hypercholesterolemia), full gene sequence PDHA1 (pyruvate dehydrogenase [lipoamide] alpha 1) (eg, lactic acidosis), full gene sequence PDHX (pyruvate dehydrogenase complex, component X) (eg, lactic acidosis), full gene sequence PHEX (phosphate-regulating endopeptidase homolog, X-linked) (eg, hypophosphatemic rickets), full gene sequence PKD2 (polycystic kidney disease 2 [autosomal dominant]) (eg, polycystic kidney disease), full gene sequence PKP2 (plakophilin 2) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 9), full gene sequence PNKD (paroxysmal nonkinesigenic dyskinesia) (eg, paroxysmal nonkinesigenic dyskinesia), full gene sequence POLG (polymerase [DNA directed], gamma) (eg, Alpers-Huttenlocher syndrome, autosomal dominant progressive external ophthalmoplegia), full gene sequence POMGNT1 (protein O-linked mannose beta1,2-N acetylglucosaminyltransferase) (eg, muscle-eye-brain disease, Walker-Warburg syndrome), full gene sequence POMT1 (protein-O-mannosyltransferase 1) (eg, limb-girdle muscular dystrophy [LGMD] type 2K, Walker-Warburg syndrome), full gene sequence POMT2 (protein-O-mannosyltransferase 2) (eg, limb-girdle muscular dystrophy [LGMD] type 2N, Walker-Warburg syndrome), full gene sequence PRKAG2 (protein kinase, AMP-activated, gamma 2 non-catalytic subunit) (eg, familial hypertrophic							

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	cardiomyopathy with Wolff-Parkinson-White syndrome, lethal congenital glycogen storage disease of heart), full gene sequence PRKCG (protein kinase C, gamma) (eg, spinocerebellar ataxia), full gene sequence PSEN2 (presenilin 2 [Alzheimer disease 4]) (eg, Alzheimer disease), full gene sequence PTPN11 (protein tyrosine phosphatase, non-receptor type 11) (eg, Noonan syndrome, LEOPARD syndrome), full gene sequence PYGM (phosphorylase, glycogen, muscle) (eg, glycogen storage disease type V, McArdle disease), full gene sequence RAF1 (v-raf-1 murine leukemia viral oncogene homolog 1) (eg, LEOPARD syndrome), full gene sequence RET (ret proto-oncogene) (eg, Hirschsprung disease), full gene sequence RPE65 (retinal pigment epithelium-specific protein 65kDa) (eg, retinitis pigmentosa, Leber congenital amaurosis), full gene sequence RYR1 (ryanodine receptor 1, skeletal) (eg, malignant hyperthermia), targeted sequence analysis of exons with functionally-confirmed mutations SCN4A (sodium channel, voltage-gated, type IV, alpha subunit) (eg, hyperkalemic periodic paralysis), full gene sequence SCNN1A (sodium channel, nonvoltage-gated 1 alpha) (eg, pseudohypoaldosteronism), full gene sequence SCNN1B (sodium channel, nonvoltage-gated 1, beta) (eg, Liddle syndrome, pseudohypoaldosteronism), full gene sequence SCNN1G (sodium channel, nonvoltage-gated 1, gamma) (eg, Liddle syndrome, pseudohypoaldosteronism), full gene sequence SDHA (succinate dehydrogenase complex, subunit A, flavoprotein [Fp]) (eg, Leigh syndrome, mitochondrial complex II deficiency), full gene sequence SETX (senataxin) (eg, ataxia), full gene sequence SGCE (sarcoglycan, epsilon) (eg, myoclonic dystonia), full gene sequence SH3TC2 (SH3 domain and tetratricopeptide repeats 2) (eg, Charcot-Marie-Tooth disease), full gene sequence SLC9A6 (solute carrier family 9 [sodium/hydrogen exchanger], member 6) (eg, Christianson syndrome), full gene sequence							

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	SLC26A4 (solute carrier family 26, member 4) (eg, Pendred syndrome), full gene sequence SLC37A4 (solute carrier family 37 [glucose-6-phosphate transporter], member 4) (eg, glycogen storage disease type Ib), full gene sequence SMAD4 (SMAD family member 4) (eg, hemorrhagic telangiectasia syndrome, juvenile polyposis), full gene sequence SOS1 (son of sevenless homolog 1) (eg, Noonan syndrome, gingival fibromatosis), full gene sequence SPAST (spastin) (eg, spastic paraplegia), full gene sequence SPG7 (spastic paraplegia 7 [pure and complicated autosomal recessive]) (eg, spastic paraplegia), full gene sequence STXBP1 (syntaxin-binding protein 1) (eg, epileptic encephalopathy), full gene sequence TAZ (tafazzin) (eg, methylglutaconic aciduria type 2, Barth syndrome), full gene sequence TCF4 (transcription factor 4) (eg, Pitt-Hopkins syndrome), full gene sequence TH (tyrosine hydroxylase) (eg, Segawa syndrome), full gene sequence TMEM43 (transmembrane protein 43) (eg, arrhythmogenic right ventricular cardiomyopathy), full gene sequence TNNT2 (troponin T, type 2 [cardiac]) (eg, familial hypertrophic cardiomyopathy), full gene sequence TRPC6 (transient receptor potential cation channel, subfamily C, member 6) (eg, focal segmental glomerulosclerosis), full gene sequence TSC1 (tuberous sclerosis 1) (eg, tuberous sclerosis), full gene sequence TSC2 (tuberous sclerosis 2) (eg, tuberous sclerosis), duplication/deletion analysis UBE3A (ubiquitin protein ligase E3A) (eg, Angelman syndrome), full gene sequence UMOD (uromodulin) (eg, glomerulocystic kidney disease with hyperuricemia and isosthenuria), full gene sequence VWF (von Willebrand factor) (von Willebrand disease type 2A), extended targeted sequence analysis (eg, exons 11-16, 24-26, 51, 52) WAS (Wiskott-Aldrich syndrome [eczema-thrombocytopenia]) (eg, Wiskott-Aldrich syndrome), full gene sequence							

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<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
81407	Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform) ABCC8 (ATP-binding cassette, sub-family C [CFTR/MRP], member 8) (eg, familial hyperinsulinism), full gene sequence AGL (amylo-alpha-1, 6-glucosidase, 4-alpha-glucanotransferase) (eg, glycogen storage disease type III), full gene sequence AHI1 (Abelson helper integration site 1) (eg, Joubert syndrome), full gene sequence ASPM (asp [abnormal spindle] homolog, microcephaly associated [Drosophila]) (eg, primary microcephaly), full gene sequence CACNA1A (calcium channel, voltage-dependent, P/Q type, alpha 1A subunit) (eg, familial hemiplegic migraine), full gene sequence CHD7 (chromodomain helicase DNA binding protein 7) (eg, CHARGE syndrome), full gene sequence COL4A4 (collagen, type IV, alpha 4) (eg, Alport syndrome), full gene sequence COL4A5 (collagen, type IV, alpha 5) (eg, Alport syndrome), duplication/deletion analysis COL6A1 (collagen, type VI, alpha 1) (eg, collagen type VI-related disorders), full gene sequence COL6A2 (collagen, type VI, alpha 2) (eg, collagen type VI-related disorders), full gene sequence COL6A3 (collagen, type VI, alpha 3) (eg, collagen type VI-related disorders), full gene sequence CREBBP (CREB binding protein) (eg, Rubinstein-Taybi syndrome), full gene sequence F8 (coagulation factor VIII) (eg, hemophilia A), full gene sequence JAG1 (jagged 1) (eg, Alagille syndrome), full gene sequence KDM5C (lysine [K]-specific demethylase 5C) (eg, X-linked mental retardation), full gene sequence KIAA0196 (KIAA0196) (eg, spastic paraplegia), full gene sequence L1CAM (L1 cell adhesion molecule) (eg, MASA syndrome, X-linked hydrocephaly), full gene sequence LAMB2 (laminin, beta 2 [laminin	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
	S]) (eg, Pierson syndrome), full gene sequence MYBPC3 (myosin binding protein C, cardiac) (eg, familial hypertrophic cardiomyopathy), full gene sequence MYH6 (myosin, heavy chain 6, cardiac muscle, alpha) (eg, familial dilated cardiomyopathy), full gene sequence MYH7 (myosin, heavy chain 7, cardiac muscle, beta) (eg, familial hypertrophic cardiomyopathy, Liang distal myopathy), full gene sequence MYO7A (myosin VIIA) (eg, Usher syndrome, type 1), full gene sequence NOTCH1 (notch 1) (eg, aortic valve disease), full gene sequence NPHS1 (nephrosis 1, congenital, Finnish type [nephrin]) (eg, congenital Finnish nephrosis), full gene sequence OPA1 (optic atrophy 1) (eg, optic atrophy), full gene sequence PCDH15 (protocadherin-related 15) (eg, Usher syndrome, type 1), full gene sequence PKD1 (polycystic kidney disease 1 [autosomal dominant]) (eg, polycystic kidney disease), full gene sequence PLCE1 (phospholipase C, epsilon 1) (eg, nephrotic syndrome type 3), full gene sequence SCN1A (sodium channel, voltage-gated, type 1, alpha subunit) (eg, generalized epilepsy with febrile seizures), full gene sequence SCN5A (sodium channel, voltage-gated, type V, alpha subunit) (eg, familial dilated cardiomyopathy), full gene sequence SLC12A1 (solute carrier family 12 [sodium/potassium/chloride transporters], member 1) (eg, Bartter syndrome), full gene sequence SLC12A3 (solute carrier family 12 [sodium/chloride transporters], member 3) (eg, Gitelman syndrome), full gene sequence SPG11 (spastic paraplegia 11 [autosomal recessive]) (eg, spastic paraplegia), full gene sequence SPTBN2 (spectrin, beta, non-erythrocytic 2) (eg, spinocerebellar ataxia), full gene sequence TMEM67 (transmembrane protein 67) (eg, Joubert syndrome), full gene sequence TSC2 (tuberous sclerosis 2) (eg, tuberous sclerosis), full gene sequence USH1C (Usher syndrome 1C [autosomal recessive, severe]) (eg, Usher syndrome, type 1), full gene sequence VPS13B							

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	(vacuolar protein sorting 13 homolog B [yeast]) (eg, Cohen syndrome), duplication/deletion analysis WDR62 (WD repeat domain 62) (eg, primary autosomal recessive microcephaly), full gene sequence							

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81408	Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis) ABCA4 (ATP-binding cassette, sub-family A [ABC1], member 4) (eg, Stargardt disease, age-related macular degeneration), full gene sequence ATM (ataxia telangiectasia mutated) (eg, ataxia telangiectasia), full gene sequence CDH23 (cadherin-related 23) (eg, Usher syndrome, type 1), full gene sequence CEP290 (centrosomal protein 290kDa) (eg, Joubert syndrome), full gene sequence COL1A1 (collagen, type I, alpha 1) (eg, osteogenesis imperfecta, type I), full gene sequence COL1A2 (collagen, type I, alpha 2) (eg, osteogenesis imperfecta, type I), full gene sequence COL4A1 (collagen, type IV, alpha 1) (eg, brain small-vessel disease with hemorrhage), full gene sequence COL4A3 (collagen, type IV, alpha 3 [Goodpasture antigen]) (eg, Alport syndrome), full gene sequence COL4A5 (collagen, type IV, alpha 5) (eg, Alport syndrome), full gene sequence DMD (dystrophin) (eg, Duchenne/Becker muscular dystrophy), full gene sequence DYSF (dysferlin, limb girdle muscular dystrophy 2B [autosomal recessive]) (eg, limb-girdle muscular dystrophy), full gene sequence FBN1 (fibrillin 1) (eg, Marfan syndrome), full gene sequence ITPR1 (inositol 1,4,5-trisphosphate receptor, type 1) (eg, spinocerebellar ataxia), full gene sequence LAMA2 (laminin, alpha 2) (eg, congenital muscular dystrophy), full gene sequence LRRK2 (leucine-rich repeat kinase 2) (eg, Parkinson disease), full gene sequence MYH11 (myosin, heavy chain 11, smooth muscle) (eg, thoracic aortic aneurysms and aortic dissections), full gene sequence NEB (nebulin) (eg, nemaline myopathy 2), full gene sequence NF1 (neurofibromin 1) (eg, neurofibromatosis, type 1), full gene sequence PKHD1 (polycystic kidney and hepatic disease 1) (eg, autosomal recessive polycystic kidney disease), full gene sequence RYR1 (ryanodine receptor 1, skeletal)	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	<input checked="" type="checkbox"/>

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	(eg, malignant hyperthermia), full gene sequence RYR2 (ryanodine receptor 2 [cardiac]) (eg, catecholaminergic polymorphic ventricular tachycardia, arrhythmogenic right ventricular dysplasia), full gene sequence or targeted sequence analysis of > 50 exons USH2A (Usher syndrome 2A [autosomal recessive, mild]) (eg, Usher syndrome, type 2), full gene sequence VPS13B (vacuolar protein sorting 13 homolog B [yeast]) (eg, Cohen syndrome), full gene sequence VWF (von Willebrand factor) (eg, von Willebrand disease types 1 and 3), full gene sequence							
86152	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood);	Apr 2012	Cell Enumeration Circulating Tumor Cells	25	CPT 2013	October 2016	Remove from list, part of CLFS.	☑
86153	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required	Apr 2012	Cell Enumeration Circulating Tumor Cells	25	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
88363	Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)	Feb 2010	Archival Retrieval for Mutational Analysis	17	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
88375	Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session	Jan 2013	Optical Endomicroscopy	15	CPT 2014	October 2017	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
88380	Microdissection (ie, sample preparation of microscopically identified target); laser capture	Feb 2007	Manual Microdissection	12	CPT 2008	September 2011	Survey for January 2014 (added 88380 as part of the family).	☑

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88381	Microdissection (ie, sample preparation of microscopically identified target); manual	Feb 2007	Manual Microdissection	12	CPT 2008	September 2013	Survey for January 2014 (added 88380 as part of the family).	☑
88384	Code Deleted	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	☑
88385	Code Deleted	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	☑
88386	Code Deleted	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	☑
88387	Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)	Apr 2009	Tissue Examination for Molecular Studies	21	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
88388	Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (List separately in addition to code for primary procedure)	Apr 2009	Tissue Examination for Molecular Studies	21	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
90769	Code Deleted CPT 2009	Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	☑
90770	Code Deleted CPT 2009	Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	☑
90771	Code Deleted CPT 2009	Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	☑

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90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	October 2021	Review utilization in 3 years (2018) and survey if utilization has increased significantly.	<input type="checkbox"/>
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	October 2021	Review utilization in 3 years (2018) and survey if utilization has increased significantly.	<input type="checkbox"/>
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	October 2021	Review utilization in 3 years (2018) and survey if utilization has increased significantly.	<input type="checkbox"/>
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report	Apr 2012	Wireless Motility Capsule	27	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
91117	Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg, meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report	Apr 2010	Colon Motility	21	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	<input checked="" type="checkbox"/>
91200	Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report	April 2015	Liver Elastography	19	CPT 2016	October 2019		<input type="checkbox"/>
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	Apr 2010	Anterior Segment Imaging	22	CPT 2011	April 2015	Survey for October 2015. The RUC noted that it is the specialty societies decision whether 92133 and 92134 need to be surveyed with this service.	<input checked="" type="checkbox"/>

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92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	Apr 2010	Computerized Scanning Ophthalmology Diagnostic Imaging	23	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	<input checked="" type="checkbox"/>
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina	Apr 2010	Computerized Scanning Ophthalmology Diagnostic Imaging	23	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	<input checked="" type="checkbox"/>
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report	Apr 2014	Corneal Hysteresis Determination	23	CPT 2015	October 2018	Survey for January 2019.	<input type="checkbox"/>
92228	Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral	Apr 2010	Diabetic Retinopathy Imaging	24	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	<input checked="" type="checkbox"/>
93050	Arterial pressure waveform analysis for assessment of central arterial pressures, includes obtaining waveform(s), digitization and application of nonlinear mathematical transformations to determine central arterial pressures and augmentation index, with interpretation and report, upper extremity artery, non-invasive	Apr 2015	Arterial Pressure Waveform Analysis	20	CPT 2016	October 2019		<input type="checkbox"/>
93260	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; implantable subcutaneous lead defibrillator system	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	<input type="checkbox"/>

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93261	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator system	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	<input type="checkbox"/>
93279	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>
93280	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>
93281	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>

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93282	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead transvenous implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>
93283	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead transvenous implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>
93284	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead transvenous implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>
93285	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; implantable loop recorder system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>

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93286	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>
93287	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>
93288	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>
93289	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>

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93290	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>
93291	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable loop recorder system, including heart rhythm derived data analysis	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>
93292	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; wearable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>
93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>

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93294	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>
93295	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>
93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>

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93298	Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>
93299	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and establish guidelines for further RAW review of retrospective work neutrality.	<input checked="" type="checkbox"/>
93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	<input checked="" type="checkbox"/>
93463	Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed (List separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	<input checked="" type="checkbox"/>
93464	Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	<input checked="" type="checkbox"/>

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93583	Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed	Jan 2013	Percutaneous Alcohol Ablation of Septum	17	CPT 2014	October 2017	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	Jan 2016	Closure of Paravalvular Leak	22	CPT 2017	October 2020		<input type="checkbox"/>
93591	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve	Jan 2016	Closure of Paravalvular Leak	22	CPT 2017	October 2020		<input type="checkbox"/>
93592	Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)	Jan 2016	Closure of Paravalvular Leak	22	CPT 2017	October 2020		<input type="checkbox"/>
93644	Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	<input type="checkbox"/>
93982	Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report	Apr 2007	Wireless Pressure Sensor Implantation	25	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
93XX1		Jan 2018	Pulmonary Wireless Pressure Sensor Services	08	CPT 2019	October 2022		<input type="checkbox"/>
94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

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94012	Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
94013	Measurement of lung volumes (ie, functional residual capacity [FRC], forced vital capacity [FVC], and expiratory reserve volume [ERV]) in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time	Apr 2010	Sleep Testing	28	CPT 2011	October 2016	Survey for physician work and review direct practice expense inputs for April 2017. These services have continued to grow and the inclusion of the PACS workstation equipment was questioned.	<input checked="" type="checkbox"/>
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)	Apr 2010	Sleep Testing	28	CPT 2011	October 2016	Survey for physician work and review direct practice expense inputs for April 2017. These services have continued to grow and the inclusion of the PACS workstation equipment was questioned.	<input checked="" type="checkbox"/>
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	Apr 2008	Actigraphy Sleep Assessment	25	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>

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95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)	Apr 2010	Sleep Testing	28	CPT 2011	October 2016	Survey for physician work and review direct practice expense inputs for April 2017. These services have continued to grow and the inclusion of the PACS workstation equipment was questioned.	☑
95905	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report	Feb 2009	Nerve Conduction Tests	18	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
95940	Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)	Jan 2012	Intraoperative Neurophysiology Monitoring	12	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
95941	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)	Jan 2012	Intraoperative Neurophysiology Monitoring	12	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
95980	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑

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95981	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
95982	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
95X01		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X02		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X03		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X04		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X05		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X06		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X07		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X08		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X09		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X10		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X11		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>

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95X12		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X13		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X14		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X15		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X16		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X17		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X18		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X19		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X20		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X21		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X22		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
95X23		Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	CPT 2023		<input type="checkbox"/>
96020	Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or other qualified health care professional (ie, psychologist), with review of test results and report	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
96904	Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma	Feb 2006	Whole Body Integumentary Photography	19	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>

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96931	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, first lesion	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020		<input type="checkbox"/>
96932	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, first lesion	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020		<input type="checkbox"/>
96933	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, first lesion	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020		<input type="checkbox"/>
96934	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, each additional lesion (List separately in addition to code for primary procedure)	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020		<input type="checkbox"/>
96935	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition only, each additional lesion (List separately in addition to code for primary procedure)	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020		<input type="checkbox"/>
96936	Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, each additional lesion (List separately in addition to code for primary procedure)	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020		<input type="checkbox"/>
96X00		Jan 2018	Electrocorticography	18	CPT 2019	October 2022		<input type="checkbox"/>
97605	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	<input type="checkbox"/>

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97606	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	<input type="checkbox"/>
97607	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	<input type="checkbox"/>
97608	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	October 2021	In October 2018, RUC recommended to review again after 3 more years of data (2021).	<input type="checkbox"/>
97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day	Oct 2013	HCPAC - Ultrasonic Wound Assessment	17	CPT 2015	October 2018	Survey for January 2019.	<input type="checkbox"/>
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	<input checked="" type="checkbox"/>

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98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	<input checked="" type="checkbox"/>
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	<input checked="" type="checkbox"/>
990X0		Jan 2018	Chronic Care Remote Physiologic Monitoring	20	CPT 2019	October 2022		<input type="checkbox"/>
990X1		Jan 2018	Chronic Care Remote Physiologic Monitoring	20	CPT 2019	October 2022		<input type="checkbox"/>
99363	Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)	Apr 2006	Anticoagulant Management Services	I	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>

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99364	Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days of therapy (must include a minimum of 3 INR measurements)	Apr 2006	Anticoagulant Management Services	I	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	<input checked="" type="checkbox"/>
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	<input checked="" type="checkbox"/>
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	<input checked="" type="checkbox"/>
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	<input checked="" type="checkbox"/>

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99446	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	<input checked="" type="checkbox"/>
99447	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	<input checked="" type="checkbox"/>
99448	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	<input checked="" type="checkbox"/>
99449	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	<input checked="" type="checkbox"/>

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99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team.	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	October 2021		<input type="checkbox"/>
99487	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.;	Oct 2012	Complex Chronic Care Coordination Services	9	CPT 2013	October 2020	Review in 3 years (October 2020)	<input type="checkbox"/>
99488	Code Deleted	Oct 2012	Complex Chronic Care Coordination Services	09	CPT 2013	October 2017	Code Deleted	<input checked="" type="checkbox"/>

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99489	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	Oct 2012	Complex Chronic Care Coordination Services	9	CPT 2013	October 2020	Review in 3 years (October 2020)	<input type="checkbox"/>
99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.	Apr 2014	Chronic Care Management	28	CPT 2015	October 2020	Review in 3 years (October 2020)	<input type="checkbox"/>

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99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	October 2021		<input type="checkbox"/>

<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	October 2021		<input type="checkbox"/>
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	October 2021		<input type="checkbox"/>

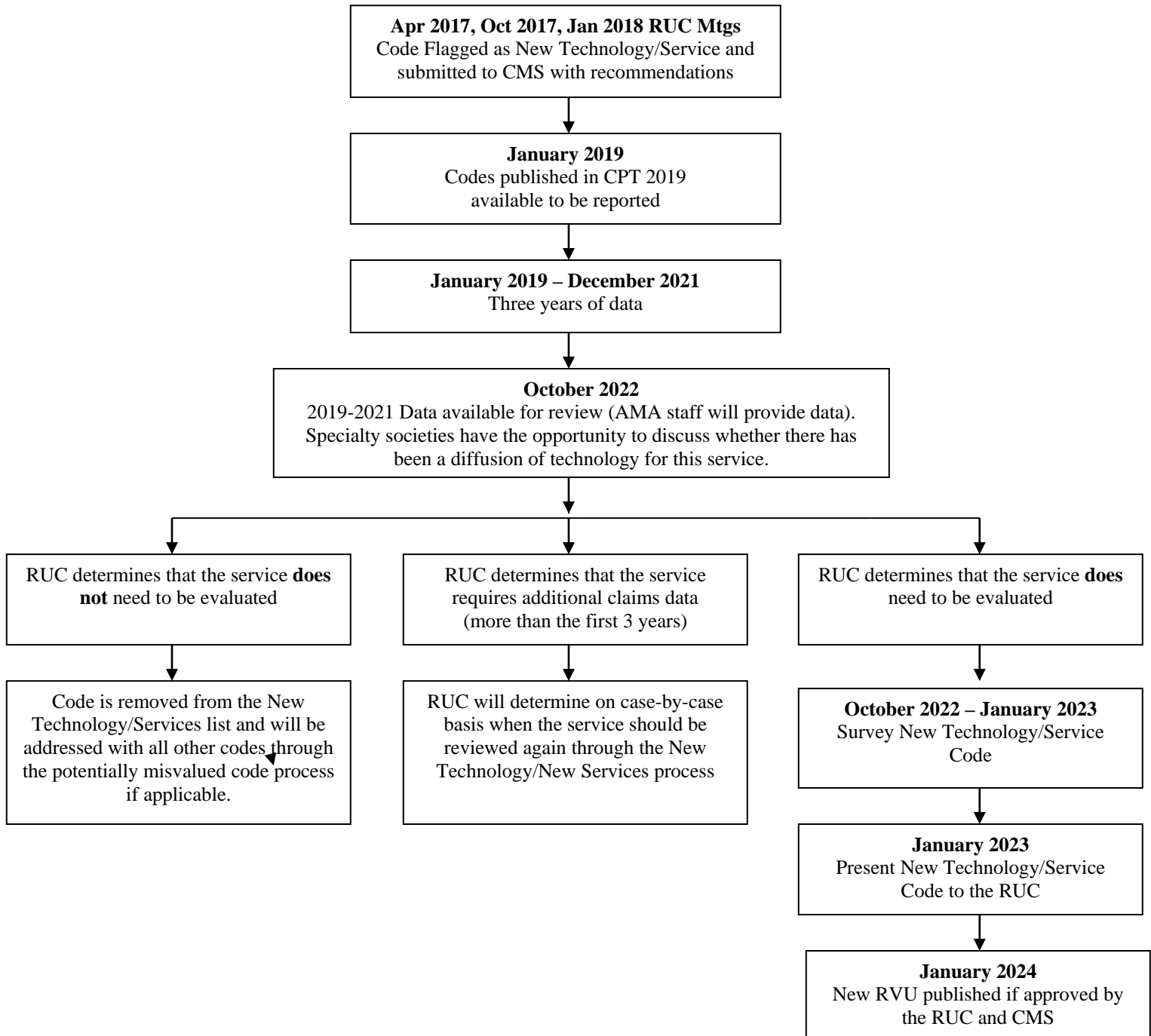
<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>Tab</i>	<i>CPT Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
99495	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient 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	Oct 2012	Transitional Care Management Services	08	CPT 2013	October 2017	Survey for October 2018	<input checked="" type="checkbox"/>
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	Oct 2012	Transitional Care Management Services	08	CPT 2013	October 2017	Survey for October 2018	<input checked="" type="checkbox"/>
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	Jan 2014	Advance Care Planning	19	CPT 2015	October 2019	Review in 2 years (October 2019)	<input type="checkbox"/>
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)	Jan 2014	Advance Care Planning	19	CPT 2015	October 2019	Review in 2 years (October 2019)	<input type="checkbox"/>
994X0		Jan 2018	Interprofessional Internet Consultation	21	CPT 2019	October 2022		<input type="checkbox"/>
994X6		Jan 2018	Interprofessional Internet Consultation	21	CPT 2019	October 2022		<input type="checkbox"/>
994X7		Apr 2017	Chronic Care Management Services	09	CPT 2019	October 2022		<input type="checkbox"/>

<i>CPT Code</i>	<i>Long Descriptor</i>	<i>RUC Meeting</i>	<i>Issue</i>	<i>CPT Tab</i>	<i>Year</i>	<i>Date to Re-Review</i>	<i>RUC Rec</i>	<i>Complete</i>
994X9		Jan 2018	Chronic Care Remote Physiologic Monitoring	20	CPT 2019	October 2022		<input type="checkbox"/>
G0445	High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes		Fecal Bacteriotherapy		CPT 2013	October 2018	The specialty societies indicated that they tried to develop a category I code to replace 44705 which is not currently covered by Medicare, but the CPT Editorial Panel did not accept the coding change proposal due to a lack in literature provided. The Workgroup recommended that these services be reviewed in 2 year after additional utilization data is available (October 2018). In October 2018, the RUC recommended to remove from list , no demonstrated technology diffusion that impacts work or practice expense.	<input checked="" type="checkbox"/>

New Technology/Services Timeline

1. Code is identified as a new technology/service at the RUC meeting in which it is initially reviewed.
2. Code is flagged in the next version of the RUC database with date to be reviewed
3. Code will be reviewed in 5 years (depending on what meeting in the CPT/RUC cycle it is initially reviewed) after at least three years of data are available.

Example



Society	Acronym
Academy of Nutrition and Dietetics	ANDi
Academy of Physicians in Clinical Research	APCR
AMDA-The Society for Post-Acute and Long-Term Care Medicine	AMDA
American Academy of Allergy, Asthma & Immunology	AAAAI
American Academy of Audiology	AAA
American Academy of Child and Adolescent Psychiatry	AACAP
American Academy of Dermatology	AAD
American Academy of Disability Evaluating Physicians	AADEP
American Academy of Facial Plastic and Reconstructive Surgery	AAFPRS
American Academy of Family Physicians	AAFP
American Academy of Hospice and Palliative Medicine	AAHPM
American Academy of Neurology	AAN
American Academy of Ophthalmology	AAO
American Academy of Orthopaedic Surgeons	AAOS
American Academy of Otolaryngic Allergy	AAOA
American Academy of Otolaryngology - Head and Neck Surgery	AAO-HNS

American Academy of Pain Medicine	AAPM
American Academy of Pediatrics	AAP
American Academy of Physical Medicine & Rehabilitation	AAPMR
American Academy of Physician Assistants	AAPA
American Academy of Sleep Medicine	AASM
American Association of Clinical Endocrinologists	AACE
American Association of Clinical Urologist, Inc.	AACU
American Association of Hip and Knee Surgeons	AAHKS
American Association of Neurological Surgeons	AANS
American Association of Neuromuscular & Electrodagnostic Medicine	AANEM
American Association of Oral and Maxillofacial Surgeons	AAOMS
American Association of Plastic Surgeons	AAPS
American Association of Thoracic Surgery	AATS
American Burn Association	ABA
American Chiropractic Association	ACA
American Clinical Neurophysiology Society	ACNS
American College of Allergy, Ashma & Immunology	ACAAI

American College of Cardiology	ACC
American College of Chest Physicians	CHEST
American College of Emergency Physicians	ACEP
American College of Gastroenterology	ACG
American College of Gastroenterology	ACG
American College of Medical Genetics	ACMG
American College of Mohs Surgery	ACMS
American College of Nuclear Medicine	ACNM
American College of Obstetricians and Gynecologists	ACOG
American College of Occupational and Environmental Medicine	ACOEM
American College of Phlebology	ACPh
American College of Physicians	ACP
American College of Preventive Medicine	ACPM
American College of Radiation Oncology	ACRO
American College of Radiology	ACR
American College of Rheumatology	ACR _h
American College of Surgeons	ACS

American Dental Association	ADA
American Gastroenterological Association	AGA
American Geriatrics Society	AGS
American Institute of Ultrasound in Medicine	AIUM
American Medical Association	AMA
American Medical Women's Association	AMWA
American Nurses Association	ANA
American Occupational Therapy Association	AOTA
American Optometric Association	AOA
American Optometric Association	AOA
American Orthopaedic Foot and Ankle Society	AOFAS
American Osteopathic Association	AOA
American Pediatric Surgical Association	APSA
American Physical Therapy Association	APTA
American Podiatric Medical Association	APMA
American Psychiatric Association	APA
American Psychological Association	APA

American Roentgen Ray Society	ARRS
American Society for Aesthetic Plastic Surgery	ASAPS
American Society for Blood and Marrow Transplantation	ASBMT
American Society for Clinical Pathology	ASCP
American Society for Clinical Pathology	ASCP
American Society for Dermatologic Surgery	ASDS
American Society for Gastrointestinal Endoscopy	ASGE
American Society for Radiation Oncology	ASTRO
American Society for Reproductive Medicine	ASRM
American Society for Surgery of the Hand	ASSH
American Society of Abdominal Surgeons	ASAS
American Society of Addiction Medicine	ASAM
American Society of Anesthesiologists	ASA
American Society of Breast Surgeons	ASBS
American Society of Cataract and Refractive Surgery	ASCRS(cat)
American Society of Clinical Oncology	ASCO
American Society of Colon and Rectal Surgeons	ASCRS(col)

American Society of Dermatopathology	ASDP
American Society of Echocardiography	ASE
American Society of General Surgeons	ASGS
American Society of General Surgeons	ASGS
American Society of Hematology	ASH
American Society of Interventional Pain Physicians	ASIPP
American Society of Maxillofacial Surgeons	ASMS
American Society of Neuroimaging	ASN
American Society of Neuroradiology	ASNR
American Society of Plastic Surgeons	ASPS
American Society of Retina Specialists	ASRS
American Society of Transplant Surgeons	ASTS
American Speech-Language-Hearing Association	ASHA
American Thoracic Society	ATS
American Urological Association	AUA
Association of University Radiologists	AUR
Centers for Medicare and Medicaid Services	CMS

Centers for Medicare and Medicaid Services	CMD
College of American Pathologists	CAP
Congress of Neurological Surgeons	CNS
Contact Lens Association of Ophthalmologists	CLAO
Heart Rhythm Society	HRS
Infectious Diseases Society of America	IDSA
International Society for the Advancement of Spine Surgery	ISASS
Medical Group Management Association	MGMA
MedPAC	MedPAC
National Association of Social Workers	NASW
North American Spine Society	NASS
Radiological Society of North America	RSNA
Renal Physicians Association	RPA
Society for Investigative Dermatology	SID
Society for Vascular Surgery	SVS
Society of American Gastrointestinal and Endoscopic Surgeons	SAGES
Society of Critical Care Medicine	SCCM

Society of Interventional Radiology	SIR
Society of Nuclear Medicine and Molecular Imaging	SNMMI
Society of Thoracic Surgeons	STS
The Endocrine Society	ES
The Society for Cardiovascular Angiography and Interventions	SCAI
The Spine Intervention Society	SIS
The Triological Society	TTS
Underseas and Hyperbaric Medical Society	UHMS

October 23, 2018

Seema Verma
Administrator
Center for Medicare
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Verma:

The RUC Health Care Professionals Advisory Committee (HCPAC) Review Board submits the enclosed recommendation to the Centers for Medicare and Medicaid Services (CMS). At the October 2018 meeting, the following issue was reviewed by the HCPAC:

- Auditory Function Evaluation (92626, 92627)

The RUC and HCPAC are fully committed to this ongoing effort to improve relativity in the work, practice expense, and professional liability insurance values. The HCPAC appreciates the opportunity to provide recommendations related to the 2020 Medicare Physician Payment Schedule. If you have any questions regarding this submission, please contact Samantha Ashley (ph: 312-464-4720; email: samantha.ashley@ama-assn.org) at the AMA for clarification regarding these recommendations.

Sincerely,



Michael D. Bishop, MD
HCPAC Chair



Dee Adams Nikjeh, PhD, CCC-SLP
HCPAC Co-Chair

cc: HCPAC Participants
Edith Hambrick, MD
Ryan Howe
Karen Nakano, MD
Marge Watchorn
Michael Soracoe

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS Request - Audiology Services / High Volume Growth

October 2018

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, 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.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Medicine Special Otorhinolaryngologic Services Evaluative and Therapeutic Services <i>Codes 92601 and 92603 describe post-operative analysis and fitting of previously placed external devices, connection to the cochlear implant, and programming of the stimulator. Codes 92602 and 92604 describe subsequent sessions for measurements and adjustment of the external transmitter and re-programming of the internal stimulator.</i> <i>(For placement of cochlear implant, use 69930)</i> 92601 <i>Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming</i>				
92626	L1	Evaluation of auditory rehabilitation status <u>function for surgically implanted device(s) candidacy or post-operative status of a surgically implanted device(s)</u> ; first hour	XXX	1.40 (No Change)
92627	L2	each additional 15 minutes (List separately in addition to code for primary procedure) <i>(Use 92627 in conjunction with 92626)</i>	ZZZ	0.33 (No Change)

		<p><i>(When reporting 92626, 92627, use the face-to-face time with the patient or family)</i></p> <p><u>(Do not report 92626, 92627 in conjunction with 92590, 92591, 92592, 92593, 92594, 92595 for hearing aid evaluation, fitting, follow-up, or selection [92590, 92591, 92592, 92593, 92594, 92595]).</u></p>		
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**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 92626 Tracking Number WW4

Original Specialty Recommended RVU: **1.40**Global Period: XXX Current Work RVU: **1.40**Presented Recommended RVU: **1.40**RUC Recommended RVU: **1.40**

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old female hearing aid user with progressive hearing loss is no longer receiving benefit from amplification. This is demonstrated by a reduced ability to understand speech in all listening environments, even with adjustments and optimization of the patient's amplification system. The patient is referred for an assessment of candidacy for an implanted hearing device.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The qualified health care professional reviews the chart for information related to the etiology of hearing loss, clinical notes regarding hearing aid or cochlear implant use, and other health issues that may influence communication and the ability to process auditory information.

Description of Intra-Service Work: The qualified health care professional takes a detailed case history with attention to history of hearing loss, incidence of familial hearing loss, and use of amplification. The electroacoustic integrity of existing hearing aids is verified prior to subsequent aided testing. The patient is seated in a sound-controlled environment with loudspeakers located at defined azimuths for controlled signal presentation and sound intensity. Speech perception of word and sentence intelligibility in a quiet environment is determined independently at varying sound intensity levels at one or more loudspeaker locations. Testing is then repeated in varying levels of background noise. The performance of each aided ear is quantified separately and then together in the binaural mode. Results of the examination are scored and interpreted based on available performance standards to determine implantation candidacy or prognosis for success and a report is prepared.

Description of Post-Service Work: The qualified health care professional describes the results to the patient and/or family/caregivers and discusses candidacy for an implant or other auditory interventions. The referring provider is notified of the test outcomes and recommendations.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Leisha R. Eiten, AuD, CCC-A; Paul M. Pessis, AuD				
Specialty Society(ies):	American Speech-Language-Hearing Association, American Academy of Audiology				
CPT Code:	92626				
Sample Size:	4000	Resp N:	71	Response: 1.7 %	
Description of Sample:	Random sample of applicable subsets; specifically, AAA and ASHA audiologists who indicated experience in cochlear implants and/or auditory rehabilitation.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	15.00	50.00	2920.00
Survey RVW:	0.40	1.20	1.50	2.00	90.00
Pre-Service Evaluation Time:			15.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	20.00	45.00	60.00	60.00	120.00
Immediate Post Service-Time:	20.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	92626	Recommended Physician Work RVU: 1.40		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	7.00	0.00	7.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	60.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	10.00	0.00	10.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92620	XXX	1.50	RUC Time

CPT Descriptor Evaluation of central auditory function, with report; initial 60 minutes

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92603	XXX	2.25	RUC Time

CPT Descriptor Diagnostic analysis of cochlear implant, age 7 years or older; with programming

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92507	XXX	1.30	RUC Time	241,336

CPT Descriptor 1 Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92540	XXX	1.50	RUC Time	94,332

CPT Descriptor 2 Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92606	XXX	1.40	RUC Time

CPT Descriptor Therapeutic service(s) for the use of non-speech-generating device, including programming and modification

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 29 % of respondents: 40.8 %

Number of respondents who choose 2nd Key Reference Code: 14 % of respondents: 19.7 %

TIME ESTIMATES (Median)

	CPT Code: <u>92626</u>	Top Key Reference CPT Code: <u>92620</u>	2nd Key Reference CPT Code: <u>92603</u>
Median Pre-Service Time	7.00	7.00	20.00
Median Intra-Service Time	60.00	60.00	82.00
Median Immediate Post-service Time	10.00	10.00	20.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	77.00	77.00	122.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	31%	48%	21%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
3%	38%	59%

Technical Skill/Physical Effort

<u>Less</u>	<u>Identical</u>	<u>More</u>
0%	55%	44%

Physical effort required	0%	86%	13%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

7%	24%	61%
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2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	14%	36%	29%	21%
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Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

14%	29%	57%
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Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	7%	57%	35%
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Physical effort required	0%	93%	7%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

29%	29%	43%
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Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT code 92626 was flagged by the Relativity Assessment Workgroup (RAW) due to unusually rapid growth in its Medicare utilization data from 2006 through 2011. The CPT Editorial Panel subsequently approved revisions to provide a more precise description of the intended use for CPT code 92626 and its add-on code 92627. *Additional background information is available at the end of the rationale.*

Survey Sample:

The survey data and recommendations are based upon a random sample of applicable subsets of the AAA and ASHA memberships. Specifically, the random sample was drawn from audiologists who indicated experience in cochlear implants and/or auditory rehabilitation. The total sample size was 4000 with 71 completed responses.

Expert Panel Recommendations:

A panel of audiologists was convened to consider the survey data and provide recommendations regarding appropriate times and professional work values, as outlined below.

We recommend **maintaining the current work RVU of 1.40 and the current times of 7 minutes (pre), 60 minutes (intra), and 10 minutes (post) for a total of 77 minutes.** We do not have compelling evidence to request increased work or times and believe the survey supports maintaining the current value.

To support this recommendation, we propose a direct crosswalk to **CPT code 92606** (Therapeutic service(s) for the use of non-speech-generating device, including programming and modification), also with a work RVU of 1.40 and a pre-service time of 7 minutes, an intra-service time of 60 minutes, and a post-service time of 10 minutes for a total of 77 minutes.

Time

The expert panel reviewed the median survey times of 15 minutes (pre), 60 minutes (intra), and 20 minutes (post) and agreed with the intra-service median of 60 minutes, which is also the current intra-service time. However, the panel recommended to decrease the pre- and post-service times to the current times. We believe the current times of 7 minutes (pre) and 10 minutes (post) are appropriate and reflect the complexity of working with patients with communication impairments. These times are also supported by the crosswalk code and key reference service.

Work RVU

The expert panel reviewed the median survey work RVU of 1.50. However, we do not have compelling evidence to support an increase in value. We believe that the current work RVU of 1.40 is appropriate and accurately reflects current practice, which has not fundamentally changed since the last review of 92626. Additionally, the recommended work RVU is supported by the key reference service, MPC codes, and direct crosswalk as outlined below.

Comparison to Other Codes

The following table outlines the key reference service, MPC, and crosswalk codes to illustrate appropriate rank order and support the requested values for time and professional work for 92626.

CPT Code	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST	Note
92557*	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	0.60	0.0210	28	3	20	5	2 nd key reference
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	1.30	0.0215	60	5	50	5	HCPAC MPC
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or post-operative status of a surgically implanted device(s); first hour	1.40	0.0170	77	7	60	10	Survey code
92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification	1.40	0.0170	77	7	60	10	Crosswalk

CPT Code	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST	Note
92540	Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording	1.50	0.0187	77	7	60	10	HCPAC MPC
92620	Evaluation of central auditory function, with report; initial 60 minutes	1.50	0.0187	77	7	60	10	1 st key reference
92603*	Diagnostic analysis of cochlear implant, age 7 years or older; with programming	2.25	0.0165	122	20	82	20	2 nd key reference

* The survey yielded a tie between CPT codes 92557 (comprehensive audiometry) and 92603 (analysis of cochlear implant) for 2nd key reference. The expert panel selected 92603 to include as the 2nd key reference on the SOR because it is a more comparable service to 92626. However, 92557 is listed in the table for additional reference.

Background

In 2013, CPT code 92626 was flagged by the Relativity Assessment Workgroup (RAW) due to unusually rapid growth in its Medicare utilization data from 2006 through 2011. In July 2014, a coding brief was published in the CPT Assistant to clarify that it was to be used to report the evaluation of the auditory function of a patient either prior to or after receiving hearing devices, auditory osseointegrated implants, middle-ear implants, and/or cochlear implant(s), or to monitor the progress of therapeutic intervention.

The RAW requested that the specialties (audiology) review CPT code 92626 three years after the 2014 publication of the CPT Assistant coding brief. The audiology specialty societies reviewed this code in 2017 and determined that utilization continued to increase despite education efforts. At the October 2017 RUC meeting, RAW agreed with the specialty societies' recommendation to bring this code back to CPT for revision to clarify its intended use. At its May 2018 meeting, the CPT Editorial Panel approved revisions to provide a more precise description of the intended use for CPT code 92626.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Although 92626 includes add-on code 92627 for each additional 15 minutes of evaluation time, Medicare data shows that 92627 is billed in addition to 92626 less than 50% of the time.
-

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92626

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Audiology How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 46809

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We used proprietary actuarial data related to commercial billing for 92626 and 2017 Medicare data to estimate total utilization.

Specialty Audiology Frequency 42610 Percentage 91.02 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 25,537

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2017 Medicare utilization data.

Specialty Audiology Frequency 23246 Percentage 91.02 %

Specialty Otolaryngology Frequency 1991 Percentage 7.79 %

Specialty Speech-language pathologist Frequency 248 Percentage 0.97 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Tests

BETOS Sub-classification:

Other tests

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 92626

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 92627	Tracking Number WW5	Original Specialty Recommended RVU: 0.33
		Presented Recommended RVU: 0.33
Global Period: ZZZ	Current Work RVU: 0.33	RUC Recommended RVU: 0.33

CPT Descriptor: 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)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old female hearing aid user with progressive hearing loss is no longer receiving benefit from amplification. This is demonstrated by a reduced ability to understand speech in all listening environments, even with adjustments and optimization of the patient's amplification system. The patient is referred for an assessment of candidacy for an implanted hearing device. The patient requires an additional 15 minutes of testing beyond the first hour.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The patient is seated in a sound-controlled environment with loudspeakers located at defined azimuths for controlled signal presentation and sound intensity. Speech perception of word and sentence intelligibility in a quiet environment is determined independently at varying sound intensity levels at one or more loudspeaker locations. Testing is then repeated in varying levels of background noise. The performance of each aided ear is quantified separately and then together in the binaural mode.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Leisha R. Eiten, AuD, CCC-A; Paul M. Pessis, AuD				
Specialty Society(ies):	American Speech-Language-Hearing Association, American Academy of Audiology				
CPT Code:	92627				
Sample Size:	4000	Resp N:	63	Response: 1.5 %	
Description of Sample:	Random sample of applicable subsets; specifically, AAA and ASHA audiologists who indicated experience in cochlear implants and/or auditory rehabilitation.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	4.00	20.00	1000.00
Survey RVW:	0.01	0.35	0.60	1.15	60.00
Pre-Service Evaluation Time:			0.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	1.00	15.00	15.00	31.00	150.00
Immediate Post Service-Time:	0.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	92627	Recommended Physician Work RVU: 0.33		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	0.00	0.00	0.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	15.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
ZZZ Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	0.00	0.00	0.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92621	ZZZ	0.35	RUC Time

CPT Descriptor Evaluation of central auditory function, with report; each additional 15 minutes (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92557	XXX	0.60	RUC Time

CPT Descriptor Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
97150	XXX	0.29	RUC Time	1,188,945

CPT Descriptor 1 Therapeutic procedure(s), group (2 or more individuals)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11045	ZZZ	0.50	RUC Time	422,398

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
90785	ZZZ	0.33	RUC Time

CPT Descriptor Interactive complexity (List separately in addition to the code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 34 **% of respondents:** 53.9 %

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 14.2 %

TIME ESTIMATES (Median)

	CPT Code: <u>92627</u>	Top Key Reference CPT Code: <u>92621</u>	2nd Key Reference CPT Code: <u>92557</u>
Median Pre-Service Time	0.00	0.00	3.00
Median Intra-Service Time	15.00	15.00	20.00
Median Immediate Post-service Time	0.00	0.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	15.00	15.00	28.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	12%	44%	35%	9%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
12%	53%	35%

Technical Skill/Physical Effort

<u>Less</u>	<u>Identical</u>	<u>More</u>
6%	59%	35%
0%	79%	21%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

12%

38%

50%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

0%

11%

78%

11%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

0%

22%

78%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

0%

22%

78%

Physical effort required

0%

78%

22%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%

33%

66%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT code 92627 is the add-on code to CPT code 92626. 92626 was flagged by the Relativity Assessment Workgroup (RAW) due to unusually rapid growth in its Medicare utilization data from 2006 through 2011. The CPT Editorial Panel subsequently approved revisions to provide a more precise description of the intended use for CPT code 92626 and its add-on code 92627. *Additional background information is available at the end of the rationale.*

Survey Sample:

The survey data and recommendations are based upon a random sample of applicable subsets of the AAA and ASHA memberships. Specifically, the random sample was drawn from audiologists who indicated experience in cochlear implants and/or auditory rehabilitation. The total sample size was 4000 with 63 completed responses.

Expert Panel Recommendations:

A panel of audiologists was convened to consider the survey data and provide recommendations regarding appropriate times and professional work values, as outlined below.

We recommend **maintaining the current work RVU of 0.33 and the median survey times of 0 minutes (pre), 15 minutes (intra), and 0 minutes (post) for a total of 15 minutes.** We do not have compelling evidence to request increased work and believe the survey supports maintaining the current value.

To support this recommendation, we propose a direct crosswalk to **CPT code 90785** (Interactive complexity [List separately in addition to the code for primary procedure]) with a work RVU of 0.33 and a pre-service time of 0 minutes, an intra-service time of 0 minutes, and a post-service time of 11 minutes for a total time of 11 minutes.

Time

The expert panel reviewed the median survey times of 0 minutes (pre), 15 minutes (intra), and 0 minutes (post) and agreed with the intra-service median of 15 minutes, which is also the current time.

Work RVU

The expert panel reviewed the median work RVU of 0.60. However, we do not have compelling evidence to support an increase in value. We believe that the current work RVU of 0.33 is appropriate and accurately reflects current practice, which has not fundamentally changed since the last review of 92627. To support this, we reviewed the RUC database for ZZZ codes. Although we were unable to find one that is a direct crosswalk for both work and time, we propose CPT code **90785** as an option. It is a ZZZ code with 0.33 work RVUs and 11 minutes of total time. We also offer CPT code **95885** as an additional comparison because it is a ZZZ code with a similar work RVU of 0.35 and the same intra-service time of 15 minutes. Finally, the recommended work RVU is supported by the key reference service and MPC codes as outlined below.

Comparison to Other Codes

The following table outlines the key reference service, MPC, and crosswalk codes to illustrate appropriate rank order and support the requested values for time and professional work for 92627.

CPT Code	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST	Note
97150	Therapeutic procedure(s), group (2 or more individuals)	0.29	0.0290	10	0	10	0	HCPAC MPC
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	0.33	0.0220	15	0	15	0	Survey code
90785	Interactive complexity (List separately in addition to code for primary procedure)	0.33	0.0000	11	0	0	11	Crosswalk
95885	Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)	0.35	0.0233	15	0	15	0	Additional comparison code
92621	Evaluation of central auditory function, with report; each additional 15 minutes (List separately in addition to code for primary procedure)	0.35	0.0233	15	0	15	0	1st key reference service

CPT Code	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST	Note
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)	0.50	0.0333	15	0	15	0	HCPAC MPC
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	0.60	0.0210	28	3	20	5	2nd key reference

Background

CPT code 92627 is the add-on code to 92626. In 2013, CPT code 92626 was flagged by the Relativity Assessment Workgroup (RAW) due to unusually rapid growth in its Medicare utilization data from 2006 through 2011. In July 2014, a coding brief was published in the CPT Assistant to clarify that it was to be used to report the evaluation of the auditory function of a patient either prior to or after receiving hearing devices, auditory osseointegrated implants, middle-ear implants, and/or cochlear implant(s), or to monitor the progress of therapeutic intervention.

The RAW requested that the specialties (audiology) review CPT code 92626 three years after the 2014 publication of the CPT Assistant coding brief. The audiology specialty societies reviewed this code in 2017 and determined that utilization continued to increase despite education efforts. At the October 2017 RUC meeting, RAW agreed with the specialty societies recommendation to bring this code back to CPT for revision to clarify its intended use. At its May 2018 meeting, the CPT Editorial Panel approved revisions to provide a more precise description of the intended use for CPT codes 92626 and 92627.

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Medicare 5% file data shows that of the 333 times reported in 2016, 92627 was billed with its base code 92626 99% of the time, 92504 (ear microscopy) 73% of the time, and 92585 (auditory evoked potentials) 56% of the time.

CPT Code	Descriptor	RVW	Global	Total Time	PRE	INTRA	POST	% billed with
92626	Evaluation of auditory rehabilitation status; first hour	1.40	XXX	77	7	60	10	99%
92504	Binocular microscopy (separate diagnostic procedure)	0.18	XXX	9	2	5	2	73%
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive	0.50	XXX	12	-	-	-	56%

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92627

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Audiology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 15324

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We used proprietary actuarial data related to commercial billing for 92627 and 2017 Medicare data to estimate total utilization.

Specialty Audiology Frequency 14554 Percentage 94.97 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 9,671

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2017 Medicare utilization data.

Specialty Audiology Frequency 9185 Percentage 94.97 %

Specialty Otolaryngology Frequency 429 Percentage 4.43 %

Specialty Speech-language pathologist Frequency 58 Percentage 0.59 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Tests

BETOS Sub-classification:

Other tests

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 92627

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

92626-92627 Rec Summary

[illegible]

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	
5	ISSUE: Excision of bone																																								
6	TAB: 84																																								
7						RVW					Total	PRE			INTRA					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged						
8	source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	
9	1st REF	11111	xyz	30	0.029			4.25			131	5	5	5			30			5	1					1.0					1										
10	2nd REF	22222	def	15	0.055			5.15			137	10	5	5			35			5						1.0					1					1					
11	CURRENT	55555	abc		0.053			5.00			133	17						27			8	1					1.0					1									
12	SVY	55555	abc	78	0.045	2.00	3.00	5.00	7.00	8.00	146	10	5	10	15	20	30	35	40	10	1					1.0					1										
13	REC	55555	abc		0.020	4.25					142	17	1	3			30			10										1	1.0	1									
14																																									
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**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor:

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

92627 each additional 15 minutes (List separately in addition to code for primary procedure)

Global Period: 92626 - XXX 92627 - ZZZ Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:
The practice expense elements were determined by a consensus panel of audiologists from different practice settings (eg, private practice, clinic, hospital-based) and geographic regions of the country.
2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:
The panel drew upon the current practice expense inputs for CPT codes 92626 and 92627.
3. Is this code(s) typically billed with an E/M service?
92626 – No 92627 – No

Is this code(s) typically billed with the E/M service in the nonfacility?
92626 – No 92627 – No
4. What specialty is the dominant provider in the nonfacility?
92626 – Audiologist 92627 – Audiologist

What percent of the time does the dominant provider provide the service(s) in the nonfacility?
92626 - 91% 92627 – 95%

Is the dominant provider in the nonfacility different then for the global?
92626 – No 92627 – No
5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: **N/A – we are not recommending clinical labor time**
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time. **N/A – we are not recommending an increase over the current aggregate cost.**
7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: **N/A**

8. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*: **N/A**
9. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. **N/A**
10. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: **N/A**
11. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. **N/A**
12. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**
13. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**
14. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:
 - **EQ285 Speakers, sound field** – highly technical
 - **EQ053 Audiometer, clinical-diagnostic** – highly technical
 - **EQ054 Audiometric soundproof booth (exam and control rooms)** – highly technical

Because the provider of the entire service is the qualified health care professional, we are using the QHP’s intra-service time to calculate the equipment time.

15. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:

92626: The consensus panel recommends removing medical supply item SA033 (kit, therapeutic toys-games), as the typical patient is no longer pediatric. The consensus panel also recommends adding medical supply items SJ053 (swab-pad, alcohol) and SM025 (specula tips, otoscope). Adding these two items does not increase the aggregate current cost, given the removal of the toy kit.

92627: The consensus panel recommends removing SA033 (kit, therapeutic toys-games). The consensus panel also recommends decreasing the number of audiology scoring forms (SK008) from 4 to 1.

See the table on page 3 for further details on each recommendation.

16. If there is any other item on your spreadsheet that needs further explanation please include here: **N/A**

17. Please include an explanation of each line item:

Recommendations for 92626

ROW	CODE	92626 (first hour)	current	REC	Rationale
MEDICAL SUPPLIES					
102	SA033	Kit, therapeutic toys-games	1	0	Remove – the typical patient has changed from pediatric to adult
103	SK008	Audiology scoring forms	4	4	Retain – forms are used to score required tests
105	SJ053	Swab-pad, alcohol	0	2	Add – required to clean the audiometric equipment
106	SM025	Specula tips, otoscope	0	1	Add – required for the otoscopic exam
EQUIPMENT					
112	EQ285	Speakers, sound field	60	60	Retain – highly technical equipment needed for duration of intraservice time.
113	EQ053	Audiometer, clinical-diagnostic	60	60	Retain – highly technical equipment needed for duration of intraservice time.
114	EQ054	Audiometric soundproof booth (exam and control rooms)	60	60	Retain – highly technical equipment needed for duration of intraservice time.

Recommendations for 92627

ROW	CODE	92627 (each additional 15 min.)	current	REC	Rationale
MEDICAL SUPPLIES					
102	SA033	Kit, therapeutic toys-games	1	0	Remove – the typical patient has changed from pediatric to adult
103	SK008	Audiology scoring forms	4	1	Decrease – 4 forms is based on 60 minutes and is too high. We divided the current input by four to reflect each additional 15 minutes
EQUIPMENT					
112	EQ285	Speakers, sound field	15	15	Retain – highly technical equipment needed for duration of intraservice time.
113	EQ053	Audiometer, clinical-diagnostic	15	15	Retain – highly technical equipment needed for duration of intraservice time.
114	EQ054	Audiometric soundproof booth (exam and control rooms)	15	15	Retain – highly technical equipment needed for duration of intraservice time.

[illegible]

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Site of Service Anomaly - 2017

October 2018

Tissue Grafting Procedures

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 IWPOT 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.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery Integumentary Other Flaps and Grafts				
<i>Code 15740 describes a cutaneous flap, transposed into a nearby but not immediately adjacent defect, with a pedicle that incorporates an anatomically named axial vessel into its design. The flap is typically transferred through a tunnel underneath the skin and sutured into its new position. The donor site is closed directly.</i>				
<i>Neurovascular pedicle procedures are reported with 15750. This code includes not only skin but also a functional motor or sensory nerve(s). The flap serves to reinnervate a damaged portion of the body dependent on touch or movement (eg, thumb).</i>				
<i>Repair of donor site requiring skin graft or local flaps should be reported as an additional procedure.</i>				
<i>For random island flaps, V-Y subcutaneous flaps, advancement flaps, and other flaps from adjacent areas without clearly defined anatomically named axial vessels, see 14000-14302.</i>				
<u>Code 15769 may be used to report autologous soft tissue grafts such as fat, dermis, fascia, or other soft tissues which are harvested from the patient using an excisional technique. The autologous soft tissue grafts are then placed into a defect during the same operation. Autologous grafts that are already defined in the CPT code set including skin, bone, nerve, tendon, fascia lata or vessels should be reported with the specific codes for each tissue type. For harvesting, preparation or injection(s) of platelet-rich plasma, use 0232T.</u>				
<u>Codes 15771, 15772, 15773, 15774 may be used to report autologous fat grafting when the adipose cells are harvested via a liposuction technique, prepared with minimal manipulation, and then injected via cannula in multiple small aliquots to the defect. The regions listed refer to the recipient area (not the donor site). Volumes are based on total injectate. For multiple sites of injection, sum the total volume of injectate to anatomic sites that are grouped together into the same code descriptor. Do not report 11950, 11951, 11952, 11954 in conjunction with 15771, 15772, 15773, 15774 for the same anatomic site.</u>				

● 15769	B1	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia) (For injection[s] of platelet-rich plasma, use 0232T)	090	6.68
● 15771	B2	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50cc or less injectate (Report 15771 only once per session)	090	6.73
✚ ● 15772	B3	each additional 50cc injectate, or part thereof (List separately in addition to code for primary procedure) (Use 15772 in conjunction with 15771)	ZZZ	2.50
● 15773	B4	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25cc or less injectate (Report 15773 only once per session)	090	6.83
✚ ● 15774	B5	each additional 25cc injectate, or part thereof (List separately in addition to code for primary procedure) (Use 15774 in conjunction with 15773)	ZZZ	2.41

		(For injection[s], autologous white blood cell concentrate [autologous protein solution], any site, including image guidance, harvesting and preparation when performed, use 0481T) (Do not report 15769, 15771, 15772, 15773, 15774 in conjunction with 15876, 15877, 15878, 15879, 0232T, 0481T, 0489T, 0490T)		
Musculoskeletal System Grafts (or Implants) Codes for obtaining autogenous bone, cartilage, tendon, fascia lata grafts, bone marrow, or other tissues through separate skin/fascial incisions should be reported separately, unless the code descriptor references the harvesting of the graft or implant (eg, including obtaining graft). <u>Autologous grafts that are already defined in the CPT code set including skin, bone, nerve, tendon, fascia lata, or vessels should be reported with the more specific codes for each tissue type. Code 15769 may be used for other autologous soft tissue grafts harvested by direct excision. See 15771, 15772, 15773, 15774 for autologous fat grafting harvested by liposuction technique.</u> <i>Do not append modifier 62 to bone graft codes 20900-20938.</i> <i>(For spinal surgery bone graft[s] see codes 20930-20938)</i> 20900 <i>Bone graft, any donor area; minor or small (eg, dowel or button)</i> 20902 <i>major or large</i> 20910 <i>Cartilage graft; costochondral</i> 20912 <i>nasal septum</i> <i>(For ear cartilage, use 21235)</i> 20920 <i>Fascia lata graft; by stripper</i> 20922 <i>by incision and area exposure, complex or sheet</i> 20924 <i>Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)</i>				
D 20926	-	Tissue grafts, other (eg, paratenon, fat, dermis) (Do not report 20926 in conjunction with 0489T, 0490T) (For harvesting of adipose tissue for autologous adipose-derived regenerative cell therapy, see 0489T, 0490T) (For injection of autologous adipose-derived regenerative cells, see 0489T, 0490T)	090	N/A (2018 work RVU = 5.79)

		<p>(For harvesting, preparation, and injection[s] of platelet-rich plasma, use 0232T)</p> <p><u>(20926 has been deleted)</u></p> <p><u>(To report autologous soft tissue grafts harvested by direct excision, use 15769)</u></p> <p><u>(To report autologous fat grafting harvested by liposuction technique, see 15771, 15772, 15773, 15774)</u></p>		
<p>Other Procedures</p> <p>15876 <i>Suction assisted lipectomy; head and neck</i></p> <p>15877 <i>trunk</i></p> <p>15878 <i>upper extremity</i></p> <p>15879 <i>lower extremity</i></p> <p><i>(Do not report 15876, 15877, 15878, 15879 in conjunction with 15771, 15772, 15773, 15774, 0489T, 0490T)</i></p> <p><i>(For harvesting of adipose tissue for autologous adipose-derived regenerative cell therapy, see 0489T, 0490T)</i></p> <p><u>(For autologous fat grafting harvested by liposuction technique, see 15771, 15772, 15773, 15774)</u></p> <p>Repair, Revision, and/or Reconstruction</p> <p>27412 <i>Autologous chondrocyte implantation, knee</i></p> <p><i>(Do not report 27412 in conjunction with <u>15769, 15771, 15772, 15773, 15774</u> 20926, 27331, 27570)</i></p> <p><i>(For harvesting of chondrocytes, use 29870)</i></p>				

Respiratory System**Nose****Repair**

(For obtaining tissues for graft, see 15769, 20900, 20902, 20910, 20912, 20920, 20922, 20924 ~~20926~~, 21210)

(For correction of nasal defects using fat harvested via liposuction technique, see 15773, 15774)

30400 *Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip*

30465 *Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)*

(30465 excludes obtaining graft. For graft procedure, see 15769, 20900, 20902, 20910, 20912, 20920, 20922, 20924 ~~20926~~, 21210)

(30465 is used to report a bilateral procedure. For unilateral procedure, use modifier 52)

Larynx**Endoscopy**

31545 *Laryngoscopy, direct, operative, with operating microscope or telescope, with submucosal removal of non-neoplastic lesion(s) of vocal cord; reconstruction with local tissue flap(s)*

31546 *reconstruction with graft(s) (includes obtaining autograft)*

(Do not report 31546 in addition to conjunction with 15769, 15771, 15772, 15773, 15774 ~~20926~~ for graft harvest)

(For reconstruction of vocal cord with allograft, use 31599)

(Do not report 31545 or 31546 in conjunction with 31540, 31541, 69990)

Eye**Ocular Adnexa****Eyelids****Repair (Brow Ptosis, Blepharoptosis, Lid****Retraction, Ectropion, Entropion)**

67911 *Correction of lid retraction*

(For obtaining ~~autogenous~~ autologous graft materials, see 15769, 20920, 20922 ~~or 20926~~)

(For correction of trichiasis by mucous membrane graft, use 67835)

(For correction of lid defects using fat harvested via liposuction technique, see 15773, 15774)

Category III Codes

0232T	<p><i>Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed</i></p> <p>(Do not report 0232T in conjunction with <u>15769, 15771, 15772, 15773, 15774</u>, 20550, 20551, 20600, 20604, 20605, 20606, 20610, 20611, 20926, 36415, 36592, 76942, 77002, 77012, 77021, 86965, 0481T)</p> <p><i>(Do not report 38220-38230 for bone marrow aspiration for platelet rich stem cell injection. For bone marrow aspiration for platelet rich stem cell injection, use 0232T)</i></p> <p><i>(0233T has been deleted. To report skin advanced glycation endproducts measurement by multi-wavelength fluorescent spectroscopy, use 88749)</i></p>
0481T	<p><i>Injection(s), autologous white blood cell concentrate (autologous protein solution), any site, including image guidance, harvesting and preparation when performed</i></p> <p>(Do not report 0481T in conjunction with <u>15769, 15771, 15772, 15773, 15774</u>, 20550, 20551, 20600, 20604, 20605, 20606, 20610, 20611, 20926, 36415, 36592, 76942, 77002, 77012, 77021, 86965, 0232T)</p> <p><i>(Do not report 38220, 38221, 38222, 38230 for bone marrow aspiration for autologous white blood cell concentrate [autologous protein solution] injection. For bone marrow aspiration for autologous white blood cell concentrate [autologous protein solution] injection, use 0481T)</i></p>
0489T	<p><i>Autologous adipose-derived regenerative cell therapy for scleroderma in the hands; adipose tissue harvesting, isolation and preparation of harvested cells including incubation with cell dissociation enzymes, removal of non-viable cells and debris, determination of concentration and dilution of regenerative cells</i></p> <p>(Do not report 0489T in conjunction with <u>15769, 15771, 15772, 15773, 15774</u>, 15876, 15877, 15878, 15879, 20600, 20604, 20926)</p>
0490T	<p><i>multiple injections in one or both hands</i></p> <p>(Do not report 0490T in conjunction with <u>15769, 15771, 15772, 15773, 15774</u>, 15876, 15877, 15878, 15879, 20600, 20604, 20926)</p> <p><i>(Do not report 0490T for a single injection)</i></p> <p><i>(For complete procedure, use 0490T in conjunction with 0489T)</i></p>

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 15769	Tracking Number	Original Specialty Recommended RVU: 6.68
		Presented Recommended RVU: 6.68
Global Period: 090	Current Work RVU:	RUC Recommended RVU: 6.68

CPT Descriptor: grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58-year-old male presents with a left sided parotid mass. The mass is excised, leaving a defect in the parotid bed. An enbloc fat graft is planned to correct the soft tissue deficiency.

Percentage of Survey Respondents who found Vignette to be Typical: 73%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 74% , In the ASC 25%, In the office 1%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 38% , Overnight stay-less than 24 hours 45% , Overnight stay-more than 24 hours 17%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 27%

Description of Pre-Service Work:

- Review NPO status
- Mark appropriate side and site of surgery.
- Review medical history. Reconcile medications and allergies.
- Review results of preadmission testing (lab, EKG, chest x-ray)
- Meet with patient and family to review planned procedure and post-operative management, including post-operative pain management and likely post-operative cosmetic and functional results.
- Check prescription drug monitoring database.
- Reexamine patient to make sure that physical findings have not changed and update H&P
- Obtain informed consent
- Review airway and medical management with anesthesiologist, including avoidance of paralysis.
- Review planned airway management and procedure with OR staff
- Verify that all required instruments and supplies are available
- Change into scrub clothes
- Monitor/assist with positioning of patient - with placement of a transverse shoulder roll to provide neck extension.
- Mark out planned incisions at recipient and donor sites
- Inject planned incision with topical vasoconstrictor and local anesthesia.
- Monitor/assist with prepping and draping
- Scrub and gown
- Perform surgical

Description of Intra-Service Work: An incision is performed followed by a meticulous dissection and preparation of the recipient bed and facial nerve identification. The margins of the previous incision are re-excised with fibrous and poorly vascularized tissue being debrided and removed. Hemostasis is obtained, and the wound is packed with wet sponges. The needed graft size is measured and planned. The donor site is carefully measured and remarked. An elliptical abdominal incision is preformed just through the epithelium. All of the epithelium is then fastidiously removed from the dermis. The elliptical incision is then performed again but the second time being through the dermis and subcutaneous tissues. A dissection deep to the subcutaneous tissues is performed. The graft is removed and set aside in saline for later

implantation. The wound is undermined and is closed primarily in three separate layers. The sponges are removed from the recipient wound and the site is reinspected. The donor abdominal dermis and fat is trimmed to fill the defect, and placed en bloc into the defect to fill the soft tissue void. The graft is then fixed in place with long-lasting absorbable sutures. A drain is brought out through a separate stab incision and is sutured in place. The wound is closed in a layered fashion.

Description of Post-Service Work: The prepped areas of the respective donor and recipient sites are cleaned. A dressing is applied to the donor site. A compression dressing is fashioned and is wrapped around the head to compress the recipient site parotid bed. Operative report is dictated. Postoperative orders are written.

Discharge Management Visit: Discharge medications are reconciled and prescriptions are written. There is a discussion with the family and patient regarding the procedure and findings. There is reiteration of the convalescence, precautions, follow up appointments, expected postoperative course, signs and symptoms of complications. Instructions, appropriate discharge timing, follow up, and precautions are discussed with the postoperative nursing team.

Post op visit 1: 99213

The patient's convalescence to that point is reviewed and discussed. The dressings from the donor and recipient sites are removed. The drain output is assessed, and the drain suture and drain are removed, if appropriate. The donor site wound is inspected and palpated. Facial nerve function and vascular status of the recipient wound are checked. Patient and family questions and concerns are addressed. Ongoing care is reiterated. A compression dressing is fashioned, and the recipient site wound is redressed and re-wrapped.

Post op visit 2: 99212

The patient's convalescence to that point is reviewed. The compression dressing from the recipient site is removed. If the drain was not removed at the initial postoperative visit, the drain output is assessed, and the drain suture and drain are removed, if appropriate. The wound is inspected and palpated. The status of the recipient wound is checked. The donor site wound is rechecked. Patient and family questions and concerns are addressed. Ongoing care is reiterated.

Post op visit 3: 99212

The patient's convalescence to that point is reviewed. The sutures from the donor and recipient sites are removed. The wounds are inspected and palpated. Patient and family questions and concerns are addressed. Long term care, strategies to maximize cosmesis, and expected outcomes are discussed in detail.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Mark Villa, MD, Jeffrey Kozlow, MD, Peter Manes, MD, Jay Shah, MD, Lance Manning, MD				
Specialty Society(ies):	American Society of Plastic Surgeons, American Academy of Otolaryngology-Head and Neck Surgery				
CPT Code:	15769				
Sample Size:	6389	Resp N:	163	Response: 2.5 %	
Description of Sample:	A random sample from membership database of plastic surgeons and ENTs.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	4.00	10.00	65.00
Survey RVW:	1.00	6.68	9.90	12.00	111.11
Pre-Service Evaluation Time:			25.00		
Pre-Service Positioning Time:			10.00		
Pre-Service Scrub, Dress, Wait Time:			10.00		
Intra-Service Time:	10.00	30.00	45.00	60.00	200.00
Immediate Post Service-Time:	15.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	19.00	99238x 0.50 99239x 0.00 99217x 0.00			
Office time/visit(s):	62.00	99211x 0.00 12x 1.00 13x 2.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	15769	Recommended Physician Work RVU: 6.68		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	25.00	33.00	-8.00	
Pre-Service Positioning Time:	3.00	3.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	10.00	15.00	-5.00	
Intra-Service Time:	45.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
9A General Anes or Complex Reg Blk/Strghtfow Proc				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	15.00	30.00	-15.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>55.00</u>	99211x 0.00	12x 2.00	13x 1.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15260	090	11.64	RUC Time

CPT Descriptor Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
21556	090	7.66	RUC Time

CPT Descriptor Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
25071	090	5.91	RUC Time	1,446

CPT Descriptor 1 Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
14060	090	9.23	RUC Time	92,863

CPT Descriptor 2 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 62 % of respondents: 38.0 %

Number of respondents who choose 2nd Key Reference Code: 24 % of respondents: 14.7 %

TIME ESTIMATES (Median)

	CPT Code: <u>15769</u>	Top Key Reference CPT Code: <u>15260</u>	2nd Key Reference CPT Code: <u>21556</u>
Median Pre-Service Time	38.00	28.00	68.00
Median Intra-Service Time	45.00	100.00	60.00
Median Immediate Post-service Time	15.00	30.00	25.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	19.00
Median Discharge Day Management Time	38.0	0.00	0.00
Median Office Visit Time	55.0	115.00	62.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	191.00	273.00	234.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	6%	50%	39%	5%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	13%	52%	35%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	11%	47%	42%
Physical effort required	5%	50%	45%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

16%

44%

40%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

29%

42%

29%

0%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

54%

25%

21%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

4%

71%

25%

Physical effort required

0%

75%

25%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

17%

46%

37%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Why is this code being reviewed?

A code change proposal was brought before the CPT Editorial Panel in May 2018 requesting modifications to the 20926 with five codes in the Integumentary section to better describe tissue grafting procedures. This was a result of the service hitting the Site of Service Anomaly Screen in 2017.

Description of Random Survey Sample

Our physician work RVU recommendation was derived by conducting a targeted random survey of AAO-HNS and ASPS members. The AAOHNS members sample focused on those with a designation of facial plastics in our database. The standard 090 global survey instrument was utilized.

Physician Time**Pre-Time**

Regarding physician time, we recommend using pre-service package 3 straightforward patient/ difficult procedure which includes 33 minutes of evaluation, 3 minutes of positioning, and 15 minutes of scrub, dress, and wait time. Our expert panel felt this package was most appropriate given that this procedure utilizes general anesthesia. We took the lesser of the package or the survey, where applicable.

Evaluation time: Our experts felt that the 25 minutes of evaluation time provided by respondents was appropriate and therefore, reduced the survey time for evaluation by 8 minutes.

Positioning time: Regarding time for positioning, our expert panel reviewed the 3 minutes of time assigned by package and felt this was sufficient for this particular procedure.

Scrub, Dress, and Wait time: Last, we recommend the survey time of 10 minute for scrub, dress, and wait.

Total Pre-Time: These modifications result in an overall pre-service time recommendation of 25/3/10, totaling 38 minutes for 15769.

Intra Time

Our expert panel agreed with our surveyees regarding the time for intra service work and are recommending the survey median time of 45 minutes for intra service work.

Immediate Post Time

Likewise, our experts felt that the survey's post time was an accurate reflection of the post time required for this procedure and are recommending the median post time of 15 minutes.

Physician Work / Compelling Evidence

We believe the above recommendation is supported by the key reference codes, as well as a robust survey response. We therefore are recommending the survey's 25th percentile value of 6.68. This is an increase in value from the existing service of 20926 which had an RVU of 5.79. We believe this is appropriate based on a change in dominant specialty. Previously, the dominant specialty was Orthopedics. Per the RUC database, this had now changed to Otolaryngology. The increase in work value is also justified given that the previous code, 20926, reflected multiple methods and approaches for obtaining grafting material, which are now better identified with greater specification in the newly created codes. This code, 15769, represents significant work and effort in the obtaining and placement of grafting material, accounting for the request for the increase in value. Our vignette and DOW represent significantly increased work and effort when compared to 20926, which served as a catch all code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 20926

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty American Society of Plastic Surgeons

How often? Sometimes

Specialty American Academy of Otolaryngology-Head and Neck Surgery

How often? Sometimes

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 6000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is three times the Medicare volume per the RUC database.

Specialty Otolaryngology	Frequency 5400	Percentage 90.00 %
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Specialty Plastic Surgery	Frequency 300	Percentage 5.00 %
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Specialty Neurosurgery	Frequency 300	Percentage 5.00 %
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,000

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty Oto	Frequency 1800	Percentage 90.00 %
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Specialty Plastic Surgeons	Frequency 100	Percentage 5.00 %
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Specialty Neurosurgeons	Frequency 100	Percentage 5.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 15770

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 15771 Tracking Number B2

Original Specialty Recommended RVU: **6.73**Presented Recommended RVU: **6.73**

Global Period: 090 Current Work RVU:

RUC Recommended RVU: **6.73**

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year-old female patient presents with a post lumpectomy defect in the superior medial pole of the breast wishes to use her own tissue to repair the concavity. Exam documents a 40 ml volumetric defect in the area of the lumpectomy. Fat grafting to the breast is requested.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 48% , In the ASC 50%, In the office 2%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 90% , Overnight stay-less than 24 hours 10% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 33%

Description of Pre-Service Work: Orders for preoperative medications are written, and laboratory results, imaging, and patient photographs, are reviewed. The planned procedure and postoperative management are reviewed with the patient and the patient's family. The patient's history and physical are updated. The operative site is marked, and the proposed areas for both graft injection and graft harvest are reviewed with the patient. Informed consent is obtained. The length and type of anesthesia are reviewed with the anesthesiologist. The availability of all required supplies and instruments are verified. The patient is transferred from the gurney and positioned on the operating room table. Bony prominences are padded, and thermal regulation drapes are applied. The position of the extremities and head is assessed and adjusted, as needed based on the multiple surgical sites and secured in the typical scenario where the patient will be sat upright during the operation. The surgeon scrubs and gowns. Both recipient and donor sites are prepared and draped with additional time often required for the multiple sites of surgery. A surgical time-out is performed with the operating surgical team.

Description of Intra-Service Work: The graft donor sites (often thighs or abdomen) are infiltrated with a liposuction wetting ("tumescence") solution. After waiting for the hemostatic effects of the epinephrine and anesthetic effects of the lidocaine, a liposuction cannula is connected to gentle sub-atmospheric pressure and used to harvest the fat and associated aspirate from the donor site soft tissues taking care to avoid the creation of soft tissue deformities. The donor incisions are closed in a layered fashion. The lipoaspirate is placed into syringes and then placed in an operating room centrifuge. After completion of the centrifuge cycle, the separated blood is then drained and the oil is wicked away from the usable fat graft. The graft is then transferred into small volume syringes. Small cannulas are then used to subcutaneously inject the fat in small aliquots to fill the soft tissue defect. This requires placement of the grafts in multiple planes and depths in order to ensure viability of the graft. The fat grafts are infiltrated into the soft tissues until the desired volumetric filling is achieved. Filling is often evaluated with the patient in an upright position on the operating room table which requires sitting the patient up. The small stab wounds are then closed primarily.

Description of Post-Service Work:

Immediate Post-Op - Sterile dressings are applied along with a post-operative compression garment to the donor site. The patient is transferred to the recovery room with signout to the recovery room nursing staff. The procedure and outcome are discussed with the patient and family. An operative note is dictated. Post-operative instructions are written and orders for discharge are completed.

Office Visits - At each visit, a discussion is held with patient including post-operative recovery concerns and patient-reported outcomes. Dressings are taken down. Donor and recipient sites are evaluated for wound infection, hematoma, edema, and soft tissue contours. Pain controlled is assessed. Sutures are removed, when appropriate. The wounds are redressed. Patient questions are answered, and instructions on wound care, activity, and bathing are reinforced. Progress notes are entered into medical record and letters to the primary care/referring physician are completed at each visit. For the first post-op visit at one week post-op, the focus of the visit is on immediate post-operative recovery and evaluation for surgical site complications. Instruction is reviewed on immediate post-operative restrictions, signs of concern, and expectations. For the second post-op visit at four weeks post-op, the focus is on residual surgical site concerns along with evaluation of significant contour deformities or fat necrosis. The relaxation of post-op restrictions is reviewed and patient expectations are addressed. The third post-op visit is at three months post-op and includes an overall evaluation of the effects of the fat grafting on the soft tissues and discussion with the patient regarding future grafting if indicated. The donor sites are also evaluated for soft tissue contour irregularities. Post-operative photographs are taken.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Mark Villa, MD, Jeffrey Kozlow, MD				
Specialty Society(ies):	American Society of Plastic Surgeons				
CPT Code:	15771				
Sample Size:	2000	Resp N:	60	Response: 3.0 %	
Description of Sample:	A random sample from membership database of those who have indicated they perform tissue grafting procedures.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	8.00	15.00	25.00	120.00
Survey RVW:	1.95	6.73	9.50	12.18	111.11
Pre-Service Evaluation Time:			30.00		
Pre-Service Positioning Time:			10.00		
Pre-Service Scrub, Dress, Wait Time:			10.00		
Intra-Service Time:	10.00	43.00	60.00	80.00	120.00
Immediate Post Service-Time:	16.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	55.00	99211x 0.00 12x 2.00 13x 1.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	15771	Recommended Physician Work RVU: 6.73		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	30.00	33.00	-3.00	
Pre-Service Positioning Time:	10.00	3.00	7.00	
Pre-Service Scrub, Dress, Wait Time:	10.00	15.00	-5.00	
Intra-Service Time:	60.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) 9A General Anes or Complex Reg Blk/Strghtforw Proc				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	16.00	30.00	-14.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>55.00</u>	99211x 0.00	12x 2.00	13x 1.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15120	090	10.15	RUC Time

CPT Descriptor 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)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
14301	090	12.65	RUC Time

CPT Descriptor Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
25076	090	6.74	RUC Time	965

CPT Descriptor 1 Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15823	090	6.81	RUC Time	94,664

CPT Descriptor 2 Blepharoplasty, upper eyelid; with excessive skin weighting down lid

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 9 % of respondents: 15.0 %

Number of respondents who choose 2nd Key Reference Code: 8 % of respondents: 13.3 %

TIME ESTIMATES (Median)

	CPT Code: <u>15771</u>	Top Key Reference CPT Code: <u>15120</u>	2nd Key Reference CPT Code: <u>14301</u>
Median Pre-Service Time	50.00	72.00	58.00
Median Intra-Service Time	60.00	75.00	100.00
Median Immediate Post-service Time	16.00	30.00	25.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	19.00	19.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	55.0	62.00	85.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	181.00	258.00	287.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	44%	44%	11%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
11%	56%	33%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	33%	22%	44%
Physical effort required	0%	22%	78%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

11%

33%

56%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

0%

13%

87%

0%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

0%

75%

25%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

25%

12%

63%

Physical effort required

0%

13%

87%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

13%

37%

50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2017, AMA Staff reviewed services with anomalous sites of service when compared to Medicare utilization data. One service was identified, CPT code 20926, in which the Medicare data from 2013-2016 indicated that it was performed less than 50% of the time in the inpatient setting yet include inpatient hospital Evaluation and Management services within the global period.

The specialty societies submitted an action plan and indicated that they believe the site of service issue is due to miscoding. The CPT manual includes a parenthetical that was added in 2011 that states (For injection(s) of platelet rich plasma, use 0232T) which resulted in some decrease in utilization for a few years, but now the utilization is creeping up again. The specialty societies believe the typical patient related to this code would be treated in a facility setting and that the site of service anomaly, for both the outpatient and the office setting is the result of miscoding.

The specialty societies 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.

After discussions, the specialty societies involved found differences in how the code was utilized. It was believed that ~1/3 of the cases represented use of a soft tissue graft harvested by an excisional technique, ~1/3 of the cases represented autologous fat grafting primarily by plastic surgeons harvested via a liposuction technique and then injected via cannula to fill soft tissue defects, and ~ 1/3 was misuse for protein rich plasma injections or other procedures. The specialty societies agreed that 20926 should be deleted and five new codes which better describe tissue grafting procedures by site and volume be created. 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 20926 and was supported by multiple specialties at the CPT panel meeting. Four additional codes, 15771-15774, were created 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:

15771 is a brand-new code and describes a procedure that was otherwise not described in CPT. The code describes new technology to perform tissue transfer that was unavailable as the time the original code was established. As such, CPT code 20926 was used while waiting to see about procedural longevity. In addition, the primary specialty for 20926 historically has been orthopedic surgery and the primary specialty for 15771 is expected to be plastic surgery.

Survey Sample and Process:

A survey request was sent to a random selection of members from the American Society of Plastic Surgeons who have indicated that they perform tissue grafting procedures.

Recommendation:

We are recommending a work RVU of 6.73, the survey 25th percentile.

Pre-time Package 3-FAC (Straightforward Patient/Difficult Procedure)

Evaluation Time – We are recommending 30 minutes of evaluation time which is a decrease of 3 minutes from the pre-service package time based on our survey median.

Positioning Time – We are recommending 10 minutes of positioning time which is an increase of 7 minutes from the pre-service package time due to the multiple sites and the need to secure arm which is supported by our median survey time.

Scrub, Dress, Wait Time – We are recommending 10 minutes of scrub, dress and wait time which is a decrease of 5 minutes from the selected pre-service package time based on our survey median.

Post-time Package 9A (General Anes or Complex Reg Blk/Straightforward Procedure)

Recommended time has been reduced to 16 minutes which is a decrease of 14 minutes from the post package time selected to match our survey time.

Key Reference Codes

CPT	DESCRIPTOR	IWPUT	RVW	TOTAL TIME	PRE	INTRA	POST	99238	99213	99212
15771	grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50cc or less injectate	0.058	6.73	193	50	60	16	0	1	2
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)	0.0679	10.15	258	72	75	30	0.5	2	1
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm	0.0698	12.65	287	58	100	25	0.5	3	1

MPC Comparison

CPT	DESCRIPTOR	IWPUT	RVW	TOTAL TIME	PRE	INTRA	POST	99238	99213	99212
25076	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm	0.0467	6.74	206	60	45	20	0.5	2	1
15771	grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50cc or less injectate	0.058	6.73	193	50	60	16	0	1	2
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	0.0722	6.81	161	16	485	10	0.5	1	3

Review of IWPUT demonstrated that 15771 is similar to both our KRC and MPC codes with a wRVU at the 25th percentile.

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 20926

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Plastic Surgeons How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 6000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Plastic Surgeons Frequency 6000 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,000

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database

Specialty Plastic Surgeons Frequency 3000 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 19318

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 15772	Tracking Number B3	Original Specialty Recommended RVU: 2.50
		Presented Recommended RVU: 2.50
Global Period: ZZZ	Current Work RVU:	RUC Recommended RVU: 2.50

CPT Descriptor: 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)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year-old female patient presents with a post lumpectomy defect in the superior medial pole of the breast wishes to use her-own tissue to repair the concavity. Exam documents a 75ml volumetric defect in the area of the lumpectomy. Fat grafting to the breast is requested.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: As an add-on code to 15X01, the additional work involved includes the additional time and effort required to harvest, prepare, and inject additional volumes of grafted fat. This includes infiltration of the donor site with a liposuction wetting (“tumescence”) solution. After waiting for hemostatic effects of the epinephrine and anesthetic effects of the lidocaine, a liposuction cannula is connected to gentle sub-atmospheric pressure and used to harvest the additional fat and associated aspirate from the donor site soft tissues taking care to avoid the creation of soft tissue deformities. The donor incisions are closed in a layered fashion. The lipoaspirate is placed into syringes and then placed in an operating room centrifuge. Each centrifuge is able to hold six syringes which results in an average of 50cc of additional usable fat graft. After completion of the centrifuge cycle, the separated blood is then drained and the oil is wicked away from the usable fat graft. The graft is then transferred into small volume syringes. Small cannulas are then used to subcutaneously inject the fat in small aliquots to fill the soft tissue defect. This requires placement of the grafts in multiple planes and depths in order to ensure viability of the graft. The fat grafts are infiltrated into the soft tissues until the desired volumetric filling is achieved. Filling is often evaluated with the patient in an upright position on the operating room table which requires sitting the patient up.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Mark Villa, MD, Jeffrey Kozlow, MD				
Specialty Society(ies):	American Society of Plastic Surgeons				
CPT Code:	15772				
Sample Size:	2000	Resp N:	60	Response: 3.0 %	
Description of Sample:	A random sample from membership database who have indicated they perform tissue grafting procedures.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	6.00	12.00	28.00	100.00
Survey RVW:	0.80	2.50	3.55	9.59	111.11
Pre-Service Evaluation Time:			0.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	2.00	22.00	45.00	76.00	150.00
Immediate Post Service-Time:	0.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	15772	Recommended Physician Work RVU: 2.50		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	0.00	0.00	0.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	45.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) ZZZ Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	0.00	0.00	0.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15121	<u>ZZZ</u>	2.00	<u>RUC Time</u>

CPT Descriptor 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)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
14302	<u>ZZZ</u>	3.73	<u>RUC Time</u>

CPT Descriptor 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)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
37253	<u>ZZZ</u>	1.44	<u>RUC Time</u>	38,310

CPT Descriptor 1 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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36476	<u>ZZZ</u>	2.65	<u>RUC Time</u>	9,885

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99292	<u>ZZZ</u>	2.25	<u>RUC Time</u>

CPT Descriptor Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 17 % of respondents: 28.3 %

Number of respondents who choose 2nd Key Reference Code: 14 % of respondents: 23.3 %

TIME ESTIMATES (Median)

	CPT Code: <u>15772</u>	Top Key Reference CPT Code: <u>15121</u>	2nd Key Reference CPT Code: <u>14302</u>
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	45.00	30.00	40.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	45.00	30.00	40.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	6%	65%	29%	0%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	23%	65%	12%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	12%	70%	18%
Physical effort required	6%	47%	47%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	18%	47%	35%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	7%	50%	29%	14%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	7%	57%	36%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	28%	28%	43%
Physical effort required	14%	29%	57%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	14%	43%	43%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2017, AMA Staff reviewed services with anomalous sites of service when compared to Medicare utilization data. One service was identified, CPT code 20926, in which the Medicare data from 2013-2016 indicated that it was performed less than 50% of the time in the inpatient setting yet include inpatient hospital Evaluation and Management services within the global period.

The specialty societies submitted an action plan and indicated that they believe the site of service issue is due to miscoding. The CPT manual includes a parenthetical that was added in 2011 that states (For injection(s) of platelet rich plasma, use 0232T) which resulted in some decrease in utilization for a few years, but now the utilization is creeping up again. The specialty societies believe the typical patient related to this code would be treated in a facility setting and that the site of service anomaly, for both the outpatient and the office setting is the result of miscoding.

The specialty societies 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.

After discussions, the specialty societies involved found differences in how the code was utilized. It was believed that ~1/3 of the cases represented use of a soft tissue graft harvested by an excisional technique, ~1/3 of the cases represented autologous fat grafting primarily by plastic surgeons harvested via a liposuction technique and then injected via cannula to fill soft tissue defects, and ~ 1/3 was misuse for protein rich plasma injections or other procedures. The specialty societies agreed that 20926 should be deleted and five new codes which better describe tissue grafting procedures by site and volume be created. 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 20926 and was supported by multiple specialties at the CPT panel meeting. Four additional codes, 15771-15774, were created 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. 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.

Compelling Evidence:

15772 is a brand-new add-on code and describes a procedure that was otherwise not described in CPT. The code describes a new technology to perform tissue transfer that was unavailable at the time the original code was established. As such, CPT code 20926 was used while waiting to see about procedural longevity. In addition, the primary specialty for 20926 historically has been orthopedic surgery and the primary specialty for 15772 is expected to be plastic surgery.

Survey Sample and Process:

A survey request was sent to a random selection of members from the American Society of Plastic Surgeons who have indicated that they perform tissue grafting procedures.

Recommendation:

We are recommending a work RVU of 2.50, the survey 25th percentile.

Key Reference Codes

CPT	DESCRIPTOR	IWPUT	RVW	TOTAL TIME	PRE	INTRA	POST	99238	99213	99212
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)	0.056	2.50	45	0	45	0	0	0	0
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)	0.0667	2.00	30	0	30	0	0	0	0
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)	0.0933	3.73	40	0	40	0	0	0	0

MPC Comparison

CPT	DESCRIPTOR	IWPUT	RVW	TOTAL TIME	PRE	INTRA	POST	99238	99213	99212
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)	0.0709	1.44	21	0	20	1	0	0	0
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)	0.056	2.50	45	0	45	0	0	0	0
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)	0.0883	2.65	30	0	30	0	0	0	0

Review of IWPUT demonstrated that 157712 is similar to both our KRC and MPC codes with a wRVU at the 25th percentile.

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 15777

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 15773 Tracking Number B4

Original Specialty Recommended RVU: **6.83**Presented Recommended RVU: **6.83**

Global Period: 090 Current Work RVU:

RUC Recommended RVU: **6.83**

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60 year-old male patient presented 15 years after radical local excision of a rhabdomyosarcoma of his left masseter followed by irradiation. Exam shows a 20 ml volumetric soft tissue defect on left jaw at the previous surgical site.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 45% , In the ASC 47%, In the office 7%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 96% , Overnight stay-less than 24 hours 4% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Orders for preoperative medications are written, and laboratory results, imaging, and patient photographs, are reviewed. The planned procedure and postoperative management are reviewed with the patient and the patient's family. The patient's history and physical are updated. The operative site is marked, and the proposed areas for both graft injection and graft harvest are reviewed with the patient. Informed consent is obtained. The length and type of anesthesia are reviewed with the anesthesiologist. The availability of all required supplies and instruments are verified. The patient is transferred from the gurney and positioned on the operating room table. Bony prominences are padded, and thermal regulation drapes are applied. The position of the extremities and head is assessed and adjusted, as needed based on the multiple surgical sites and secured in the typical scenario where the patient will be sat upright during the operation. The surgeon scrubs and gowns. Both recipient and donor sites are prepared and draped with additional time often required for the multiple sites of surgery. Protective corneal shields are placed. A surgical time-out is performed with the operating surgical team.

Description of Intra-Service Work: The patient is brought back to the operating room. Both the face and the abdominal donor site are prepped. The abdominal donor site is infiltrated with a liposuction wetting ("tumescent") solution. A liposuction cannula is connected to gentle sub-atmospheric pressure and used to harvest the fat and associated aspirate from the abdominal soft tissue. The donor incisions are closed. The lipoaspirate is placed into syringes and then placed in an operating room centrifuge. The separate blood is then drained and the oil is wicked away from the usable fat graft. The graft is then transferred into small volume syringes. Small cannulas are then used to subcutaneously inject the fat in small aliquots to fill the soft tissue defect. This requires placement of the grafts in multiple planes and depths in order to ensure viability of the graft. The small stab wounds are then closed primarily.

Description of Post-Service Work:

Immediate Post-Op - Sterile dressings are applied along with a post-operative compression garment to the donor site. The patient is transferred to the recovery room with signout to the recovery room nursing staff. The procedure and outcome are discussed with the patient and family. An operative note is dictated. Post-operative instructions are written and orders for discharge are completed.

Office Visits - At each visit, a discussion is held with patient including post-operative recovery concerns and patient-reported outcomes. Dressings are taken down. Donor and recipient sites are evaluated for wound infection, hematoma, edema, and soft tissue contours. Pain controlled is assessed. Sutures are removed, when appropriate. The wounds are redressed. Patient questions are answered, and instructions on wound care, activity, and bathing are reinforced. Progress notes are entered into medical record and letters to the primary care/referring physician are completed at each visit. For the first post-op visit at one week post-op, the focus of the visit is on immediate post-operative recovery and evaluation for surgical site complications. Instruction is reviewed on immediate post-operative restrictions, signs of concern, and expectations. For the second post-op visit at four weeks post-op, the focus is on residual surgical site concerns along with evaluation of significant contour deformities or fat necrosis. The relaxation of post-op restrictions is reviewed and patient expectations are addressed. The third post-op visit is at three months post-op and includes and overall evaluation of the effects of the fat grafting on the soft tissues and discussion with the patient regarding future grafting if indicated. The donor sites are also evaluated for soft tissue contour irregularities. Post-operative photographs are taken.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Mark Villa, MD, Jeffrey Kozlow, MD				
Specialty Society(ies):	American Society of Plastic Surgeons				
CPT Code:	15773				
Sample Size:	2000	Resp N:	55	Response: 2.7 %	
Description of Sample:	A random sample from membership database of those who indicated they perform tissue grafting procedures.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	8.00	15.00	213.00
Survey RVW:	2.25	6.83	10.00	12.08	111.11
Pre-Service Evaluation Time:			30.00		
Pre-Service Positioning Time:			10.00		
Pre-Service Scrub, Dress, Wait Time:			10.00		
Intra-Service Time:	10.00	45.00	60.00	90.00	150.00
Immediate Post Service-Time:	15.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	55.00	99211x 0.00 12x 2.00 13x 1.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	15773	Recommended Physician Work RVU: 6.83		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	30.00	33.00	-3.00	
Pre-Service Positioning Time:	10.00	3.00	7.00	
Pre-Service Scrub, Dress, Wait Time:	10.00	15.00	-5.00	
Intra-Service Time:	60.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) 9A General Anes or Complex Reg Blk/Strghtforw Proc				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	15.00	30.00	-15.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>55.00</u>	99211x 0.00	12x 2.00	13x 1.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15823	090	6.81	RUC Time

CPT Descriptor Blepharoplasty, upper eyelid; with excessive skin weighting down lid**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15120	090	10.15	RUC Time

CPT Descriptor 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)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
25076	090	6.74	RUC Time	965

CPT Descriptor 1 Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
26615	090	7.07	RUC Time	2,132

CPT Descriptor 2 Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 12 % of respondents: 21.8 %

Number of respondents who choose 2nd Key Reference Code: 8 % of respondents: 14.5 %

TIME ESTIMATES (Median)

	CPT Code: <u>15773</u>	Top Key Reference CPT Code: <u>15823</u>	2nd Key Reference CPT Code: <u>15120</u>
Median Pre-Service Time	50.00	16.00	72.00
Median Intra-Service Time	60.00	45.00	75.00
Median Immediate Post-service Time	15.00	10.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	19.00	19.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	55.0	71.00	62.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	180.00	161.00	258.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	17%	42%	42%	0%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
17%	58%	25%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	42%	33%	25%
Physical effort required	0%	33%	67%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

33%

42%

25%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

0%

50%

50%

0%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

25%

50%

25%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

25%

63%

12%

Physical effort required

0%

63%

37%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

25%

25%

50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2017, AMA Staff reviewed services with anomalous sites of service when compared to Medicare utilization data. One service was identified, CPT code 20926, in which the Medicare data from 2013-2016 indicated that it was performed less than 50% of the time in the inpatient setting yet include inpatient hospital Evaluation and Management services within the global period.

The specialty societies submitted an action plan and indicated that they believe the site of service issue is due to miscoding. The CPT manual includes a parenthetical that was added in 2011 that states (For injection(s) of platelet rich plasma, use 0232T) which resulted in some decrease in utilization for a few years, but now the utilization is creeping up again. The specialty societies believe the typical patient related to this code would be treated in a facility setting and that the site of service anomaly, for both the outpatient and the office setting is the result of miscoding.

The specialty societies 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.

After discussions, the specialty societies involved found differences in how the code was utilized. It was believed that ~1/3 of the cases represented use of a soft tissue graft harvested by an excisional technique, ~1/3 of the cases represented autologous fat grafting primarily by plastic surgeons harvested via a liposuction technique and then injected via cannula to fill soft tissue defects, and ~ 1/3 was misuse for protein rich plasma injections or other procedures. The specialty societies agreed that 20926 should be deleted and five new codes which better describe tissue grafting procedures by site and volume be created. 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 20926 and was supported by multiple specialties at the CPT panel meeting. Four additional codes, 15771-15774, were created 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. 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.

Compelling Evidence:

15773 is a brand-new code and describes a procedure that was otherwise not described in CPT. The code describes a new technology to perform tissue transfer that was unavailable at the time the original code was established. As such, CPT code 20926 was used while waiting to see about procedural longevity. In addition, the primary specialty for 20926 historically has been orthopedic surgery and the primary specialty for 15773 is expected to be plastic surgery.

Survey Sample:

A survey request was sent to a random sample of members from the American Society of Plastic Surgeons who have indicated that they perform tissue grafting procedures.

Recommendation:

We are recommending a work RVU of 6.83, which is the 25th percentile of the survey.

Pre-time Package 3-FAC (Straightforward Patient/Difficult Procedure)

Evaluation Time – We are recommending 30 minutes of evaluation time which is a decrease of 3 minutes from the pre-service package time based on our survey.

Positioning Time – We are recommending 10 minutes of positioning time which is an increase of 7 minutes from the pre-service package time due to the multiple sites and the need to secure arms. This time is supported by our survey.

Scrub, Dress, Wait Time – We are recommending 10 minutes of scrub, dress and wait time which is a decrease of 5 minutes from the selected pre-service package time based on our survey response.

Post-time Package 9A (General Anes or Complex Reg Blk/Straightforward Procedure)

Recommended time has been reduced to 15 minutes which is a decrease of 15 minutes from the post package time selected based on our survey responses.

Key Reference Codes

CPT	DESCRIPTOR	IWPUT	RVW	TOTAL TIME	PRE	INTRA	POST	99238	99213	99212
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	0.060	6.83	193	50	60	15	0	1	2
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid	0.0722	6.81	161	16	45	10	0.5	1	3
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)	0.0679	10.15	258	72	75	30	0.5	2	1

MPC Comparison

CPT	DESCRIPTOR	IWPUT	RVW	TOTAL TIME	PRE	INTRA	POST	99238	99213	99212
25076	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm	0.0467	6.74	206	60	45	20	0.5	2	1
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	0.060	6.83	193	50	60	15	0	1	2
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone	0.0443	7.07	217	55	45	20	0.5	2	2

Review of IWPUT demonstrated that 15773 is similar to both our KRC and MPC codes with a wRVU at the 25th percentile.

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 20926

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Plastic Surgeons How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 6,000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Plastic Surgeons Frequency 6000 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,000

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC Database

Specialty Plastic Surgeons Frequency 3000 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 19318

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 15774	Tracking Number	Original Specialty Recommended RVU: 2.41
		Presented Recommended RVU: 2.41
Global Period: ZZZ	Current Work RVU:	RUC Recommended RVU: 2.41

CPT Descriptor: 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)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60 year-old male patient presented 15 years after radical local excision of a rhabdomyosarcoma of his left masseter followed by irradiation. Exam shows a 40 ml volumetric soft tissue defect on left jaw at the previous surgical site.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: As an add-on code to 15X03, the additional work involved includes the additional time and effort required to harvest, prepare, and inject additional volumes of grafted fat. This includes infiltration of the donor site with a liposuction wetting ("tumescent") solution. After waiting for hemostatic effects of the epinephrine and anesthetic effects of the lidocaine, a liposuction cannula is connected to gentle sub-atmospheric pressure and used to harvest the additional fat and associated aspirate from the donor site soft tissues taking care to avoid the creation of soft tissue deformities. The donor incisions are closed in a layered fashion. The lipoaspirate is placed into syringes and then placed in an operating room centrifuge. Each centrifuge is able to hold six syringes which results in an average of 50cc of additional usable fat graft. After completion of the centrifuge cycle, the separated blood is then drained and the oil is wicked away from the usable fat graft. The graft is then transferred into small volume syringes. Small cannulas are then used to subcutaneously inject the fat in small aliquots to fill the soft tissue defect. This requires placement of the grafts in multiple plane and depths in order to ensure viability of the graft. The fat grafts are infiltrated into the soft tissues until the desired volumetric filling is achieved. Filling is often evaluated with the patient in an upright position on the operating room table.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Mark Villa, MD, Jeffrey Kozlow, MD				
Specialty Society(ies):	American Society of Plastic Surgeons				
CPT Code:	15774				
Sample Size:	2000	Resp N:	54	Response: 2.7 %	
Description of Sample:	A random sample from membership database of those that indicated they perform tissue grafting procedures.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	3.00	8.00	213.00
Survey RVW:	1.00	2.41	3.65	7.00	111.11
Pre-Service Evaluation Time:			0.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	2.00	20.00	45.00	89.00	150.00
Immediate Post Service-Time:	0.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	15774	Recommended Physician Work RVU: 2.41		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	0.00	0.00	0.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	45.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) ZZZ Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	0.00	0.00	0.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
14302	ZZZ	3.73	RUC Time

CPT Descriptor 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)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15121	ZZZ	2.00	RUC Time

CPT Descriptor 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)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
37253	ZZZ	1.44	RUC Time	38,310

CPT Descriptor 1 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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36476	ZZZ	2.65	RUC Time	9,885

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99292	ZZZ	2.25	RUC Time

CPT Descriptor Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 15 % of respondents: 27.7 %

Number of respondents who choose 2nd Key Reference Code: 13 % of respondents: 24.0 %

TIME ESTIMATES (Median)

	CPT Code: <u>15774</u>	Top Key Reference CPT Code: <u>14302</u>	2nd Key Reference CPT Code: <u>15121</u>
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	45.00	40.00	30.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	45.00	40.00	30.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	7%	40%	40%	13%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	20%	60%	20%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	27%	40%	33%
Physical effort required	20%	33%	47%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	13%	47%	40%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	8%	61%	31%	0%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	15%	70%	15%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	15%	77%	8%
Physical effort required	8%	38%	54%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	15%	46%	39%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2017, AMA Staff reviewed services with anomalous sites of service when compared to Medicare utilization data. One service was identified, CPT code 20926, in which the Medicare data from 2013-2016 indicated that it was performed less than 50% of the time in the inpatient setting yet include inpatient hospital Evaluation and Management services within the global period.

The specialty societies submitted an action plan and indicated that they believe the site of service issue is due to miscoding. The CPT manual includes a parenthetical that was added in 2011 that states (For injection(s) of platelet rich plasma, use 0232T) which resulted in some decrease in utilization for a few years, but now the utilization is creeping up again. The specialty societies believe the typical patient related to this code would be treated in a facility setting and that the site of service anomaly, for both the outpatient and the office setting is the result of miscoding.

The specialty societies 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.

After discussions, the specialty societies agreed that 20926 should be deleted and 5 new codes which better describe tissue grafting procedures by site and volume be created.

Compelling Evidence:

15774 is a brand-new add-on code and describes a procedure that was otherwise not described in CPT. As such, CPT code 20926 was used while waiting to see about procedural longevity.

Survey Sample and Process:

A survey request was sent to a random selection of members from the American Society of Plastic Surgeons who have indicated that they perform tissue grafting procedures.

Recommendation:

We are recommending a work RVU of 2.41, the survey 25th percentile.

Key Reference Codes

CPT	DESCRIPTOR	IWPUT	RVW	TOTAL TIME	PRE	INTRA	POST	99238	99213	99212
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)	0.054	2.41	45	0	45	0	0	0	0
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)	0.0933	3.73	40	0	40	0	0	0	0
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)	0.0667	2.00	30	0	30	0	0	0	0

MPC Comparison

CPT	DESCRIPTOR	IWPUT	RVW	TOTAL TIME	PRE	INTRA	POST	99238	99213	99212
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)	0.0709	1.44	21	0	20	1	0	0	0
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)	0.054	2.41	45	0	45	0	0	0	0
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)	0.0883	2.65	30	0	30	0	0	0	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 20926

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Plastic Surgeons

How often? Sometimes

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 3000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Plastic Surgeons

Frequency 3000

Percentage 100.00 %

Specialty

Frequency 0

Percentage 0.00 %

Specialty

Frequency 0

Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,500

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Plastic Surgeons

Frequency 1500

Percentage 100.00 %

Specialty

Frequency 0

Percentage 0.00 %

Specialty

Frequency 0

Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 15777

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	
13	ISSUE: Tissue Grafting Procedures																																								
14	TAB: 4																																								
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged						
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	
17	1st REF	15260	Full thickness graft, free, including direct closure of donor site, nose,	62	0.056			11.64			273	17	1	10			100			30													5								
18	2nd REF	21556	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg,	24	0.046			7.66			234	33	20	15			60			25					0.5							2	1								
19	CURRENT	20926	Tissue grafts, other (eg, paratenon, fat, dermis)		0.039			5.79			202	19	0	25			32			20				1	1.0							3									
20	SVY	15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)	163	0.140	1.00	6.68	9.90	12.00	111.11	167	25	10	10	10	30	45	60	200	15													2	1							
21	AAOHNS SVY	15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis,	110	0.121	1.00	6.88	9.12	11.64	29.00	195	25	10	10	10	25	35	60	200	15					1.0								2	1							
22	ASPS SVY	15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis,	53	0.182	2.00	6.49	11.64	12.50	111.11	168	32	10	10	10	30	46	70	150	15													1	2							
23	REC	15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis,		0.054	6.68					191	25	3	10			45			15					1.0							1	2								
25																																									
26						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged						
27	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	
28	1st REF	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)	9	0.068			10.15			258	40	12	20			75			30					0.5								2	1							
29	2nd REF	14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm	8	0.070			12.65			287	33	10	15			100			25					0.5								3	1							

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor:

Global Period: 090 Meeting Date: September 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

Our specialties formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisors and multiple clinical experts who practice in the areas of oral and maxillofacial surgery and general otolaryngologists. The expert panel members also practice in settings that vary by size, geography, and represent both private and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

We utilized the existing PE inputs as a reference for CPT Code 20926.

3. Is this code(s) typically billed with an E/M service? **No**
4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

Pre time: we are requesting the standard pre time for a 90 day global. Previously all pre-time was lumped into one line item for regulatory compliance, likely before the standards were established by the PE Subcommittee.

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence:

Regarding compelling evidence, we believe that compelling evidence exists because the dominant specialty has changed from orthopedics to otolaryngology.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: **N/A**
7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

Pre time: we are requesting the standard pre time for a 90 day global. Previously all pre-time was lumped into one line item for regulatory compliance, likely before the standards were established by the PE Subcommittee.

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. N/A
9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: N/A
10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: N/A
11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

We are only recommending a power table for the facility setting. This is used in the post operative visits and uses the post operative formula.

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: N/A
13. If there is any other item on your spreadsheet that needs further explanation please include here: N/A
14. Please include an explanation of each line item:

Line 15 – staff must complete pre-service and diagnostic/referral forms

Line 16 – staff coordinate pre-surgery services

Line 17 – staff schedule space and equipment in the facility

Line 18 staff provide pre-service education and get patient consent

Line 19 staff complete pre-procedure phone calls

Line 74 – a discharge management visit is conducted to properly discharge the patient from the facility setting

Line 88 – two post operative 99212 visits are performed. These are the second and third visits after the procedure.

Line 89 – one 99213 post operative visit is performed. This is the first visit after the procedure.

Line 102 – multispecialty packs are used at each of the three post operative visits

Line 104 – pack, post op incision care (suture) – For suture removal at post-operative visit

Line 140 – power table – used to perform the procedure in the office and for the post operative visits

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor:

Global Period: 090 Meeting Date: September 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

Our specialties formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisors and multiple clinical experts who practice in the areas of oral and maxillofacial surgery and general otolaryngologists. The expert panel members also practice in settings that vary by size, geography, and represent both private and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

We utilized the existing PE inputs as a reference for CPT Code 20926.

3. Is this code(s) typically billed with an E/M service? **No**
Is this code(s) typically billed with the E/M service in the nonfacility? **No**
(Please see provided data in PE Subcommittee folder)
4. What specialty is the dominant provider in the nonfacility? **Otolaryngology**
What percent of the time does the dominant provider provide the service(s) in the nonfacility? **36%**
Is the dominant provider in the nonfacility different then for the global? **No**
(Please see provided data in PE Subcommittee folder)
5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

Supplies – we have removed the post operative incision pack (staple) and replaced it with the (suture) pack.

Equipment – we have removed the cast cutter which is not needed for the procedure.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: **N/A**

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code)
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:
9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:
10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. **N/A**
11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:
12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. **N/A**
13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**
14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**
15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:

The only equipment needed for the post op visits is the table. We used the post op visit formula for that item.
16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: **N/A**
17. If there is any other item on your spreadsheet that needs further explanation please include here: **N/A**
18. Please include an explanation of each line item:

Line 88 – two post operative 99212 visits are performed. These are the second and third visits after the procedure.

Line 89 – one 99213 post operative visit is performed. This is the first visit after the procedure.

Line 102 – multispecialty packs are used during each of the three post operative visits

Line 104 – pack, post op incision care (suture) – For suture removal at post-operative visit

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

Meeting Date: October 2018

Global Period: 090

CPT Long Descriptor:

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

Global Period: ZZZ

CPT Long Descriptors:

15772 - Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50cc injectate, or part thereof

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

Our specialties formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisors and multiple clinical experts who practice in the areas of oral and maxillofacial surgery and general otolaryngologists. The expert panel members also practice in settings that vary by size, geography, and represent both private and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

We utilized the existing PE inputs as a reference for CPT Code 20926.

3. Is this code(s) typically billed with an E/M service? **No**
4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

Pre time: we are requesting the standard pre time for a 90 day global. Previously all pre-time was lumped into one line item for regulatory compliance, likely before the standards were established by the PE Subcommittee.

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence:

Regarding compelling evidence, we believe that compelling evidence exists because the dominant specialty has changed from orthopedics to plastic surgery.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: **N/A**
7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

Pre time: we are requesting the standard pre time for a 90 day global. Previously all pre-time was lumped into one line item for regulatory compliance, likely before the standards were established by the PE Subcommittee.

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. **N/A**
9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**
10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**
11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:
12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: **N/A**
13. If there is any other item on your spreadsheet that needs further explanation please include here: **N/A**
14. Please include an explanation of each line item:

Line 15 – staff must complete pre-service and diagnostic/referral forms

Line 16 – staff coordinate pre-surgery services

Line 17 – staff schedule space and equipment in the facility

Line 18 staff provide pre-service education and get patient consent

Line 19 staff complete pre-procedure phone calls

Line 88 – two post operative 99212 visits are performed. These are the second and third visits after the procedure.

Line 89 – one 99213 post operative visit is performed. This is the first visit after the procedure.

Line 140 – power table – used to perform the procedure and for the post operative visits

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

Meeting Date: October 2018

Global Period: 090

CPT Long Descriptor:

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

Global Period: ZZZ

CPT Long Descriptors:

15772 - Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50cc injectate, or part thereof

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

Our society formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisors and clinical experts. The expert panel members also practice in settings that vary by size, geography and represent both private and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

We utilized existing PE inputs for CPT code 20926 as a reference.

3. Is this code(s) typically billed with an E/M service? No

Is this code(s) typically billed with the E/M service in the nonfacility? No
(Please see provided data in PE Subcommittee folder)

4. What specialty is the dominant provider in the nonfacility? Plastic Surgeons

What percent of the time does the dominant provider provide the service(s) in the nonfacility?

Based on RUC database, we estimate 36% of procedures may be done in the non-facility

Is the dominant provider in the nonfacility different then for the global? No

(Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

Pre time: we are requesting the standard pre time for a 90 day global. Previously all pre-time was lumped into one line item for regulatory compliance, likely before the standards were established by the PE Subcommittee.

- 6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.**

We are establishing non-facility time for this procedure which did not historically have PE inputs in this site of service and was only done in the facility. Per the RUC database, it is now done 36% of the time in the non-facility and therefore, we felt it required modification to reflect actual practice. None of the times requested are above the standards for those activities, however, the total PE inputs/time has increased due to adding the new site of service.

Regarding compelling evidence – the dominant specialty has changed from orthopedics to plastic surgery.

Supplies – we have removed the post operative incision pack (staple) and replaced it with the (suture) pack. We also added in the supplies needed to perform this procedure in the non-facility setting which is discussed above.

Equipment – we have removed the cast cutter and replaced it with the equipment needed to perform this procedure in the non-facility setting which is discussed above.

- 7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: N/A**
- 8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code)**
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

Staff must take the following vitals: Heart rate, blood pressure and pulse oximetry

- 9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, Assist physician or other qualified healthcare professional---directly related to physician work time or Perform procedure/service---NOT directly related to physician work time:**

Staff are present during the entire procedure, Staff are there directly assisting the physician passing instruments, receiving the donor specimen, keeping the surgical field clear with suction, passing gauze, sutures and dressing supplies.

- 10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. N/A**

- 11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:**

Existing PE was all lumped into the assist during procedure line item. We have divided out clinical staff activities for the necessary activities and assigned the standard time for those activities per the PE guidelines.

- 12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source.** Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.

N/A

- 13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:** *invoices pending*

- 14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:** *invoices pending*

- 15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”).** If you have selected “other formula” for any of the equipment please explain here:

The only equipment needed for the post op visits is the camera. We used the post op visit formula for that item. For the remaining items, we only require those items when procedure is done in the non-facility.

- 16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:** *N/A*

- 17. If there is any other item on your spreadsheet that needs further explanation please include here:** *N/A*

18. Please include an explanation of each line item:

Line 15 – staff must complete pre-service and diagnostic/referral forms

Line 16 – staff coordinate pre-surgery services

Line 17 – staff schedule space and equipment in the facility

Line 18 staff provide pre-service education and get patient consent

Line 19 staff complete pre-procedure phone calls

Line 33 – greet patient, gown them and ensure any records needed are available.

Line 34 – obtain 3 vitals: Heart rate, blood pressure and pulse oximetry

Line 37 – prepare the room for the patient’s arrival and set up materials needed for procedure.

Line 40 – prepare, set up and start IV

Line 49 – the staff are assisting directly during the entire 45 minute procedure

Line 60 – patients are monitored for 15 minutes after the procedure, so the standard time of 15 minutes per hour was reduced to accurately reflect 15 minutes of monitoring (3.75 was rounded up).

Line 62 – staff clean the room and chair after the procedure.

Line 64 – staff clean the basic instrument pack after the procedure

CPT Code: 15771, 15772

Specialty Society: American Society of Plastic Surgeons

Line 67 – check dressings, wounds – looking for any dehiscence, signs of infection

Line 73 – review home care instructions – review potential signs to look for and what the patient will experience the days following procedure.

Line 88 – two post operative 99212 visits are performed. These are the second and third visits after the procedure.

Line 89 – one 99213 post operative visit is performed. This is the first visit after the procedure.

Line 102 – multispecialty packs are used at each of the three post operative visits

Line 104 – pack, post op incision care (suture) – For suture removal at post-operative visit #1

Line 105 – iv starter kit

Line 106, cap surgical – used to cover the surgeons hair and maintain sterile environment

Line 108 – chlorhexidine 0.12% (Peridex) – disinfectant before surgery

Line 109 – Lidocaine 1% with epi For local anesthesia and vasoconstriction

Line 110 - sterile drape for Mayo stand – used to cover the Mayo stand and keep a sterile environment for the supplies

Line 112 – catheter, suction To suction fat during procedure.

Line 113 – drape, sterile, fenestrated 16x29 – one drape needed to cover the donor site

Line 114 – drape, towel, sterile 18 in x 26 in - one drape needed to cover the recipient site

Line 115 – invoice pending

Line 116 - invoice pending

Line 117 - invoice pending

Line 118 - invoice pending

Line 119 – syringe – used to draw up the fat

Line 120 – microspunge, cellulose (10 pack) To wick oil off the fat

~~Line 121 – test tube To collect fat-DELETED~~

Line 122 – tray, suturing To close the wounds

Line 123 – suture, nylon – to close ports/stab incisions

Line 124 – bandage, strip (bandaid) – to cover the sutures

Line 127 – tape, surgical paper Used to secure dressing

Line 133 – dressing, 4 x 4 (Tegaderm) to cover wounds

~~Line 132 – canister, suction – used to hold suctioned blood during procedure~~

Line 140– power table – used to perform the procedure in the office and for the post operative visits

Line 141 - mayo stand – holds the instruments during the procedure

Line 142 – instrument pack – contains knife handle, scissors, forceps and retractors needed for procedure

Line 143- exam light – used to light the surgical field during the procedure.

Line 144 – centrifuge, with rotor – used to separate fat

Line 145 – camera, digital – used to obtain post op photos

Line 146- invoice pending

Line 147- invoice pending

Line 148- invoice pending

Line 149- invoice pending

Line 150- invoice pending

Line 151 - invoice pending

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

Meeting Date: October 2018

Global Period: 090

CPT Long Descriptor:

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

Global Period: ZZZ

CPT Long Descriptor:

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

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

Our specialties formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisors and multiple clinical experts who practice in the areas of oral and maxillofacial surgery and general otolaryngologists. The expert panel members also practice in settings that vary by size, geography, and represent both private and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

We utilized the existing PE inputs as a reference for CPT Code 20926.

3. Is this code(s) typically billed with an E/M service? **No**
4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

Pre time: we are requesting the standard pre time for a 90 day global. Previously all pre-time was lumped into one line item for regulatory compliance, likely before the standards were established by the PE Subcommittee.

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence:

Regarding compelling evidence, we believe that compelling evidence exists because the dominant specialty has changed from orthopedics to plastic surgery.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: **N/A**
7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

Pre time: we are requesting the standard pre time for a 90 day global. Previously all pre-time was lumped into one line item for regulatory compliance, likely before the standards were established by the PE Subcommittee.

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. **N/A**
9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**
10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**
11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:
12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: **N/A**
13. If there is any other item on your spreadsheet that needs further explanation please include here: **N/A**
14. Please include an explanation of each line item:

Line 15 – staff must complete pre-service and diagnostic/referral forms

Line 16 – staff coordinate pre-surgery services

Line 17 – staff schedule space and equipment in the facility

Line 18 staff provide pre-service education and get patient consent

Line 19 staff complete pre-procedure phone calls

Line 88 – two post operative 99212 visits are performed. These are the second and third visits after the procedure.

Line 89 – one 99213 post operative visit is performed. This is the first visit after the procedure.

Line 140 – power table – used to perform the procedure and for the post operative visits

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

Meeting Date: October 2018

Global Period: 090

CPT Long Descriptor:

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

Global Period: ZZZ

CPT Long Descriptor:

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

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

Our society formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisors and clinical experts. The expert panel members also practice in settings that vary by size, geography and represent both private and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

We utilized existing PE inputs for CPT code 20926 as a reference.

3. Is this code(s) typically billed with an E/M service? No
Is this code(s) typically billed with the E/M service in the nonfacility? No
(Please see provided data in PE Subcommittee folder)

4. What specialty is the dominant provider in the nonfacility? Plastic Surgeons
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Based on RUC database, we estimate 36% of procedures may be done in the non-facility
Is the dominant provider in the nonfacility different then for the global? No
(Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

Pre time: we are requesting the standard pre time for a 90 day global. Previously all pre-time was lumped into one line item for regulatory compliance, likely before the standards were established by the PE Subcommittee.

6. **If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.**

We are establishing non-facility time for this procedure which did not historically have PE inputs in this site of service and was only done in the facility. Per the RUC database, it is now done 36% of the time in the non-facility and therefore, we felt it required modification to reflect actual practice. None of the times requested are above the standards for those activities, however, the total PE inputs/time has increased due to adding the new site of service.

Regarding compelling evidence – the dominant specialty has changed from orthopedics to plastic surgery.

Supplies – we have removed the post operative incision pack (staple) and replaced it with the (suture) pack. We also added in the supplies needed to perform this procedure in the non-facility setting which is discussed above.

Equipment – we have removed the cast cutter and replaced it with the equipment needed to perform this procedure in the non-facility setting which is discussed above.

7. **If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:** N/A
8. **How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code)**
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

Staff must take the following vitals: Heart rate, blood pressure and pulse oximetry

9. **Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time or Perform procedure/service---NOT directly related to physician work time:***

Staff are present during the entire procedure, Staff are there directly assisting the physician passing instruments, receiving the donor specimen, keeping the surgical field clear with suction, passing gauze, sutures and dressing supplies.

10. **If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.** N/A

- 11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:**

Existing PE was all lumped into the assist during procedure line item. We have divided out clinical staff activities for the necessary activities and assigned the standard time for those activities per the PE guidelines.

- 12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. N/A**

- 13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:** *invoices pending*

- 14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:** *invoices pending*

- 15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:**

The only equipment needed for the post op visits is the camera. We used the post op visit formula for that item. For the remaining items, we only require those items when procedure is done in the non-facility.

- 16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:** *N/A*

- 17. If there is any other item on your spreadsheet that needs further explanation please include here:** *N/A*

- 18. Please include an explanation of each line item:**

Line 15 – staff must complete pre-service and diagnostic/referral forms

Line 16 – staff coordinate pre-surgery services

Line 17 – staff schedule space and equipment in the facility

Line 18 staff provide pre-service education and get patient consent

Line 19 staff complete pre-procedure phone calls

Line 33 – greet patient, gown them and ensure any records needed are available.

Line 34 – obtain 3 vitals: Heart rate, blood pressure and pulse oximetry

Line 37 – prepare the room for the patient’s arrival and set up materials needed for procedure.

Line 40 – prepare, set up and start IV

Line 49 – the staff are assisting directly during the entire 45 minute procedure

Line 60 – patients are monitored for 15 minutes after the procedure, so the standard time of 15 minutes per hour was reduced to accurately reflect 15 minutes of monitoring (3.75 was rounded up).

Line 62 – staff clean the room and chair after the procedure.

Line 64 – staff clean the basic instrument pack after the procedure

Line 67 – check dressings, wounds – looking for any dehiscence, signs of infection

CPT Code: 15773, 15774

Specialty Society: American Society of Plastic Surgeons

Line 73 – review home care instructions – review potential signs to look for and what the patient will experience the days following procedure.

Line 88 – two post operative 99212 visits are performed. These are the second and third visits after the procedure.

Line 89 – one 99213 post operative visit is performed. This is the first visit after the procedure.

Line 102 – multispecialty packs are used at each of the three post operative visits

Line 104 – pack, post op incision care (suture) – For suture removal at post-operative visit #1

Line 105 – iv starter kit

Line 106, cap surgical – used to cover the surgeons hair and maintain sterile environment

Line 108 – chlorhexidine 0.12% (Peridex) – disinfectant before surgery

Line 109 – Lidocaine 1% with epi For local anesthesia and vasoconstriction

Line 110 - sterile drape for Mayo stand – used to cover the Mayo stand and keep a sterile environment for the supplies

Line 112 – catheter, suction To suction fat during procedure.

Line 113 – drape, sterile, fenestrated 16x29 – one drape needed to cover the donor site

Line 114 – drape, towel, sterile 18 in x 26 in - one drape needed to cover the recipient site

Line 115 – invoice pending

Line 116 - invoice pending

Line 117 - invoice pending

Line 118 - invoice pending

Line 119 – syringe – used to draw up the fat **UPDATE made to #s for x3 code**

Line 120 – microspunge, cellulose (10 pack) To wick oil off the fat

~~Line 121 – test tube To collect fat-DELETED~~

Line 122 – tray, suturing To close the wounds

Line 123 – suture, nylon – to close ports/stab incisions

Line 124 – bandage, strip (bandaid) – to cover the sutures

Line 127 – tape, surgical paper Used to secure dressing

Line 133 – dressing, 4 x 4 (Tegaderm) to cover wounds

~~Line 132 – canister, suction – used to hold suctioned blood during procedure~~

Line 140– power table – used to perform the procedure in the office and for the post operative visits

Line 141 - mayo stand – holds the instruments during the procedure

Line 142 – instrument pack – contains knife handle, scissors, forceps and retractors needed for procedure

Line 143- exam light – used to light the surgical field during the procedure.

Line 144 – centrifuge, with rotor – used to separate fat

Line 145 – camera, digital – used to obtain post op photos

Line 146- invoice pending

Line 147- invoice pending

Line 148- invoice pending

Line 149- invoice pending

Line 150- invoice pending

Line 151 - invoice pending

	A	B	D	E	F	I	J	K	L	M
1	RUC Practice Expense Spreadsheet					CURRENT		RECOMMENDED		RECOMM
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>				CPT Code # 20926		CPT Code # 15769		CPT Code
3		<u>RUC Collaboration Website</u>				Tissue grafts, other (eg, paratenon, fat, dermis)		Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)		Grafting autologous harvest liposuction technique breasts, sc and/or legs
4	Clinical Activity Code	Meeting Date: September 2018 Tab: 4 Specialty: ASPS, AAO-HNS	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute					
5		LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac
6		GLOBAL PERIOD				090	090	090	090	090
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				\$ -	\$ 66.67	\$ -	\$ 69.75	\$ 134.90
8		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	0.0	153.0	0.0	162.0	215.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	0.0	60.0	0.0	60.0	35.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	0.0	12.0	0.0	12.0	90.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	0.0	81.0	0.0	90.0	90.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE				\$ -	\$ 56.61	\$ -	\$ 59.94	\$ 79.55
13		PRE-SERVICE PERIOD								
14		Start: Following visit when decision for surgery or procedure made								
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37		5		5	5
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37		20		20	10
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37		8		8	0
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37		20		20	10
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37		7		7	10
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37					
21	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37					
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37					
29		End: When patient enters office/facility for surgery/procedure								
30		SERVICE PERIOD								
31		Start: When patient enters office/facility for surgery/procedure:								
32		Pre-Service (of service period)								
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	L037D	RN/LPN/MTA	0.37					3
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37					3
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37					
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37					
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37					2
38	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37					
39	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37					
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37					2
41	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37					
48		Intra-service (of service period)								
49	CA018	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37					60
50	CA019	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37					
51	CA020	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37					
52	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37					
59		Post-Service (of service period)								
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37					4
61	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37					
62	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37					3
63	CA025	Clean scope	L037D	RN/LPN/MTA	0.37					
64	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37					10
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37					
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37					
67	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37					1
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,	L037D	RN/LPN/MTA	0.37					
69	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37					
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to	L037D	RN/LPN/MTA	0.37					
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37					
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry	L037D	RN/LPN/MTA	0.37					
73	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37					2
74	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	n/a	12	n/a	12	n/a
81		End: Patient leaves office								
82		POST-SERVICE PERIOD								
83		Start: Patient leaves office/facility								
84	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37					
85	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37					
86		Office visits: List Number and Level of Office Visits	MINUTES			# visits	# visits	# visits	# visits	# visits
87		99211 16 minutes	16							
88		99212 27 minutes	27				3		2	2
89		99213 36 minutes	36						1	1
90		99214 53 minutes	53							
91		99215 63 minutes	63							
92	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	0.0	81.0	0.0	90.0	90.0
99		End: with last office visit before end of global period								

	A	B	D	E	F	I	J	K	L	M
1	RUC Practice	Expense Spreadsheet				CURRENT		RECOMMENDED		RECOMM
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>				CPT Code # 20926		CPT Code # 15769		CPT Code
3		<u>RUC Collaboration Website</u>				Tissue grafts, other (eg, paratenon, fat, dermis)		Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)		Grafting autologous harvest liposuction technique breasts, sc and/or legs
4	Clinical Activity Code	Meeting Date: September 2018 Tab: 4 Specialty: ASPS, AAO-HNS	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute					
5		LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac
6		GLOBAL PERIOD				090	090	090	090	090
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				\$ -	\$ 66.67	\$ -	\$ 69.75	\$ 134.90
8		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	0.0	153.0	0.0	162.0	215.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	0.0	60.0	0.0	60.0	35.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	0.0	12.0	0.0	12.0	90.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	0.0	81.0	0.0	90.0	90.0
100	Supply Code	MEDICAL SUPPLIES	PRICE	UNIT						
101		TOTAL COST OF SUPPLY QUANTITY x PRICE				\$ -	\$ 8.49	\$ -	\$ 8.34	\$ 44.39
102	SA048	pack, minimum multi-specialty visit	1.143	pack			3		3	3
103	SA052	pack, post-op incision care (staple)	5.056	pack			1		0	
104	SA054	pack, post-op incision care (suture)	4.907	pack					1	1
105	SA019	kit, iv starter	1.6	kit						
106	SB001	cap, surgical	0.209	item						1
107	SJ041	povidone soin (Betadine)	0.008	ml						
108	SH023	chlorhexidine 0.12% (Peridex)	0.408	oz						3
109	SH046	lidocaine 1% w-epi inj (Xylocaine w-epi)	0.064	ml						10
110	SB012	drape, sterile, for Mayo stand	1.688	item						1
111	SD124	tourniquet, non latex 1 in x 18 in	0.226	item						
112	SD031	catheter, suction	0.62	item						1
113	SB011	drape, sterile barrier 16in x 29in	0.557	item						1
114	SM019	drape-towel, sterile 18in x 26in	0.282	item						1
115	NEW	INFUSION TUBING	0	item						1
116	NEW	WETTING SOLUTION (saline, Lidocaine, Bicarb)	0	item						1
117	NEW	LIPOSUCTION TUBING	0	item						1
118	NEW	Liposuction Cannister Liner	0	item						1
119	SC051	syringe 10-12ml	0.184	item						6
120	SG085	microsponge, cellulose (10 pack uou)	3.62	item						1
121	SL143	test tube	0.273	item						0
122	SA069	tray, suturing	8.993	tray						1
123	SF037	suture, nylon, 4-0 to 6-0, p, ps	6.717	item						2
124	SG021	bandage, strip 0.75in x 3in (Bandaid)	0.043	item						3
125	SG051	gauze, non-sterile 4in x 4in	0.035	item						
126	SG074	Steri-strip (6 strip ouo)	1.116	item						
127	SG079	tape, surgical paper 1in (Micropore)	0.002	inch						8
128	SG016	bandage, Kerliz, steril 4.5 in	1.772	item						
129	SF039	suture, silk, 2-0 to 5-0, x, fs, c	2.936	item						
130	SD110	reservoir, drain (Jackson-Pratt)	22	item						
131	SC034	needle, blunt tip	0.33	item						
132	SD009	cannister, suction	3.908	item						
133	SG037	dressing, 4in x 4.75in (Tegaderm)	1.771	item						2
134										
135		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A								
137	Equipment Code	EQUIPMENT	Purchase Price	Equipment Formula	Cost Per Minute					
138		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE				\$ -	\$ 1.57	\$ -	\$ 1.47	\$ 10.96
139	EQ081	cast cutter	1160.62	Default	0.003079968		81			
140	EF031	table, power	6153.63	Office Visits	0.016330051		81		90	164
141	EF015	Mayo stand	530.76	Default	0.001180619					74
142	EQ137	Instrument pack, basic (\$500-\$1499)	500	Default	0.002323783					80
143	EQ168	Light, exam	1630.12	Default	0.004325893					74
144	EP007	centrifuge (with rotor)	4291.65	Highly Technical	0.013851867					67
145	ED003	Camera, digital (6 mexapixel)	1106.5	Highly Technical	0.00438417					67
146	NEW	WETTING SOLUTION PUMP	0	Default	0					74
147	NEW	LIPOSUCTION SYSTEM	22039.05	Default	0.087323041					74
148		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A								

	A	B	N	O	P	Q	R	S	T
1	RUC Practice	Expense Spreadsheet	ENDED	RECOMMENDED	RECOMMENDED	RECOMMENDED	RECOMMENDED		
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>	# 15771	CPT Code # 15772	CPT Code # 15773	CPT Code # 15774			
3		<u>RUC Collaboration Website</u>	ing of ous fat ed by ction to trunk, alp, arms, s: 50cc or	each additional 50cc injectate, or part thereof (list separately in addition to code for primary procedure)	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits.	each additional 25cc injectate, or part thereof (list separately in addition to code for primary procedure)			
4	Clinical Activity Code	Meeting Date: September 2018 Tab: 4 Specialty: ASPS, AAO-HNS							
5		LOCATION	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	090	zzz	zzz	090	090	zzz	zzz
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 65.31	\$ 28.09	\$ -	\$ 134.90	\$ 65.31	\$ 28.09	\$ -
8		TOTAL CLINICAL STAFF TIME	150.0	45.0	0.0	215.0	150.0	45.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	60.0	0.0	0.0	35.0	60.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	45.0	0.0	90.0	0.0	45.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	90.0	0.0	0.0	90.0	90.0	0.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	\$ 55.50	\$ 16.65	\$ -	\$ 79.55	\$ 55.50	\$ 16.65	\$ -
13		PRE-SERVICE PERIOD							
14		Start: Following visit when decision for surgery or procedure made							
15	CA001	Complete pre-service diagnostic and referral forms	5			5	5		
16	CA002	Coordinate pre-surgery services (including test results)	20			10	20		
17	CA003	Schedule space and equipment in facility	8			0	8		
18	CA004	Provide pre-service education/obtain consent	20			10	20		
19	CA005	Complete pre-procedure phone calls and prescription	7			10	7		
20	CA006	Confirm availability of prior images/studies							
21	CA007	Review patient clinical extant information and questionnaire							
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)							
29		End: When patient enters office/facility for surgery/procedure							
30		SERVICE PERIOD							
31		Start: When patient enters office/facility for surgery/procedure:							
32		Pre-Service (of service period)							
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are				3			
34	CA010	Obtain vital signs				3			
35	CA011	Provide education/obtain consent							
36	CA012	Review requisition, assess for special needs							
37	CA013	Prepare room, equipment and supplies				2			
38	CA014	Confirm order, protocol exam							
39	CA015	Setup scope (nonfacility setting only)							
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient				2			
41	CA017	Sedate/apply anesthesia							
48		Intra-service (of service period)							
49	CA018	Assist physician or other qualified healthcare professional---directly		45		60		45	
50	CA019	Assist physician or other qualified healthcare professional---directly							
51	CA020	Assist physician or other qualified healthcare professional---directly							
52	CA021	Perform procedure/service---NOT directly related to physician work time							
59		Post-Service (of service period)							
60	CA022	Monitor patient following procedure/service, multitasking 1:4				4			
61	CA023	Monitor patient following procedure/service, no multitasking							
62	CA024	Clean room/equipment by clinical staff				3			
63	CA025	Clean scope							
64	CA026	Clean surgical instrument package				10			
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions							
66	CA028	Review/read post-procedure x-ray, lab and pathology reports							
67	CA029	Check dressings, catheters, wounds				1			
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,							
69	CA031	Review examination with interpreting MD/DO							
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to							
71	CA033	Perform regulatory mandated quality assurance activity (service period)							
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry							
73	CA035	Review home care instructions, coordinate visits/prescriptions				2			
74	CA036	Discharge day management		n/a		n/a		n/a	
81		End: Patient leaves office							
82		POST-SERVICE PERIOD							
83		Start: Patient leaves office/facility							
84	CA037	Conduct patient communications							
85	CA038	Coordinate post-procedure services							
86		Office visits: List Number and Level of Office Visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
87		99211 16 minutes							
88		99212 27 minutes	2			2	2		
89		99213 36 minutes	1			1	1		
90		99214 53 minutes							
91		99215 63 minutes							
92	CA039	Post-operative visits (total time)	90.0	0.0	0.0	90.0	90.0	0.0	0.0
99		End: with last office visit before end of global period							

	A	B	N	O	P	Q	R	S	T
1	RUC Practice	Expense Spreadsheet	ENDED	RECOMMENDED	RECOMMENDED	RECOMMENDED	RECOMMENDED		
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>							
3		<u>RUC Collaboration Website</u>							
4	Clinical Activity Code	Meeting Date: September 2018 Tab: 4 Specialty: ASPS, AAO-HNS	ing of bus fat ed by ction to trunk, alp, arms, s: 50cc or	each additional 50cc injectate, or part thereof (list separately in addition to code for primary procedure)		Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits.		each additional 25cc injectate, or part thereof (list separately in addition to code for primary procedure)	
5		LOCATION	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	090	zzz	zzz	090	090	zzz	zzz
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 65.31	\$ 28.09	\$ -	\$ 134.90	\$ 65.31	\$ 28.09	\$ -
8		TOTAL CLINICAL STAFF TIME	150.0	45.0	0.0	215.0	150.0	45.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	60.0	0.0	0.0	35.0	60.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	45.0	0.0	90.0	0.0	45.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	90.0	0.0	0.0	90.0	90.0	0.0	0.0
100	Supply Code	MEDICAL SUPPLIES							
101		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ 8.34	\$ 11.44	\$ -	\$ 44.39	\$ 8.34	\$ 11.44	\$ -
102	SA048	pack, minimum multi-specialty visit	3			3	3		
103	SA052	pack, post-op incision care (staple)							
104	SA054	pack, post-op incision care (suture)	1			1	1		
105	SA019	kit, iv starter							
106	SB001	cap, surgical				1			
107	SJ041	povidone soin (Betadine)							
108	SH023	chlorhexidine 0.12% (Peridex)				3			
109	SH046	lidocaine 1% w-epi inj (Xylocaine w-epi)				10			
110	SB012	drape, sterile, for Mayo stand				1			
111	SD124	tourniquet, non latex 1 in x 18 in							
112	SD031	catheter, suction				1			
113	SB011	drape, sterile barrier 16in x 29in				1			
114	SM019	drape-towel, sterile 18in x 26in				1			
115	NEW	INFUSION TUBING				1			
116	NEW	WETTING SOLUTION (saline, Lidocaine, Bicarb)				1			
117	NEW	LIPOSUCTION TUBING				1			
118	NEW	Liposuction Cannister Liner				1			
119	SC051	syringe 10-12ml		6		6		6	
120	SG085	microsponge, cellulose (10 pack uou)		1		1		1	
121	SL143	test tube		0		0		0	
122	SA069	tray, suturing				1			
123	SF037	suture, nylon, 4-0 to 6-0, p, ps		1		2		1	
124	SG021	bandage, strip 0.75in x 3in (Bandaid)				3			
125	SG051	gauze, non-sterile 4in x 4in							
126	SG074	Steri-strip (6 strip ouo)							
127	SG079	tape, surgical paper 1in (Micropore)				8			
128	SG016	bandage, Kerliz, steril 4.5 in							
129	SF039	suture, silk, 2-0 to 5-0, x, fs, c							
130	SD110	reservoir, drain (Jackson-Pratt)							
131	SC034	needle, blunt tip							
132	SD009	cannister, suction							
133	SG037	dressing, 4in x 4.75in (Tegaderm)				2			
134									
135		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A							
137	Equipment Code	EQUIPMENT							
138		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ 1.47	\$ -	\$ -	\$ 10.96	\$ 1.47	\$ -	\$ -
139	EQ081	cast cutter							
140	EF031	table, power	90			164	90		
141	EF015	Mayo stand				74			
142	EQ137	Instrument pack, basic (\$500-\$1499)				80			
143	EQ168	Light, exam				74			
144	EP007	centrifuge (with rotor)				67			
145	ED003	Camera, digital (6 mexapixel)				67			
146	NEW	WETTING SOLUTION PUMP				74			
147	NEW	LIPOSUCTION SYSTEM				74			
148		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A							

AMA/Specialty Society RVS Update Committee Summary of Recommendations
** Different Performing Specialty from Survey**

October 2018

Drug Delivery Implant Procedures

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.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery Integumentary System Introduction				
(f)11980	C1	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	000	1.10 Affirmed January 2014 RUC Recommendation
(f)11981	C2	Insertion, non-biodegradable drug delivery implant (For manual preparation and insertion of deep [eg, subfascial], intramedullary, or intra-articular drug delivery device, see 20700, 20702, 20704) (Do not report 11981 in conjunction with 20700, 20702, 20704)	XXX 000	1.30
(f)11982	C3	Removal, non-biodegradable drug delivery implant (For removal of deep [eg, subfascial], intramedullary, or intra-articular drug delivery device, see 20701, 20703, 20705) (Do not report 11982 in conjunction with 20701, 20703, 20705)	XXX 000	1.70
(f)11983	C4	Removal with reinsertion, non-biodegradable drug delivery implant	XXX 000	2.10

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

Musculoskeletal System**General****Introduction or Removal**

(For injection procedure for arthrography, see anatomical area)

(For injection of autologous adipose-derived regenerative cells, see 0489T, 0490T)

Manual preparation involves the mixing and preparation of antibiotics, or other therapeutic agent(s) with a carrier substance, by the physician or other qualified health care professional during the surgical procedure, and then shaping the mixture into a drug delivery device(s) (eg, beads, nails, spacers) for placement in the deep (eg, subfascial) intramedullary, or intra-articular space(s). Codes 20700, 20702, 20704 are add-on codes for the manual preparation and insertion of the drug delivery device during the associated primary surgical procedure listed with each add-on code. Codes 20701, 20703, 20705 are add-on codes for the removal of drug delivery device(s) during the associated primary surgical procedures listed in the parenthetical codes associated with each add-on code. Insertion of a prefabricated drug device(s) may not be reported with 20700, 20702, 20704. Report 20680 if removal of drug delivery device(s) is performed alone. Report 20700, 20702, 20704, 20701, 20703, 20705 once per anatomic location.

†●20700	C5	Manual preparation and insertion of drug delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure) (Use 20700 in conjunction with 11010, 11011, 11012, 11043, 11044, 11046 11047, 20240, 20245, 20250, 20251, 21010, 21025, 21026, 21501, 21502, 21510, 21627, 21630, 22010, 22015, 23030, 23031, 23035, 23040, 23044, 23170, 23172, 23174, 23180, 23182, 23184, 23334, 23335, 23930, 23931, 23935 24000, 24134, 24136, 24138, 24140, 24147, 24160, 25031, 25035, 25040, 25145, 25150, 25151, 26070, 26230, 26235, 26236, 26990, 26991, 26992, 27030, 27070, 27071, 27090, 27301, 27303, 27310, 27360, 27603, 27604, 27610, 27640, 27641, 28001, 28002, 28003, 28020, 28120, 28122) (Do not report 20700 in conjunction with 11981)	ZZZ	1.50
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+●20701	C6	<p>Removal of drug delivery device(s), deep(s) (eg, subfascial) (List separately in addition to code for primary procedure)</p> <p>(Use 20701 in conjunction with 11010, 11011, 11012, 11043, 11044, 11046 11047, 20240, 20245, 20250, 20251, 21010, 21025, 21026, 21501, 21502, 21510, 21627, 21630, 22010, 22015, 23030, 23031, 23035, 23040, 23044, 23170, 23172, 23174, 23180, 23182, 23184, 23334, 23335, 23930, 23931, 23935 24000, 24134, 24136, 24138, 24140, 24147, 24160, 25031, 25035, 25040, 25145, 25150, 25151, 26070, 26230, 26235, 26236, 26990, 26991, 26992, 27030, 27070, 27071, 27090, 27301, 27303, 27310, 27360, 27603, 27604, 27610, 27640, 27641, 28001, 28002, 28003, 28020, 28120, 28122)</p> <p>(Do not report 20701 in conjunction with 11982)</p>	ZZZ	1.13
+●20702	C7	<p>Manual preparation and insertion of drug delivery device(s), intramedullary (List separately in addition to code for primary procedure)</p> <p>(Use 20702 in conjunction with, 20680, 20690, 20692, 20694, 20802, 20805, 20838, 23170, 23180, 23184, 23935, 24134, 24138, 24140, 24147, 24516, 25145, 25150, 25151, 25400, 25515, 25525, 25526, 25545, 25574, 25575, 27245, 27259, 27360, 27470, 27506, 27640, 21510, 23035, 23515, 23615, 24430, 25035, 27720)</p> <p>(Do not report 20702 in conjunction with 11981)</p>	ZZZ	2.50
+●20703	C8	<p>Removal of drug delivery device(s), intramedullary (List separately in addition to code for primary procedure)</p> <p>(Use 20703 in conjunction with 20694, 20690, 20692, 20694, 20802, 20805, 20838, 23170, 23180, 23184, 23935, 24134, 24138, 24140, 24147, 24516, 25145, 25150, 25151, 25400, 25515, 25525, 25526, 25545, 25574, 25575, 27245, 27259, 27360, 27470, 27506, 27640, 21510, 23035, 23515, 23615, 24430, 25035, 27720)</p> <p>(Do not report 20703 in conjunction with 11982)</p>	ZZZ	1.80

+●20704	C9	Manual preparation and insertion of drug delivery device(s), intra-articular (List separately in addition to code for primary procedure) (Use 20704 in conjunction with 22864, 22865, 23040, 23044, 23334, 24000, 24160, 25040, 25250, 25251, 26070, 26075, 26080, 26990, 27030, 27090, 27301, 27310, 27603, 27610, 28020) (Do not report with 20704 in conjunction with 11981, 27091, 27488)	<i>ZZZ</i>	2.60
+●20705	C10	Removal of drug delivery device(s), intra-articular (List separately in addition to code for primary procedure) (Use 20705 in conjunction with 22864, 22865, 23040, 23044, 23334, 24000, 24160, 25040, 25250, 25251, 26070, 26075, 26080, 26990, 27030, 27090, 27301, 27310, 27603, 27610, 28020) (Do not report with 20705 in conjunction with 11982, 23335, 27091, 27125, 27130, 27134, 27236, 27137, 27138, 27438, 27446, 27486, 27487, 27488)	<i>ZZZ</i>	2.15



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E. Ann Gormley, MD
New England

Frederick A. Gulmi, MD
New York

Chandru P. Sundaram, MD
North Central

Barry A. Kogan, MD
Northeastern

Anthony Y. Smith, MD
South Central

Thomas F. Stringer, MD
Southeastern

Scott K. Swanson, MD
Western

August 31, 2018

Peter K. Smith, M.D.
Chairperson
RVS Update Committee (RUC)
American Medical Association
AMA Plaza
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885

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

Dear Dr. Smith,

On behalf of the American Urological Association, we write to you today asking the RUC to reaffirm the physician work values for CPT code 11980 *Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)* that is currently on the agenda for the October 2018 RUC meeting.

This code was previously surveyed and reviewed by the RUC in January 2014. The RUC recommended physician work RVU of 1.10. There has been no change in the physician work since the survey. The AUA does not believe this code needs to be re-surveyed at this time. We request that the RUC reaffirm the values established from the January 2014 meeting.

Please contact us if you have any questions.

Sincerely,

Thomas Turk, MD
AUA RUC Advisor

Headquarters

Michael T. Sheppard, CPA, CAE
Chief Executive Officer

1000 Corporate Boulevard
Linthicum, MD 21090

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**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 11981	Tracking Number C2	Original Specialty Recommended RVU: 1.30
		Presented Recommended RVU: 1.30
Global Period: 000	Current Work RVU: 1.48	RUC Recommended RVU: 1.30

CPT Descriptor: Insertion, non-biodegradable drug delivery implant

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Obstetrics/Gynecology Vignette: A 25-year-old woman who desires to prevent pregnancy presents for insertion of a subdermal contraceptive. Urology Vignette: A 70-year-old male with metastatic prostate cancer presents for the insertion of a non-biodegradable drug delivery implant.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Obstetrics/Gynecology: Patient history is reviewed for appropriateness of immediate insertion, ideally Day 1-5 following the onset of menses. Her present method of contraception is confirmed as effectiveness of the implant will be impacted by concurrent hormonal contraception and timing of the insertion. Review of pregnancy test results may be necessary. Consent for procedure is obtained. The patient is placed in the supine position. Her non-dominant arm is placed above her head, externally rotated with the elbow flexed and resting comfortably supported. The inner aspect of the upper arm is palpated to identify the medial epicondyle of the humerus. The insertion site is measured and marked 8-10 cm above the landmark. The second mark is made more proximal to serve as an insertion guide. The skin is cleansed with antiseptic solution. The skin is injected with local anesthetic to form a wheal and then the needle is passed into the subdermal space to continue the injection 4- 5 cm along the planned insertion tunnel. The insertion device is removed from the sterile packaging and the implant is confirmed to be appropriately positioned.

Urology: A physical examination and history is performed on the patient. Specific history components are paid attention to including the indication for hormone ablation, failure or noncompliance with other forms of hormone ablation such as intermittent injection therapy and possible refusal of other forms of therapy including orchiectomy with surgical castration. Patient is counseled about the risks and benefits of the implant including bleeding, infection, hormone changes including hot flashes, weight gain and muscle loss. Patient is also counseled about current guidelines for follow-up after hormone ablation including need for cardiac screening, bone density monitoring, exercise and addition of vitamin D to their diet to prevent bone loss. Examination includes evaluation of the non-dominant arm for an appropriate insertion site. Consent form is discussed with the patient and signed by the provider and patient. The non-dominant arm is placed above the head, externally rotated with the elbow flexed and resting comfortably supported. The inner aspect of the upper arm is palpated to identify the medial epicondyle of the humerus. The insertion site is measured and marked 8-10 cm above the landmark. The second mark is made more proximal to serve as an insertion guide. The surgeon washes hands and places sterile gloves on. The area of insertion is cleansed with the provided antiseptic solution. The area is draped to provide a sterile field. The surgeon prepares the operative field with a syringe, 22gauge needle and local anesthetic. The anesthetic solution is drawn up into the syringe under sterile conditions. The provider then palpates the area of insertion site to ensure that there are no contraindications for placement of the medication. The skin is infiltrated with the anesthetic solution to provide a wheal

and then a deep injection is performed for both hydro-dissection and anesthetic. Five minutes is allowed to pass for the anesthetic solution to take effect.

Description of Intra-Service Work: Obstetrics/Gynecology: The skin around the insertion site is stretched taut. The needle is inserted bevel up at the marked insertion site at a slight angle. The needle is then moved to a horizontal position, tenting the skin. The needle is gently inserted to its full length following the planned insertion line by aiming at the previous mark. The implant is released into the subdermal soft tissue. The insertion needle is removed. The distal and proximal tip of the implant are both palpated, confirming release of the implant from the applicator needle and a subdermal position. Any bleeding is controlled. A steri-strip is placed over the wound. A pressure dressing is placed.

Urology: The skin around the insertion site is stretched taut and the insertion trochar is inserted with the bevel up at the marked insertion site at a slight angle. The trochar is then inserted to its full length following the planned insertion line by aiming at the previous mark and the implant is released into the subdermal soft tissue. The insertion needle is removed. The distal and proximal tip of the implant are both palpated, confirming release of the implant from the applicator needle and a subdermal position. Any bleeding is controlled. Steri-strips are placed over the wound. A pressure dressing is placed.

Description of Post-Service Work: Obstetrics/Gynecology: The patient is instructed to continue with the pressure dressing for 24 hours and to keep the area clean and dry. Instructions are given for relief of discomfort with ice packs and OTC analgesics. Based upon the timing of the procedure and present method of contraception, additional counselling regarding back up contraception is provided. The procedure is recorded in the patient record.

Urology: The patient is instructed to continue with the pressure dressing for 24 hours and to keep the area clean and dry. Instructions are given for relief of discomfort with ice packs and OTC analgesics. Pain control counseling is provided. Post procedure patient handout is given to both the patient and his care provider which includes wound care, return precautions, side effect expectation management, and recommended follow-up for patients newly treated with hormone ablation per the guidelines for cardiac screening, exercise prescription, and bone health. The procedure is recorded in the patient record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	George Hill, MD, Jon Hathaway, MD, Mitch Schuster, MD, Thomas Turk, MD, Kyle Richards, MD and Andrew Peterson, MD				
Specialty Society(ies):	ACOG and AUA				
CPT Code:	11981				
Sample Size:	10000	Resp N:	111	Response: 1.1 %	
Description of Sample:	Random samples from ACOG (4000) and AUA (6000)				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	10.00	20.00	150.00
Survey RVW:	0.90	1.30	1.68	2.00	4.00
Pre-Service Evaluation Time:			15.00		
Pre-Service Positioning Time:			2.00		
Pre-Service Scrub, Dress, Wait Time:			4.00		
Intra-Service Time:	1.00	5.00	5.00	10.00	30.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

6-NF Proc w local/topical anes care req wait time

CPT Code:	11981	Recommended Physician Work RVU: 1.30		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	15.00	17.00	-2.00	
Pre-Service Positioning Time:	1.00	1.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	4.00	5.00	-1.00	
Intra-Service Time:	5.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) N/A Survey Code is Non-Facility				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	5.00	0.00	5.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
55876	000	1.73	RUC Time

CPT Descriptor Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
57500	000	1.20	RUC Time

CPT Descriptor Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
12013	000	1.22	RUC Time	50,886

CPT Descriptor 1 Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
12004	000	1.44	RUC Time	22,716

CPT Descriptor 2 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

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 18 % of respondents: 16.2 %

Number of respondents who choose 2nd Key Reference Code: 14 % of respondents: 12.6 %

TIME ESTIMATES (Median)

	CPT Code: <u>11981</u>	Top Key Reference CPT Code: <u>55876</u>	2nd Key Reference CPT Code: <u>57500</u>
Median Pre-Service Time	20.00	29.00	9.00
Median Intra-Service Time	5.00	20.00	15.00
Median Immediate Post-service Time	5.00	10.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	30.00	59.00	29.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	33%	61%	6%	0%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
28%	39%	33%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	22%	50%	28%

Physical effort required	44%	56%	0%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

61%

39%

0%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	50%	50%	0%	0%
------------------------------	----	-----	-----	----	----

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

43%

50%

7%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	57%	36%	7%
--------------------------	-----	-----	----

Physical effort required	57%	43%	0%
--------------------------	-----	-----	----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

64%

36%

0%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 11981 was identified in the 'different performing specialty from survey' screen. The CPT editorial panel created six add-on codes to describe orthopaedic drug delivery to differentiate the service from the service described in code 11981. CPT Codes 11982 and 11983 were identified as part of the 11981 family.

Time

The drug delivery implant procedures are typically performed in the office setting, so package 6 was selected. A minute was added to the positioning time.

Medicare 2017 data for 11981

OBG: 506 in office; 198 in facility

URO: 396 in office; 152 in facility

Billed Together

CPT Code 11981 is not typically billed with another service, nor is it typically billed with an E/M (1%).

Specialty Specific Data

The survey data by specialty is included on the summary spreadsheet. Note: The anticipated utilization of this service is suspected to be similar between urology and obstetrics/gynecology. The number of specialty responses (urology 36% and ob/gyn 64%) is disproportionate to the current and anticipated utilization.

Global Periods

The global period is changing from XXX to 000.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11981

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology How often? Commonly

Specialty Gynecology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. A national estimate is not available.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,711

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is difficult to estimate the utilization moving forward with this code family. We estimate that after the orthopedic utilization is removed and reported with their new CPT Codes, the remaining utilization for these services will be approximately 4000, with the primary reporters being urology and obstetrics/gynecology.

Specialty Urology	Frequency 600	Percentage 16.16 %
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Specialty Obstetrics/Gynecology	Frequency 800	Percentage 21.55 %
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Minor procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 11981

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 11982	Tracking Number C2	Original Specialty Recommended RVU: 1.70
		Presented Recommended RVU: 1.70
Global Period: 000	Current Work RVU: 1.78	RUC Recommended RVU: 1.70

CPT Descriptor: Removal, non-biodegradable drug delivery implant

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Obstetrics/Gynecology Vignette: A 25-year-old woman who desires to begin pregnancy planning presents for removal of a subdermal contraceptive. Urology Vignette: A 70-year-old male presents for removal of a non-biodegradable drug delivery implant.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Obstetrics/Gynecology: The history is reviewed to assure no allergies to anesthetic or antiseptic solution. The appropriate consent for treatment is obtained. The patient is placed in the supine position. Her nondominant arm is placed above her head, externally rotated with the elbow flexed and comfortably supported. The prior insertion site is palpated to locate the implant device. The area is prepped with antiseptic solution. The anesthetic lidocaine is injected into the skin over the palpated distal tip of the implant.

Urology: A physical examination and history is performed on the patient. Specific history components are paid attention to including the indication for hormone ablation and the indication for the removal of the device. The patient is counseled about the risks and benefits of removal including bleeding, infection and recurrence of the cancer with the removal of the hormonal ablation medication. Consent form is discuss with the patient and signed by the provider and patient. The arm with the device is placed above the head, externally rotated with the elbow flexed and resting comfortably supported. The arm is examined for evidence of device location and possible infection. The prior insertion site is palpated to locate the implant device. The surgeon washes their hands and places sterile gloves on. The area is prepped with antiseptic solution. The surgical field is draped with sterile drapes. The surgeon prepares the operative field with a syringe, 22 gauge needle and local anesthetic. The anesthetic is drawn up into the sterile syringe. The anesthetic is injected into the skin over the palpated distal tip of the implant and then deep around the implant to provide pain relief. The surgeon waits for five minutes for the anesthetic to take effect.

Description of Intra-Service Work: Obstetrics/Gynecology: An incision is made with a scalpel to access the implant. Fibrotic tissue is bluntly dissected away from the implant tip. Sharp incision into the tissue sheath may be required to mobilize the implant. The implant is pushed from the proximal end toward the incision. The implant is grasped with forceps and removed in an intact manner. Bleeding is controlled. Steri-strips and sterile dressing are applied to the incision.

Urology: An incision is made with a scalpel to access the implant. Scar tissue is dissected away from the implant with cautery. Sharp incision into the tissue sheath may be required to mobilize the implant. The implant is pushed from the proximal end toward the incision. The implant is grasped with forceps and removed in an intact manner. The implant is

carefully inspected to ensure it is intact. Bleeding is controlled. Steri-strips are used to close the wound. Sterile pressure dressing is applied to the incision.

Description of Post-Service Work: Obstetrics/Gynecology: The patient is instructed to continue with the pressure dressing for 24 hours and keep the area clean and dry. Instructions are given for relief of discomfort with ice packs and OTC analgesics. Patient is provided information regarding prenatal vitamins and pregnancy planning. The procedure is recorded in the patient record.

Urology: The patient is instructed to continue with the pressure dressing for 24 hours and to keep the area clean and dry. Instructions are given for relief of discomfort with ice packs and OTC analgesics. Pain control counseling is provided. Post procedure patient handout is given to both the patient and his care provider which includes wound care, return precautions, side effect expectation management, and recommended follow-up for monitoring of the prostate cancer after the removal of the hormone ablation. The procedure is recorded in the patient record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	George Hill, MD, Jon Hathaway, MD, Mitch Schuster, MD, Thomas Turk, MD, Kyle Richards, MD and Andrew Peterson, MD				
Specialty Society(ies):	ACOG and AUA				
CPT Code:	11982				
Sample Size:	10000	Resp N:	110	Response: 1.1 %	
Description of Sample:	Random samples from ACOG (4000) and AUA (6000)				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	5.00	12.00	150.00
Survey RVW:	0.90	1.70	2.00	2.34	5.20
Pre-Service Evaluation Time:			13.00		
Pre-Service Positioning Time:			2.00		
Pre-Service Scrub, Dress, Wait Time:			4.00		
Intra-Service Time:	4.00	8.00	10.00	15.00	35.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

6-NF Proc w local/topical anes care req wait time

CPT Code:	11982	Recommended Physician Work RVU: 1.70		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	13.00	17.00	-4.00	
Pre-Service Positioning Time:	1.00	1.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	4.00	5.00	-1.00	
Intra-Service Time:	10.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) N/A Survey Code is Non-Facility				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	5.00	0.00	5.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
54150	000	1.90	RUC Time

CPT Descriptor Circumcision, using clamp or other device with regional dorsal penile or ring block**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52287	000	3.20	RUC Time

CPT Descriptor Cystourethroscopy, with injection(s) for chemodenervation of the bladder**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
12004	000	1.44	RUC Time	22,716

CPT Descriptor 1 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

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
54150	000	1.90	RUC Time	246

CPT Descriptor 2 Circumcision, using clamp or other device with regional dorsal penile or ring block

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 15 % of respondents: 13.6 %

Number of respondents who choose 2nd Key Reference Code: 12 % of respondents: 10.9 %

TIME ESTIMATES (Median)

	CPT Code: <u>11982</u>	Top Key Reference CPT Code: <u>54150</u>	2nd Key Reference CPT Code: <u>52287</u>
Median Pre-Service Time	18.00	25.00	22.00
Median Intra-Service Time	10.00	15.00	21.00
Median Immediate Post-service Time	5.00	5.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	33.00	45.00	58.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	13%	53%	33%	0%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	33%	53%	13%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	20%	66%	13%
Physical effort required	20%	60%	20%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

33%

46%

20%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

8%

33%

42%

17%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

25%

42%

33%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

0%

18%

82%

Physical effort required

0%

18%

82%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

17%

33%

50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 11981 was identified in the 'different performing specialty from survey' screen. The CPT editorial panel created six add-on codes to describe orthopaedic drug delivery to differentiate the service from the service described in code 11981. CPT Codes 11982 and 11983 were identified as part of the 11981 family.

Time

The drug delivery implant procedures are typically performed in the office setting, so package 6 was selected. A minute was added to the positioning time.

Medicare 2017 data for 11982

OBG: 462 in office; 113 in facility

URO: 49 in office; 9 in facility

Billed Together

CPT Code 11982 is not typically billed with another service, nor is it typically billed with an E/M (2%).

Specialty Specific Data

The survey data by specialty is included on the summary spreadsheet. Note: The anticipated utilization of this service is suspected to be similar between urology and obstetrics/gynecology. The number of specialty responses (urology 35% and ob/gyn 65%) is disproportionate to the current and anticipated utilization.

Global Periods

The global period is changing from XXX to 000.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11982

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology How often? Commonly

Specialty Gynecology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. A national estimate is not available.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,339

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is difficult to estimate the utilization moving forward with this code family. We estimate that after the orthopedic utilization is removed and reported with their new CPT Codes, the remaining utilization for these services will be approximately 1500, with the primary reporter being obstetrics/gynecology.

Specialty obstetrics/gynecology	Frequency 600	Percentage 44.80 %
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Specialty urology	Frequency 100	Percentage 7.46 %
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Minor procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 11982

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 11983	Tracking Number C4	Original Specialty Recommended RVU: 2.10
		Presented Recommended RVU: 2.10
Global Period: 000	Current Work RVU: 3.30	RUC Recommended RVU: 2.10

CPT Descriptor: Removal with reinsertion, non-biodegradable drug delivery implant

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Gynecology Vignette: A 28-year-old woman who desires to continue prevention of pregnancy presents for removal of an expired subdermal contraceptive and subsequent re-insertion of same. Urology Vignette: A 70-year-old male with metastatic prostate cancer symptoms presents for removal of an expired non-biodegradable drug delivery implant and subsequent insertion of the same non-biodegradable drug delivery implant.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Obstetrics/Gynecology: Patient history is reviewed for allergies to antiseptic or anesthetic. Appropriate consent for procedure is obtained. The patient is placed in the supine position. Her non-dominant arm is placed above her head, externally rotated with the elbow flexed and resting comfortably supported. The patient's prior insertion site is palpated to locate the implant device and prior incision. The inner aspect of the upper arm is palpated to identify the medial epicondyle of the humerus and measure its position to the implant. A mark is made over the desired site of incision and more proximal to serve as an insertion guide for the new implant. The area is prepped with antiseptic solution. The distal end of the device is palpated, and lidocaine is injected along the implant.

Urology: A physical examination and history is performed on the patient. Specific history components are paid attention to including the indication for hormone ablation, failure or noncompliance with other forms of hormone ablation such as intermittent injection therapy and possible refusal of other forms of therapy including orchiectomy with surgical castration. Alternative therapies area reviewed with the patient. History is reviewed for possible side effects that may have occurred from the current implanted device including infection, pain and skin discomfort. The risks of replacement are discussed including bleeding, infection, hormone changes including hot flashes, weight gain and muscle loss. The patient is also counseled about current guidelines for follow-up after hormone ablation including need for cardiac screening, bone density monitoring, exercise and addition of vitamin D to their diet to prevent bone loss. Consent form is discuss with the patient and signed by the provider and patient. The arm with the device is placed above the head, externally rotated with the elbow flexed and resting comfortably supported. The arm is examined for evidence of device location and possible infection. The prior insertion site is palpated to locate the implant device. The surgeon washes their hands and places sterile gloves on. The area is prepped with antiseptic solution. The surgical field is draped with sterile drapes. The surgeon prepares the operative field with a syringe, 22gauge needle and local anesthetic. The anesthetic is drawn up into the sterile syringe. The anesthetic is injected into the skin over the palpated distal tip of the implant and then deep around the implant to provide pain relief. The surgeon waits for five minutes for the anesthetic to take effect.

Description of Intra-Service Work: Obstetrics/Gynecology: An incision is made to access the implant. Fibrotic tissue is bluntly dissected away from the implant tip. Sharp incision into the tissue sheath is made to mobilize the implant. The

implant is pushed from the proximal end toward the incision. The implant is grasped with forceps and removed in an intact manner. The patient is checked for adequate anesthetic along the planned insertion tunnel. Additional anesthetic is injected as required. A new transducer device with loaded implant is removed from sterile packaging and appropriate position of the implant within the needle is confirmed. The skin around the insertion site is stretched taut. The needle is inserted bevel up at a slight angle. The needle is then moved to a horizontal position, tenting the skin. The needle is gently inserted to its full length following the planned insertion line. The implant is released into the subdermal soft tissue. The insertion needle is removed. The distal and proximal tips of the new implant are palpated confirming release of the implant from the insertion needle and a subdermal position. Any bleeding is controlled. Steri-strips are applied to the incision. A pressure dressing is applied.

Urology: An incision is made with a scalpel to access the implant. Scar tissue is dissected away from the implant using cautery. Sharp incision into the tissue sheath may be required to mobilize the implant. The implant is pushed from the proximal end toward the incision. The implant is grasped with forceps and removed in an intact manner. The implant is carefully inspected to ensure it is intact. Bleeding is controlled. Steri-strips are used to close the wound. The skin around the insertion site is stretched taut and the insertion trochar is inserted with the bevel up at the marked insertion site at a slight angle. The trochar is then inserted to its full length following the planned insertion line by aiming at the previous mark and the implant is released into the subdermal soft tissue. The insertion needle is removed. The distal and proximal tip of the implant are both palpated, confirming release of the implant from the applicator needle and a subdermal position. Bleeding is controlled. Steri-strips are applied. Sterile pressure dressings are applied to both wounds.

Description of Post-Service Work: Obstetrics/Gynecology: The patient is instructed to continue with the pressure dressing for 24 hours and keep the area clean and dry. Instructions are given for relief of discomfort with ice pack and OTC analgesics. The procedure is recorded in the patient record.

Urology: The patient is instructed to continue with the pressure dressing for 24 hours and to keep the area clean and dry. Instructions are given for relief of discomfort with ice packs and OTC analgesics. Pain control counseling is provided. Post procedure patient handout is given to both the patient and his care provider which includes wound care, return precautions, side effect expectation management, and recommended follow-up for patients treated with hormone ablation per the guidelines for cardiac screening, exercise prescription, and bone health. The procedure is recorded in the patient record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	George Hill, MD, Jon Hathaway, MD, Mitch Schuster, MD, Thomas Turk, MD, Kyle Richards, MD and Andrew Peterson, MD				
Specialty Society(ies):	ACOG and AUA				
CPT Code:	11983				
Sample Size:	10000	Resp N:	112	Response: 1.1 %	
Description of Sample:	Random samples from ACOG (4000) and AUA (6000)				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	4.00	10.00	150.00
Survey RVW:	1.00	2.10	2.50	3.00	6.00
Pre-Service Evaluation Time:			15.00		
Pre-Service Positioning Time:			2.00		
Pre-Service Scrub, Dress, Wait Time:			4.00		
Intra-Service Time:	5.00	10.00	15.00	20.00	45.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

6-NF Proc w local/topical anes care req wait time

CPT Code:	11983	Recommended Physician Work RVU: 2.10		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	15.00	17.00	-2.00	
Pre-Service Positioning Time:	1.00	1.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	4.00	5.00	-1.00	
Intra-Service Time:	15.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) N/A Survey Code is Non-Facility				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	5.00	0.00	5.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52287	000	3.20	RUC Time

CPT Descriptor Cystourethroscopy, with injection(s) for chemodenervation of the bladder**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
55700	000	2.50	RUC Time

CPT Descriptor Biopsy, prostate; needle or punch, single or multiple, any approach**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
54150	000	1.90	RUC Time	246

CPT Descriptor 1 Circumcision, using clamp or other device with regional dorsal penile or ring block

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
52281	000	2.75	RUC Time	72,625

CPT Descriptor 2 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

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 28 % of respondents: 25.0 %

Number of respondents who choose 2nd Key Reference Code: 19 % of respondents: 16.9 %

TIME ESTIMATES (Median)

	CPT Code: <u>11983</u>	Top Key Reference CPT Code: <u>52287</u>	2nd Key Reference CPT Code: <u>55700</u>
Median Pre-Service Time	20.00	22.00	15.00
Median Intra-Service Time	15.00	21.00	15.00
Median Immediate Post-service Time	5.00	15.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	40.00	58.00	35.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	11%	54%	29%	7%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	21%	54%	25%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	7%	43%	50%
Physical effort required	11%	41%	48%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

25%

54%

21%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

16%

58%

21%

5%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

42%

37%

21%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

22%

39%

39%

Physical effort required

17%

56%

28%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

50%

28%

22%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 11981 was identified in the 'different performing specialty from survey' screen. The CPT editorial panel created six add-on codes to describe orthopaedic drug delivery to differentiate the service from the service described in code 11981. CPT Codes 11982 and 11983 were identified as part of the 11981 family.

Time

The drug delivery implant procedures are typically performed in the office setting, so package 6 was selected. A minute was added to the positioning time.

Medicare 2017 data for 11983

OBG: 198 in office; 31 in facility

URO: 475 in office; 69 in facility

Billed Together

CPT Code 11983 is not typically billed with another service, nor is it typically billed with an E/M (0%).

Specialty Specific Data

The survey data by specialty is included on the summary spreadsheet. Note: The anticipated utilization of this service is suspected to be similar between urology and obstetrics/gynecology. The number of specialty responses (urology 36% and ob/gyn 64%) is disproportionate to the current and anticipated utilization.

Global Periods

The global period is changing from XXX to 000.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11983

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology How often? Commonly

Specialty Gynecology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. A national estimate is not available.

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,185

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is difficult to estimate the utilization moving forward with this code family. We estimate that after the orthopedic utilization is removed and reported with their new CPT Codes, the remaining utilization for these services will be approximately 1300, with the primary reporter being obstetrics/gynecology.

Specialty Urology	Frequency 600	Percentage 50.63 %
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Specialty Obstetrics/Gynecology	Frequency 300	Percentage 25.31 %
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Minor procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 11983

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 20700 Tracking Number C5

Original Specialty Recommended RVU: **2.00**Presented Recommended RVU: **1.50**

Global Period: ZZZ Current Work RVU:

RUC Recommended RVU: **1.50**

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 19-year-old male undergoes surgical treatment of infected bone and soft tissues (reported separately). The surgeon then fabricates an antibiotic cement device that is placed deep (subfascial) in the affected area. [Note: This is an add-on code. Only consider the additional work for manual preparation and insertion of the antibiotic delivery device.]

Percentage of Survey Respondents who found Vignette to be Typical: 73%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The surgeon discusses the purpose of the drug delivery device with the patient and/or family; provides a brief description of the technical aspects; outlines the risks, benefits, alternatives and expected outcome; discusses the possible need for additional surgery to remove the device; and obtains informed consent.

The results of cultures and sensitivity data are reviewed to guide antibiotic selection. The surgeon confirms the patient is not allergic to the planned antibiotics and other materials that will be used to prepare the drug delivery device.

The surgeon confirms the availability and presence of the supplies and equipment needed to prepare the device (e.g. antibiotic powder; polymethyl methacrylate [PMMA] powder and liquid monomer; vacuum mixing system; and large caliber unbraided non-absorbable suture or wire).

Description of Intra-Service Work: Following thorough debridement of the infected bone and soft tissue (separately reported), the size of the “dead space” or defect is estimated. On the back table, the surgeon then makes the device. PMMA powder is mixed with antibiotic powder; most commonly 3.6 g of tobramycin and 1 g of vancomycin are used for each 40-g package of cement. Liquid monomer is added and the materials are mixed in a vacuum mixing system. As the cement begins to harden but is still soft, it is rolled into long rods 1.5 – 2.0 cm in diameter. These are cut into small segments 1.0 – 2.0 cm in length, each of which are then rolled into 1.5 – 2.0 cm diameter round beads. The beads are then threaded on the suture, maintaining reasonably equal spacing. After the cement has hardened, each bead is checked to make sure it is securely centered on the suture. A large knot is tied on one end, incorporating a metallic marker for imaging (e.g. vessel clip).

The string of beads is then provisionally set in the defect until adequate fill is obtained; beads are removed from the suture as needed. A large knot is then tied on the other end of the suture, with a metallic marker. The entire string of beads is removed, counted, and then re-inserted.

Description of Post-Service Work: The device, preparation, materials used and number and size of beads are documented in the medical record (e.g. written brief operative note and dictated complete operative note). Post-operative radiographs are reviewed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	William Creevy, MD; Hussein Elkousy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons; American Association of Hip and Knee Surgeons; Orthopaedic Trauma Association				
CPT Code:	20700				
Sample Size:	5070	Resp N:	139	Response: 2.7 %	
Description of Sample:	Random from each society membership databases.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	2.00	7.00	80.00
Survey RVW:	0.85	1.50	2.00	2.78	7.00
Pre-Service Evaluation Time:			5.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	5.00	14.00	20.00	30.00	60.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the **pre-service time package** that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	20700	Recommended Physician Work RVU: 1.50		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	5.00	0.00	5.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	20.00			
Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
ZZZ Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	2.00	0.00	2.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11047	ZZZ	1.80	RUC Time

CPT Descriptor 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)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11046	ZZZ	1.03	RUC Time

CPT Descriptor 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)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64484	ZZZ	1.00	RUC Time	450,460

CPT Descriptor 1 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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36227	ZZZ	2.09	RUC Time	11,539

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 50 % of respondents: 35.9 %

Number of respondents who choose 2nd Key Reference Code: 28 % of respondents: 20.1 %

TIME ESTIMATES (Median)

	CPT Code: <u>20700</u>	Top Key Reference CPT Code: <u>11047</u>	2nd Key Reference CPT Code: <u>11046</u>
Median Pre-Service Time	5.00	0.00	0.00
Median Intra-Service Time	20.00	30.00	20.00
Median Immediate Post-service Time	5.00	1.00	1.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	30.00	31.00	21.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	14%	30%	46%	10%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
12%	30%	58%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	14%	30%	56%

Physical effort required	14%	42%	44%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

14%	36%	50%
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2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	4%	7%	39%	39%	11%
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Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

4%	46%	50%
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Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	14%	32%	54%
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Physical effort required	11%	46%	43%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

7%	43%	50%
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Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In January 2018, the RAW identified code 11981 through a screen of "Different Performing Specialty from Survey." The RAW noted that this service was first surveyed in 2001 by the American Urological Association (AUA), but the

2016 Medicare utilization no shows orthopedic surgery as the primary provider. The RUC recommended that the service be referred to the CPT Panel to better define these services and to determine if musculoskeletal procedures should have separate codes to report.

At the May 2018 CPT Panel meeting, the Panel accepted a proposal for six new add-on codes supported by literature to report insertion and removal of drug delivery implant devices in conjunction with specific orthopedic primary procedures. These six new add-on codes are included in the musculoskeletal section of the CPT codebook and includes introductory guidelines and parenthetical notes. Separately, the CPT Panel addressed the current code family based on urology and obstetrics/gynecology procedures by adding parentheticals after codes 11981 and 11982. The code descriptors for 11981-11983 were not changed and remain based on urology and obstetrics/gynecology procedures.

Compelling Evidence for Codes 20700-20705

For CPT 2002, three new codes were developed specifically to describe insertion, removal, and removal with reinsertion of a non-biodegradable manufactured drug delivery implant. These codes were initially created to describe a once-yearly implant containing leuprolide acetate for the treatment of prostate cancer. However, because various types of medications for various indications can be administered using this type of implant, the CPT Editorial Panel voted to keep the descriptors generic. That is why the type of drug is not listed in the descriptors of these codes.

At the April 2001 RUC meeting, the RUC recommended that CMS develop RVUs for these codes by cross-walking the RVUs from CPT codes 11975, 11976, and 11977, insertion, removal and removal with reinsertion of implantable contraceptive capsules.

In April 2002, urology again submitted a letter requesting a crosswalk to the contraceptive capsule codes. The RUC adopted this as an interim solution and requested that AUA survey these codes for review at a future RUC meeting. The RUC understands that a survey of urologists who perform this procedure for a drug specific to urology would not apply to other specialties that may use this code for other drug implants in the future. The RUC agreed that the implant insertion would be equivalent work to the contraceptive capsule insertion and a survey is unlikely to produce different results and did not require a survey.

In January 2018, the RAW identified code 11981 through a screen of "Different Performing Specialty from Survey." The AAOS submitted an Action Plan that recommended referral to CPT to differentiate the musculoskeletal procedures that were never meant to be reported with codes 11981-11983 because those codes were clearly created for subcutaneous insertion of a once yearly manufactured drug-releasing implant. CPT required the AAOS to use the long form CPT proposal and submit literature to support the proposed musculoskeletal codes. AUA and ACOG did not make any changes to the current codes 11981-11983 as these codes will continue to represent insertion in the arm of a once yearly manufactured drug-releasing implant.

- ***Evidence that technology and patient has changed***

When codes 11981-11983 were created in 2002, drug delivery implants were only available for manufactured time-released implant products that were inserted just under the skin in the upper inside arm through a small puncture hole. Since that time, orthopedic surgeons have developed a method to manually fabricate drug delivery implants at the time of surgery—typically antibiotic-impregnated beads—to be implanted deep (eg, subfascial, intramedullary, intra-articular) at the time of a major open procedure for infections. The beads may subsequently be removed after the infection has resolved and a definitive procedure is performed. The work of 11981 and 11983 never included the manual preparation and implantation of a drug delivery device during a major open operation for infection and 11982 and 11983 never included the removal of the implant during a major open operation.

- ***Evidence that incorrect assumptions were made in the previous valuation of the service, such as a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data.***

Although it may appear that this compelling evidence argument would apply to the codes in this tab, the fact is that the services represented by codes 11981-11983 (insert/removal of manufactured time-released drug implant) have not changed from the original application submitted in 2001 and subsequent review by the RUC. Orthopaedic surgeons were not part of the original application in 2001 and valuation, and orthopaedic surgeons were not aware that these codes were only meant to describe subcutaneous insertion of a manufactured time-released drug implant. This resulted

in the codes being inadvertently reported for very different deep musculoskeletal procedures. The societies recommended and the RAW agreed, that referral to CPT for creation of new codes for this new and different work was appropriate. This required submission of a code change application and supporting literature to clearly describe the musculoskeletal work for a surgeon's manual preparation of drug delivery devices to be implanted deep.

Survey Sample and Process

A survey request was sent to a random selection of members from the American Academy of Orthopaedic Surgeons, American Association of Hip and Knee Surgeons, and Orthopaedic Trauma Association. The survey included all six codes.

Work Recommendation – 20700

The survey median work RVU of 2.00 is recommended for code 20700.

Time recommendation

An expert panel reviewed the survey data and determined that there was some confusion about whether the backbench manual preparation of the implant device was pre-time or intra-time. Specifically, some respondents included significantly more time in the pre-time category than the intra-time. This is evident by the increasing median pre-time for codes 20700, 20702, and 20704 (ie, the preparation of the implant for 20704 takes longer than 20700). However, we do not agree that the pre-time represents the time to manually prepare the device and that this time is mixed between the two categories of pre- and intra-time in the data.

Our expert panel believes the median total time of 30 minutes is accurate for the entire additional work required for 20700 which includes: consent for a device implant, collection of supplies and equipment to prepare the device, manually preparing the device intra-operatively, inserting the device, and then documenting the work and device (type, lot, manufacturer, etc.). We considered requesting collapsing all time into the intra-category, similar to what the RUC allows for other societies where there is a gray zone of the components of work. For example, pathology collapses all time (including review of records and dictation and documentation of final report) into the intra-time category. Allergy and immunology has similarly collapsed all work and time into the intra-time category.

We do not know of a rule about assigning work and time to add-on codes, so we are leaving the survey times in the three categories. However, we have collapsed the service description to the intra-service work category similar to what other specialties have done.

We strongly recommend the survey total time of 30 minutes as accurate for the total work of add-on code 20700 and we present the time data as 5/20/5 per the survey statistics.

Key Reference Codes

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
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)	1.80	0.059	31	0	30	1
20700	Manual preparation and insertion of drug delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)	2.00	0.089	30	5	20	5
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)	1.03	0.050	21	0	20	1

MPC Codes

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
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)	1.00	0.100	10	0	10	0
20700	Manual preparation and insertion of drug delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)	2.00	0.089	30	5	20	5
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)	2.09	0.139	15	0	15	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. (Use 206X0 in conjunction with 11010, 11011, 11012, 11043, 11044, 11046 11047, 20240, 20245, 20250, 20251, 21010, 21025, 21026, 21501, 21502, 21510, 21627, 21630, 22010, 22015, 23030, 23031, 23035, 23040, 23044, 23170, 23172, 23174, 23180, 23182, 23184, 23334, 23335, 23930, 23931, 23935 24000, 24134, 24136, 24138, 24140, 24147, 24160, 25031, 25035, 25040, 25145, 25150, 25151, 26070, 26230, 26235, 26236, 26990, 26991, 26992, 27030, 27070, 27071, 27090, 27301, 27303, 27310, 27360, 27603, 27604, 27610, 27640, 27641, 28001, 28002, 28003, 28020, 28120, 28122)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11981, 11983, 20999, primary procedure with modifier 22

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national utilization not available

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,446

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The expert panel summed the 2017 Medicare data for 11981, 11982, 11983 attributable to orthopaedic surgeons, plastic surgeons, hand surgeons, and podiatry and added 10% to account for reporting using unlisted codes or modifier 22 appended to the primary procedure. The expert panel also estimates a 15% / 15% / 70% split within each set of codes (deep, intramedullary, intra-articular) and a 50% split for 11983 between the insert and remove set of new codes. The result is: 20700=1446; 20702=1446; 20704=6748; 20701=511; 20703=511; 20705=2388 (see separate Excel utilization file for calculations).

Specialty orthopaedic surgery	Frequency 1362	Percentage 94.19 %
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Specialty	Frequency	Percentage	%
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:

Orthopedic - other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 20690

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 20701 Tracking Number C6

Original Specialty Recommended RVU: **1.13**Presented Recommended RVU: **1.13**

Global Period: ZZZ Current Work RVU:

RUC Recommended RVU: **1.13**

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 19-year-old male undergoes removal of a deep (subfascial) antibiotic delivery device during surgical treatment of a deep infection. [Note: This is an add-on code. Only consider the additional work for removal of the antibiotic delivery device.]

Percentage of Survey Respondents who found Vignette to be Typical: 77%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The surgeon reviews removal of the device with the patient and/or family; provides a brief description of the technical aspects; outlines the risks, benefits, alternatives and expected outcome; discusses the potential inability to remove the device totally, or in part, and the implications, including the need for additional surgery; and obtains informed consent.

Pre-operative radiographs, including anteroposterior and lateral views are evaluated to assess the location of the device, position of any metallic markers, and the total number of components or “beads” which is compared to the prior operative report.

Description of Intra-Service Work: The prior incision(s), in part or in total, are utilized. Exposure and dissection are completed until the device is identified. Soft tissues are carefully stripped from the device and it is manually removed. The number of beads are counted and fluoroscopy is used to confirm that the entire device has been removed..

Description of Post-Service Work: Removal of the device is documented in the medical record (e.g. written brief operative note and dictated complete operative note). Post-operative radiographs are reviewed..

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	William Creevy, MD; Hussein Elkousy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons; American Association of Hip and Knee Surgeons; Orthopaedic Trauma Association				
CPT Code:	20701				
Sample Size:	5070	Resp N:	133	Response:	2.6 %
Description of Sample:	Random from each society membership databases.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	2.00	6.00	80.00
Survey RVW:	0.85	1.13	1.75	2.05	7.00
Pre-Service Evaluation Time:			5.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	5.00	10.00	15.00	20.00	45.00
Immediate Post Service-Time:	<u>2.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	20701	Recommended Physician Work RVU: 1.13		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	1.00	0.00	1.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	15.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
ZZZ Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	2.00	0.00	2.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11047	ZZZ	1.80	RUC Time

CPT Descriptor 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)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11046	ZZZ	1.03	RUC Time

CPT Descriptor 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)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64484	ZZZ	1.00	RUC Time	450,460

CPT Descriptor 1 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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64480	ZZZ	1.20	RUC Time	22,183

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 40 % of respondents: 30.0 %

Number of respondents who choose 2nd Key Reference Code: 40 % of respondents: 30.0 %

TIME ESTIMATES (Median)

	CPT Code: <u>20701</u>	Top Key Reference CPT Code: <u>11047</u>	2nd Key Reference CPT Code: <u>11046</u>
Median Pre-Service Time	1.00	0.00	0.00
Median Intra-Service Time	15.00	30.00	20.00
Median Immediate Post-service Time	2.00	1.00	1.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	18.00	31.00	21.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	3%	13%	48%	33%	5%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
23%	53%	25%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	15%	50%	35%

Physical effort required	10%	58%	33%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

13%

53%

35%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	10%	60%	28%	3%
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Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

20%

50%

30%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	15%	58%	28%
--------------------------	-----	-----	-----

Physical effort required	20%	48%	33%
--------------------------	-----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

13%

58%

30%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In January 2018, the RAW identified code 11981 through a screen of "Different Performing Specialty from Survey." The RAW noted that this service was first surveyed in 2001 by the American Urological Association (AUA), but the

2016 Medicare utilization no shows orthopedic surgery as the primary provider. The RUC recommended that the service be referred to the CPT Panel to better define these services and to determine if musculoskeletal procedures should have separate codes to report.

At the May 2018 CPT Panel meeting, the Panel accepted a proposal for six new add-on codes supported by literature to report insertion and removal of drug delivery implant devices in conjunction with specific orthopedic primary procedures. These six new add-on codes are included in the musculoskeletal section of the CPT codebook and includes introductory guidelines and parenthetical notes. Separately, the CPT Panel addressed the current code family based on urology and obstetrics/gynecology procedures by adding parentheticals after codes 11981 and 11982. The code descriptors for 11981-11983 were not changed and remain based on urology and obstetrics/gynecology procedures.

Compelling Evidence for Codes 20700-20705

For CPT 2002, three new codes were developed specifically to describe insertion, removal, and removal with reinsertion of a non-biodegradable manufactured drug delivery implant. These codes were initially created to describe a once-yearly implant containing leuprolide acetate for the treatment of prostate cancer. However, because various types of medications for various indications can be administered using this type of implant, the CPT Editorial Panel voted to keep the descriptors generic. That is why the type of drug is not listed in the descriptors of these codes.

At the April 2001 RUC meeting, the RUC recommended that CMS develop RVUs for these codes by cross-walking the RVUs from CPT codes 11975, 11976, and 11977, insertion, removal and removal with reinsertion of implantable contraceptive capsules.

In April 2002, urology again submitted a letter requesting a crosswalk to the contraceptive capsule codes. The RUC adopted this as an interim solution and requested that AUA survey these codes for review at a future RUC meeting. The RUC understands that a survey of urologists who perform this procedure for a drug specific to urology would not apply to other specialties that may use this code for other drug implants in the future. The RUC agreed that the implant insertion would be equivalent work to the contraceptive capsule insertion and a survey is unlikely to produce different results and did not require a survey.

In January 2018, the RAW identified code 11981 through a screen of "Different Performing Specialty from Survey." The AAOS submitted an Action Plan that recommended referral to CPT to differentiate the musculoskeletal procedures that were never meant to be reported with codes 11981-11983 because those codes were clearly created for subcutaneous insertion of a once yearly manufactured drug-releasing implant. CPT required the AAOS to use the long form CPT proposal and submit literature to support the proposed musculoskeletal codes. AUA and ACOG did not make any changes to the current codes 11981-11983 as these codes will continue to represent insertion in the arm of a once yearly manufactured drug-releasing implant.

- ***Evidence that technology and patient has changed***

When codes 11981-11983 were created in 2002, drug delivery implants were only available for manufactured time-released implant products that were inserted just under the skin in the upper inside arm through a small puncture hole. Since that time, orthopedic surgeons have developed a method to manually fabricate drug delivery implants at the time of surgery—typically antibiotic-impregnated beads—to be implanted deep (eg, subfascial, intramedullary, intra-articular) at the time of a major open procedure for infections. The beads may subsequently be removed after the infection has resolved and a definitive procedure is performed. The work of 11981 and 11983 never included the manual preparation and implantation of a drug delivery device during a major open operation for infection and 11982 and 11983 never included the removal of the implant during a major open operation.

- ***Evidence that incorrect assumptions were made in the previous valuation of the service, such as a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data.***

Although it may appear that this compelling evidence argument would apply to the codes in this tab, the fact is that the services represented by codes 11981-11983 (insert/removal of manufactured time-released drug implant) have not changed from the original application submitted in 2001 and subsequent review by the RUC. Orthopaedic surgeons were not part of the original application in 2001 and valuation, and orthopaedic surgeons were not aware that these codes were only meant to describe subcutaneous insertion of a manufactured time-released drug implant. This resulted

in the codes being inadvertently reported for very different deep musculoskeletal procedures. The societies recommended and the RAW agreed, that referral to CPT for creation of new codes for this new and different work was appropriate. This required submission of a code change application and supporting literature to clearly describe the musculoskeletal work for a surgeon's manual preparation of drug delivery devices to be implanted deep.

Survey Sample and Process

A survey request was sent to a random selection of members from the American Academy of Orthopaedic Surgeons, American Association of Hip and Knee Surgeons, and Orthopaedic Trauma Association. The survey included all six codes.

Work Recommendation – 20701

The survey 25th percentile work RVU of 1.13 is recommended for code 20701.

Time recommendation

Unlike the codes for manual preparation and insertion of a drug delivery device, codes 20701, 20703, and 20705 are clear typical add-on codes with limited pre- and post-work related to the add-on service that is not part of the primary procedure.

Our expert panel believes the survey respondents may have overestimated the pre-service time which would include addition time related to discussion removal of the implant during the consent process and to confirm availability of equipment necessary to remove the device. We also believe the survey respondents may have overestimated the post-service time which would include addition time related to documentation of the additional work. **We recommend one minute for pre-service work and two minutes for post-service work related to the add-on code 20701 that is not included in the work of the primary procedure.**

Key Reference Codes

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
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)	1.80	0.059	31	0	30	1
20701	Removal of drug delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)	1.13	0.071	18	1	15	2
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)	1.03	0.050	21	0	20	1

MPC Codes

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
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)	1.00	0.100	10	0	10	0
20701	Removal of drug delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)	1.13	0.071	18	1	15	2
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)	1.20	0.080	15	0	15	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. (Use 206X3 in conjunction with 11010, 11011, 11012, 11043, 11044, 11046 11047, 20240, 20245, 20250, 20251, 21010, 21025, 21026, 21501, 21502, 21510, 21627, 21630, 22010, 22015, 23030, 23031, 23035, 23040, 23044, 23170, 23172, 23174, 23180, 23182, 23184, 23334, 23335, 23930, 23931, 23935 24000, 24134, 24136, 24138, 24140, 24147, 24160, 25031, 25035, 25040, 25145, 25150, 25151, 26070, 26230, 26235, 26236, 26990, 26991, 26992, 27030, 27070, 27071, 27090, 27301, 27303, 27310, 27360, 27603, 27604, 27610, 27640, 27641, 28001, 28002, 28003, 28020, 28120, 28122)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11982, 11983, 20999, or primary procedure with modifier 22 appended

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic surgery

How often? Sometimes

Specialty

How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national utilization not available

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 511
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The expert panel summed the 2017 Medicare data for 11981, 11982, 11983 attributable to orthopaedic surgeons, plastic surgeons, hand surgeons, and podiatry and added 10% to account for reporting using unlisted codes or modifier 22 appended to the primary procedure. The expert panel also estimates a 15% / 15% / 70% split within each set of codes (deep, intramedullary, intra-articular) and a 50% split for 11983 between the insert and remove set of new codes. The result is: 20700=1446; 20702=1446; 20704=6748; 20701=511; 20703=511; 20705=2388 (see separate Excel utilization file for calculations).

Specialty orthopaedic surgery	Frequency 480	Percentage 93.93 %
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Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:

Orthopedic - other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 20690

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 20702 Tracking Number C7

Original Specialty Recommended RVU: **3.25**Presented Recommended RVU: **2.50**

Global Period: ZZZ Current Work RVU:

RUC Recommended RVU: **2.50**

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 19-year-old male undergoes surgical treatment of infected bone and soft tissues (reported separately). The surgeon then fabricates an antibiotic cement device that is placed within the intramedullary canal of the tibia. [Note: This is an add-on code. Only consider the additional work for manual preparation and insertion of the antibiotic delivery device.]

Percentage of Survey Respondents who found Vignette to be Typical: 71%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

The surgeon discusses the purpose of the drug delivery device with the patient and/or family; provides a brief description of the technical aspects; outlines the risks, benefits, alternatives and expected outcome; discusses the possible need for additional surgery to remove the device; and obtains informed consent.

Pre-operative radiographs, including anteroposterior and lateral views of the entire bone are evaluated to estimate the size (length and diameter) of the intramedullary drug delivery device that will be prepared.

The results of cultures and sensitivity data are reviewed to guide antibiotic selection. The surgeon confirms the patient is not allergic to the planned antibiotics and other materials that will be used to prepare the drug delivery device.

The surgeon confirms the availability and presence of the supplies and equipment needed to formulate the device (e.g. antibiotic powder; polymethyl methacrylate [PMMA] powder and liquid monomer; vacuum mixing system; pressurized insertion gun; lubricant; appropriately sized silicone tubing or chest tube; and a small diameter nail, rod or wire).

Description of Intra-Service Work: Following thorough debridement of the infected bone and soft tissue (separately reported), the length and diameter of the drug delivery nail device are finalized. The instruments that were used for the “dirty” portion of the procedure are removed, new instruments are opened and set-up, the patient’s limb is prepped again and re-draped, and the surgical team changes gowns and gloves. The “clean” portion of the procedure begins.

On the back table, the surgeon makes the device. An appropriate diameter silicone tubing or chest tube is selected and then cut to the correct length. Sterile mineral oil is used to lubricate the inner portion. PMMA powder is mixed with antibiotic powder; most commonly 3.6 g of tobramycin and 1 g of vancomycin are used with each 40-g package of cement. Liquid monomer is added and the materials are mixed in a vacuum mixing system. A container with the cement in liquid form is

then transferred 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 (e.g. 5.0 mm threaded Harrington rod, 4.5 mm Ender nail, 4.0 mm ball-tipped guide-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 “PMMA antibiotic nail”. At the distal end of the nail, the wire is bent and/or a nut is threaded onto the rod.

Under fluoroscopic control, the device is advanced 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.

Description of Post-Service Work: The device preparation, materials and construct dimensions are documented in the medical record (e.g. written brief operative note and dictated complete operative note). Post-operative radiographs are reviewed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	William Creevy, MD; Hussein Elkousy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons; American Association of Hip and Knee Surgeons; Orthopaedic Trauma Association				
CPT Code:	20702				
Sample Size:	5070	Resp N:	141	Response: 2.7 %	
Description of Sample:	Random from each society membership databases.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	3.00	8.00	50.00
Survey RVW:	1.00	2.50	3.25	4.15	9.00
Pre-Service Evaluation Time:			8.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	5.00	18.00	25.00	36.00	90.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the **pre-service time package** that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	20702	Recommended Physician Work RVU: 2.50		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	5.00	0.00	5.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	25.00			
Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
ZZZ Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	2.00	0.00	2.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11047	<u>ZZZ</u>	1.80	<u>RUC Time</u>

CPT Descriptor 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)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
22515	<u>ZZZ</u>	4.00	<u>RUC Time</u>

CPT Descriptor Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36227	<u>ZZZ</u>	2.09	<u>RUC Time</u>	11,539

CPT Descriptor 1 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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
57267	<u>ZZZ</u>	4.88	<u>RUC Time</u>	5,500

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 49 **% of respondents:** 34.7 %

Number of respondents who choose 2nd Key Reference Code: 19 **% of respondents:** 13.4 %

TIME ESTIMATES (Median)

	CPT Code: <u>20702</u>	Top Key Reference CPT Code: <u>11047</u>	2nd Key Reference CPT Code: <u>22515</u>
Median Pre-Service Time	5.00	0.00	1.00
Median Intra-Service Time	25.00	30.00	30.00
Median Immediate Post-service Time	2.00	1.00	1.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	32.00	31.00	32.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	4%	18%	59%	18%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	6%	22%	71%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	14%	18%	67%
Physical effort required	2%	41%	57%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	4%	33%	63%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	11%	42%	42%	5%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	26%	37%	37%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	11%	53%	37%
Physical effort required	11%	37%	53%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	21%	42%	37%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In January 2018, the RAW identified code 11981 through a screen of "Different Performing Specialty from Survey." The RAW noted that this service was first surveyed in 2001 by the American Urological Association (AUA), but the 2016 Medicare utilization no shows orthopedic surgery as the primary provider. The RUC recommended that the service be referred to the CPT Panel to better define these services and to determine if musculoskeletal procedures should have separate codes to report.

At the May 2018 CPT Panel meeting, the Panel accepted a proposal for six new add-on codes supported by literature to report insertion and removal of drug delivery implant devices in conjunction with specific orthopedic primary procedures. These six new add-on codes are included in the musculoskeletal section of the CPT codebook and includes introductory guidelines and parenthetical notes. Separately, the CPT Panel addressed the current code family based on urology and obstetrics/gynecology procedures by adding parentheticals after codes 11981 and 11982. The code descriptors for 11981-11983 were not changed and remain based on urology and obstetrics/gynecology procedures.

Compelling Evidence for Codes 20700-20705

For CPT 2002, three new codes were developed specifically to describe insertion, removal, and removal with reinsertion of a non-biodegradable manufactured drug delivery implant. These codes were initially created to describe a once-yearly implant containing leuprolide acetate for the treatment of prostate cancer. However, because various types of medications for various indications can be administered using this type of implant, the CPT Editorial Panel voted to keep the descriptors generic. That is why the type of drug is not listed in the descriptors of these codes.

At the April 2001 RUC meeting, the RUC recommended that CMS develop RVUs for these codes by cross-walking the RVUs from CPT codes 11975, 11976, and 11977, insertion, removal and removal with reinsertion of implantable contraceptive capsules.

In April 2002, urology again submitted a letter requesting a crosswalk to the contraceptive capsule codes. The RUC adopted this as an interim solution and requested that AUA survey these codes for review at a future RUC meeting. The RUC understands that a survey of urologists who perform this procedure for a drug specific to urology would not apply to other specialties that may use this code for other drug implants in the future. The RUC agreed that the implant insertion would be equivalent work to the contraceptive capsule insertion and a survey is unlikely to produce different results and did not require a survey.

In January 2018, the RAW identified code 11981 through a screen of "Different Performing Specialty from Survey." The AAOS submitted an Action Plan that recommended referral to CPT to differentiate the musculoskeletal procedures that were never meant to be reported with codes 11981-11983 because those codes were clearly created for subcutaneous insertion of a once yearly manufactured drug-releasing implant. CPT required the AAOS to use the long form CPT proposal and submit literature to support the proposed musculoskeletal codes. AUA and ACOG did not make any changes to the current codes 11981-11983 as these codes will continue to represent insertion in the arm of a once yearly manufactured drug-releasing implant.

- ***Evidence that technology and patient has changed***

When codes 11981-11983 were created in 2002, drug delivery implants were only available for manufactured time-released implant products that were inserted just under the skin in the upper inside arm through a small puncture hole. Since that time, orthopedic surgeons have developed a method to manually fabricate drug delivery implants at the time of surgery—typically antibiotic-impregnated beads—to be implanted deep (eg, subfascial, intramedullary, intra-articular) at the time of a major open procedure for infections. The beads may subsequently be removed after the infection has resolved and a definitive procedure is performed. The work of 11981 and 11983 never included the manual preparation and implantation of a drug delivery device during a major open operation for infection and 11982 and 11983 never included the removal of the implant during a major open operation.

- ***Evidence that incorrect assumptions were made in the previous valuation of the service, such as a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data.***

Although it may appear that this compelling evidence argument would apply to the codes in this tab, the fact is that the services represented by codes 11981-11983 (insert/removal of manufactured time-released drug implant) have not changed from the original application submitted in 2001 and subsequent review by the RUC. Orthopaedic surgeons were not part of the original application in 2001 and valuation, and orthopaedic surgeons were not aware that these codes were only meant to describe subcutaneous insertion of a manufactured time-released drug implant. This resulted in the codes being inadvertently reported for very different deep musculoskeletal procedures. The societies recommended and the RAW agreed, that referral to CPT for creation of new codes for this new and different work was appropriate. This required submission of a code change application and supporting literature to clearly describe the musculoskeletal work for a surgeon's manual preparation of drug delivery devices to be implanted deep.

Survey Sample and Process

A survey request was sent to a random selection of members from the American Academy of Orthopaedic Surgeons, American Association of Hip and Knee Surgeons, and Orthopaedic Trauma Association. The survey included all six codes.

Work Recommendation – 20702

The survey median work RVU of 3.25 is recommended for code 20702.

Time recommendation

An expert panel reviewed the survey data and determined that there was some confusion about whether the backbench manual preparation of the implant device was pre-time or intra-time. Specifically, some respondents included significantly more time in the pre-time category than the intra-time. This is evident by the increasing median pre-time for codes 20700, 20702, and 20704 (ie, the preparation of the implant for 20704 takes longer than 20700). However, we do not agree that the pre-time represents the time to manually prepare the device and that this time is mixed between the two categories of pre- and intra-time in the data.

Our expert panel believes the median total time of 38 minutes is accurate for the entire additional work required for 206X1 which includes: consent for a device implant, collection of supplies and equipment to prepare the device, manually preparing the device intra-operatively, inserting the device, and then documenting the work and device (type, lot, manufacturer, etc.). We considered requesting collapsing all time into the intra-category, similar to what the RUC allows for other societies where there is a gray zone of the components of work. For example, pathology collapses all time (including review of records and dictation and documentation of final report) into the intra-time category. Allergy and immunology has similarly collapsed all work and time into the intra-time category.

We do not know of a rule about assigning work and time to add-on codes, so we are leaving the survey times in the three categories. However, we have collapsed the service description to the intra-service work category similar to what other specialties have done.

We strongly recommend the survey total time of 38 minutes as accurate for the total work of add-on code 20702 and we present the time data as 8/25/5 per the survey statistics.

Key Reference Codes

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
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)	1.80	0.059	31	0	30	1
20702	Manual preparation and insertion of drug delivery device(s), intramedullary (List separately in addition to code for primary procedure)	3.25	0.118	38	8	25	5
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)	4.00	0.132	32	1	30	1

MPC Codes

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
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)	2.09	0.139	15	0	15	0
20702	Manual preparation and insertion of drug delivery device(s), intramedullary (List separately in addition to code for primary procedure)	3.25	0.118	38	8	25	5
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)	4.88	0.108	45	0	45	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. (Use 206X1 in conjunction with, 20680, 20690, 20692, 20694, 20802, 20805, 20838, 23170, 23180, 23184, 23935, 24134, 24138, 24140, 24147, 24516, 25145, 25150, 25151, 25400, 25515, 25525, 25526, 25545, 25574, 25575, 27245, 27259, 27360, 27470, 27506, 27640, 21510, 23035, 23515, 23615, 24430, 25035, 27720)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11981, 11983, 20999, or primary procedure with modifier 22 appended

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national utilization not available

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,446

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The expert panel summed the 2017 Medicare data for 11981, 11982, 11983 attributable to orthopaedic surgeons, plastic surgeons, hand surgeons, and podiatry and added 10% to account for reporting using unlisted codes or modifier 22 appended to the primary procedure. The expert panel also estimates a 15% / 15% / 70% split within each set of codes (deep, intramedullary, intra-articular) and a 50% split for 11983 between the insert and remove set of new codes. The result is: 20700=1446; 20702=1446; 20704=6748; 20701=511; 20703=511; 20705=2388 (see separate Excel utilization file for calculations).

Specialty orthopaedic surgery	Frequency 1362	Percentage 94.19 %
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Specialty	Frequency	Percentage	%
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:

Orthopedic - other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 20690

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 20703	Tracking Number C8	Original Specialty Recommended RVU: 1.80
		Presented Recommended RVU: 1.80
Global Period: ZZZ	Current Work RVU:	RUC Recommended RVU: 1.80

CPT Descriptor: Removal of drug delivery device, intramedullary (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 19-year-old male undergoes removal of an intramedullary antibiotic cement device during surgical treatment of a deep infection. [Note: This is an add-on code. Only consider the additional work for removal of the antibiotic delivery device.]

Percentage of Survey Respondents who found Vignette to be Typical: 73%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The surgeon reviews removal of the device with the patient and/or family; provides a brief description of the technical aspects; outlines the risks, benefits, alternatives and expected outcome; discusses the potential inability to remove the device totally, or in part, and the implications, including the need for additional surgery; and obtains informed consent.

Pre-operative radiographs, including anteroposterior and lateral views are evaluated to assess the location and integrity of the device.

The surgeon confirms the presence of the equipment and specialized instruments required for removal (e.g. thin flexible osteotomes, high speed burr, nail/implant extraction kits).

Description of Intra-Service Work: The prior incision(s), in part or in total, are utilized. Exposure and dissection are completed until the device is identified.

Thin osteotomes are used to loosen the device at the bone cement interface, taking care to minimize bone loss. An extraction tool is attached and the device is removed. Not infrequently the cement fractures and multiple fragments must be removed individually. Supplemental anchoring components and/or cement in the medullary canal are removed with osteotomes, curettes, and grasping instruments; fluoroscopic control may be utilized for this portion.

Fluoroscopy is used to confirm that the entire device has been removed..

Description of Post-Service Work: Removal of the device is documented in the medical record (e.g. written brief operative note and dictated complete operative note). Post-operative radiographs are reviewed..

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	William Creevy, MD; Hussein Elkousy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons; American Association of Hip and Knee Surgeons; Orthopaedic Trauma Association				
CPT Code:	20703				
Sample Size:	5070	Resp N:	139	Response: 2.7 %	
Description of Sample:	Random from each society membership databases.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	3.00	8.00	40.00
Survey RVW:	0.85	1.80	2.50	3.68	8.00
Pre-Service Evaluation Time:			5.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	5.00	15.00	20.00	30.00	75.00
Immediate Post Service-Time:	3.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the **pre-service time package** that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	20703	Recommended Physician Work RVU: 1.80		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	1.00	0.00	1.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	20.00			
Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
ZZZ Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	2.00	0.00	2.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11047	ZZZ	1.80	RUC Time

CPT Descriptor 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)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
20985	ZZZ	2.50	RUC Time

CPT Descriptor Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
37253	ZZZ	1.44	RUC Time	38,310

CPT Descriptor 1 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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36227	ZZZ	2.09	RUC Time	11,539

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 53 % of respondents: 38.1 %

Number of respondents who choose 2nd Key Reference Code: 13 % of respondents: 9.3 %

TIME ESTIMATES (Median)

	CPT Code: <u>20703</u>	Top Key Reference CPT Code: <u>11047</u>	2nd Key Reference CPT Code: <u>20985</u>
Median Pre-Service Time	1.00	0.00	10.00
Median Intra-Service Time	20.00	30.00	20.00
Median Immediate Post-service Time	2.00	1.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	23.00	31.00	30.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	13%	43%	38%	6%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	21%	47%	32%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	11%	51%	38%
Physical effort required	6%	49%	45%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	19%	38%	43%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	8%	8%	15%	69%	0%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	15%	54%	31%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	23%	38%	38%
Physical effort required	8%	46%	46%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	8%	31%	62%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In January 2018, the RAW identified code 11981 through a screen of "Different Performing Specialty from Survey." The RAW noted that this service was first surveyed in 2001 by the American Urological Association (AUA), but the 2016 Medicare utilization no shows orthopedic surgery as the primary provider. The RUC recommended that the service be referred to the CPT Panel to better define these services and to determine if musculoskeletal procedures should have separate codes to report.

At the May 2018 CPT Panel meeting, the Panel accepted a proposal for six new add-on codes supported by literature to report insertion and removal of drug delivery implant devices in conjunction with specific orthopedic primary procedures. These six new add-on codes are included in the musculoskeletal section of the CPT codebook and includes introductory guidelines and parenthetical notes. Separately, the CPT Panel addressed the current code family based on urology and obstetrics/gynecology procedures by adding parentheticals after codes 11981 and 11982. The code descriptors for 11981-11983 were not changed and remain based on urology and obstetrics/gynecology procedures.

Compelling Evidence for Codes 20700-20705

For CPT 2002, three new codes were developed specifically to describe insertion, removal, and removal with reinsertion of a non-biodegradable manufactured drug delivery implant. These codes were initially created to describe a once-yearly implant containing leuprolide acetate for the treatment of prostate cancer. However, because various types of medications for various indications can be administered using this type of implant, the CPT Editorial Panel voted to keep the descriptors generic. That is why the type of drug is not listed in the descriptors of these codes.

At the April 2001 RUC meeting, the RUC recommended that CMS develop RVUs for these codes by cross-walking the RVUs from CPT codes 11975, 11976, and 11977, insertion, removal and removal with reinsertion of implantable contraceptive capsules.

In April 2002, urology again submitted a letter requesting a crosswalk to the contraceptive capsule codes. The RUC adopted this as an interim solution and requested that AUA survey these codes for review at a future RUC meeting. The RUC understands that a survey of urologists who perform this procedure for a drug specific to urology would not apply to other specialties that may use this code for other drug implants in the future. The RUC agreed that the implant insertion would be equivalent work to the contraceptive capsule insertion and a survey is unlikely to produce different results and did not require a survey.

In January 2018, the RAW identified code 11981 through a screen of "Different Performing Specialty from Survey." The AAOS submitted an Action Plan that recommended referral to CPT to differentiate the musculoskeletal procedures that were never meant to be reported with codes 11981-11983 because those codes were clearly created for subcutaneous insertion of a once yearly manufactured drug-releasing implant. CPT required the AAOS to use the long form CPT proposal and submit literature to support the proposed musculoskeletal codes. AUA and ACOG did not make any changes to the current codes 11981-11983 as these codes will continue to represent insertion in the arm of a once yearly manufactured drug-releasing implant.

- ***Evidence that technology and patient has changed***

When codes 11981-11983 were created in 2002, drug delivery implants were only available for manufactured time-released implant products that were inserted just under the skin in the upper inside arm through a small puncture hole. Since that time, orthopedic surgeons have developed a method to manually fabricate drug delivery implants at the time of surgery—typically antibiotic-impregnated beads—to be implanted deep (eg, subfascial, intramedullary, intra-articular) at the time of a major open procedure for infections. The beads may subsequently be removed after the infection has resolved and a definitive procedure is performed. The work of 11981 and 11983 never included the manual preparation and implantation of a drug delivery device during a major open operation for infection and 11982 and 11983 never included the removal of the implant during a major open operation.

- ***Evidence that incorrect assumptions were made in the previous valuation of the service, such as a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data.***

Although it may appear that this compelling evidence argument would apply to the codes in this tab, the fact is that the services represented by codes 11981-11983 (insert/removal of manufactured time-released drug implant) have not changed from the original application submitted in 2001 and subsequent review by the RUC. Orthopaedic surgeons were not part of the original application in 2001 and valuation, and orthopaedic surgeons were not aware that these codes were only meant to describe subcutaneous insertion of a manufactured time-released drug implant. This resulted in the codes being inadvertently reported for very different deep musculoskeletal procedures. The societies recommended and the RAW agreed, that referral to CPT for creation of new codes for this new and different work was appropriate. This required submission of a code change application and supporting literature to clearly describe the musculoskeletal work for a surgeon's manual preparation of drug delivery devices to be implanted deep.

Survey Sample and Process

A survey request was sent to a random selection of members from the American Academy of Orthopaedic Surgeons, American Association of Hip and Knee Surgeons, and Orthopaedic Trauma Association. The survey included all six codes.

Work Recommendation – 20703

The survey 25th percentile work RVU of 1.80 is recommended for code 20703.

Time recommendation

Unlike the codes for manual preparation and insertion of a drug delivery device, codes 20701, 20703, and 20705 are clear typical add-on codes with limited pre- and post-work related to the add-on service that is not part of the primary procedure.

Our expert panel believes the survey respondents may have overestimated the pre-service time which would include addition time related to discussion removal of the implant during the consent process and to confirm availability of equipment necessary to remove the device. We also believe the survey respondents may have overestimated the post-service time which would include addition time related to documentation of the additional work. **We recommend one minute for pre-service work and two minutes for post-service work related to the add-on code 20703 that is not included in the work of the primary procedure.**

Key Reference Codes

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
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)	1.80	0.059	31	0	30	1
20703	Removal of drug delivery device, intramedullary (List separately in addition to code for primary procedure)	1.80	0.087	23	1	20	2
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)	2.50	0.114	31	0	30	1

MPC Codes

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
37253	Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)	1.44	0.071	21	0	20	1
20703	Removal of drug delivery device, intramedullary (List separately in addition to code for primary procedure)	1.80	0.087	23	1	20	2
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)	2.09	0.139	15	0	15	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. (Use 206X4 in conjunction with 20694, 20690, 20692, 20694, 20802, 20805, 20838, 23170, 23180, 23184, 23935, 24134, 24138, 24140, 24147, 24516, 25145, 25150, 25151, 25400, 25515, 25525, 25526, 25545, 25574, 25575, 27245, 27259, 27360, 27470, 27506, 27640, 21510, 23035, 23515, 23615, 24430, 25035, 27720)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11982, 11983, 20999, or primary procedure with modifier 22 appended

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national utilization not available

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 511
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The expert panel summed the 2017 Medicare data for 11981, 11982, 11983 attributable to orthopaedic surgeons, plastic surgeons, hand surgeons, and podiatry and added 10% to account for reporting using unlisted codes or modifier 22 appended to the primary procedure. The expert panel also estimates a 15% / 15% / 70% split within each set of codes (deep, intramedullary, intra-articular) and a 50% split for 11983 between the insert and remove set of new codes. The result is: 20700=1446; 20702=1446; 20704=6748; 20701=511; 20703=511; 20705=2388 (see separate Excel utilization file for calculations).

Specialty orthopaedic surgery	Frequency 480	Percentage 93.93 %
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Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:

Orthopedic - other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 20690

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 20704 Tracking Number C9

Original Specialty Recommended RVU: **4.00**Presented Recommended RVU: **2.60**

Global Period: ZZZ Current Work RVU:

RUC Recommended RVU: **2.60**

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old male undergoes surgical treatment of a native joint infection (reported separately). The surgeon then fabricates an antibiotic cement device that is placed intra-articular. [Note: This is an add-on code. Only consider the additional work for manual preparation and insertion of the antibiotic delivery device.]

Percentage of Survey Respondents who found Vignette to be Typical: 77%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is;
Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The surgeon discusses the purpose of the drug delivery with the patient and/or family; provides a brief description of the technical aspects; outlines the risks, benefits, alternatives and expected outcome; discusses the possible need for additional surgery to remove the device; and obtains informed consent.

Pre-operative radiographs, including anteroposterior and lateral views are evaluated to estimate the size of the intra-articular device.

The results of cultures and sensitivity data are reviewed to guide antibiotic selection. The surgeon confirms the patient is not allergic to the planned antibiotics and other materials that will be used to prepare the drug delivery device.

The surgeon confirms the availability and presence of the material and equipment needed to formulate the device (e.g. antibiotic powder; polymethyl methacrylate [PMMA] powder and liquid monomer; vacuum mixing system; pressurized insertion gun; lubricant; and appropriately sized molds).

Description of Intra-Service Work: Following thorough debridement of the infected bone and soft tissue (separately reported), the type of drug delivery device and size of the components are selected. The instruments that were used for the “dirty” portion of the procedure are removed, new instruments are opened and set-up, the patient’s limb is prepped again and re-draped, and the surgical team changes gowns and gloves. The “clean” portion of the procedure begins.

On the back table, the surgeon makes the device. An appropriately sized mold is selected. Sterile mineral oil or ultrasound gel is used to lubricate the inner portion of the mold. PMMA powder is mixed with antibiotic powder; most commonly 3.6 g of tobramycin and 1 g of vancomycin are used with each 40-g package of cement. Liquid monomer is added and the materials are mixed in a vacuum mixing system. A container with the cement in liquid form is then transferred to a pressurized insertion gun. The liquid cement is injected under pressure to completely fill the mold. After the cement is hardened, the device is removed from the mold.

The size and fit of the device are determined by temporary application to the bone ends; range of motion and joint stability are assessed. The device is removed, the bone ends are prepared with pulse irrigation and dried. Another batch of antibiotic cement is then prepared in similar fashion. The liquid cement is applied to the bone ends +/- the medullary canal, the device is inserted and stabilized until the cement is hard and then excess cement is removed. A commercially available nail, rod, or wire may be used to supplement the cement fixation. Stability and mobility are confirmed.

Description of Post-Service Work: The device preparation, materials and construct details are documented in the medical record (e.g. written brief operative note and dictated complete operative note). Post-operative radiographs are reviewed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	William Creevy, MD; Hussein Elkousy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons; American Association of Hip and Knee Surgeons; Orthopaedic Trauma Association				
CPT Code:	20704				
Sample Size:	5070	Resp N:	141	Response: 2.7 %	
Description of Sample:	Random from each society membership databases.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	10.00	20.00	50.00
Survey RVW:	1.00	2.60	4.00	5.70	10.50
Pre-Service Evaluation Time:			10.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	8.00	20.00	30.00	45.00	90.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the **pre-service time package** that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	20704	Recommended Physician Work RVU: 2.60		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	5.00	0.00	5.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	30.00			
Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
ZZZ Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	2.00	0.00	2.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11047	ZZZ	1.80	RUC Time

CPT Descriptor 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)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
29826	ZZZ	3.00	RUC Time

CPT Descriptor Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36227	ZZZ	2.09	RUC Time	11,539

CPT Descriptor 1 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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
57267	ZZZ	4.88	RUC Time	5,500

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 32 % of respondents: 22.6 %

Number of respondents who choose 2nd Key Reference Code: 21 % of respondents: 14.8 %

TIME ESTIMATES (Median)

	CPT Code: <u>20704</u>	Top Key Reference CPT Code: <u>11047</u>	2nd Key Reference CPT Code: <u>29826</u>
Median Pre-Service Time	5.00	0.00	0.00
Median Intra-Service Time	30.00	30.00	40.00
Median Immediate Post-service Time	2.00	1.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	37.00	31.00	40.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	3%	13%	56%	28%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
3%	28%	69%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	6%	13%	81%

Physical effort required	0%	34%	66%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

3%	34%	63%
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2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	5%	38%	29%	29%
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Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

10%	38%	52%
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Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	19%	43%	38%
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Physical effort required	10%	38%	52%
--------------------------	-----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

14%	19%	67%
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Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In January 2018, the RAW identified code 11981 through a screen of "Different Performing Specialty from Survey." The RAW noted that this service was first surveyed in 2001 by the American Urological Association (AUA), but the

2016 Medicare utilization no shows orthopedic surgery as the primary provider. The RUC recommended that the service be referred to the CPT Panel to better define these services and to determine if musculoskeletal procedures should have separate codes to report.

At the May 2018 CPT Panel meeting, the Panel accepted a proposal for six new add-on codes supported by literature to report insertion and removal of drug delivery implant devices in conjunction with specific orthopedic primary procedures. These six new add-on codes are included in the musculoskeletal section of the CPT codebook and includes introductory guidelines and parenthetical notes. Separately, the CPT Panel addressed the current code family based on urology and obstetrics/gynecology procedures by adding parentheticals after codes 11981 and 11982. The code descriptors for 11981-11983 were not changed and remain based on urology and obstetrics/gynecology procedures.

Compelling Evidence for Codes 20700-20705

For CPT 2002, three new codes were developed specifically to describe insertion, removal, and removal with reinsertion of a non-biodegradable manufactured drug delivery implant. These codes were initially created to describe a once-yearly implant containing leuprolide acetate for the treatment of prostate cancer. However, because various types of medications for various indications can be administered using this type of implant, the CPT Editorial Panel voted to keep the descriptors generic. That is why the type of drug is not listed in the descriptors of these codes.

At the April 2001 RUC meeting, the RUC recommended that CMS develop RVUs for these codes by cross-walking the RVUs from CPT codes 11975, 11976, and 11977, insertion, removal and removal with reinsertion of implantable contraceptive capsules.

In April 2002, urology again submitted a letter requesting a crosswalk to the contraceptive capsule codes. The RUC adopted this as an interim solution and requested that AUA survey these codes for review at a future RUC meeting. The RUC understands that a survey of urologists who perform this procedure for a drug specific to urology would not apply to other specialties that may use this code for other drug implants in the future. The RUC agreed that the implant insertion would be equivalent work to the contraceptive capsule insertion and a survey is unlikely to produce different results and did not require a survey.

In January 2018, the RAW identified code 11981 through a screen of "Different Performing Specialty from Survey." The AAOS submitted an Action Plan that recommended referral to CPT to differentiate the musculoskeletal procedures that were never meant to be reported with codes 11981-11983 because those codes were clearly created for subcutaneous insertion of a once yearly manufactured drug-releasing implant. CPT required the AAOS to use the long form CPT proposal and submit literature to support the proposed musculoskeletal codes. AUA and ACOG did not make any changes to the current codes 11981-11983 as these codes will continue to represent insertion in the arm of a once yearly manufactured drug-releasing implant.

- ***Evidence that technology and patient has changed***

When codes 11981-11983 were created in 2002, drug delivery implants were only available for manufactured time-released implant products that were inserted just under the skin in the upper inside arm through a small puncture hole. Since that time, orthopedic surgeons have developed a method to manually fabricate drug delivery implants at the time of surgery—typically antibiotic-impregnated beads—to be implanted deep (eg, subfascial, intramedullary, intra-articular) at the time of a major open procedure for infections. The beads may subsequently be removed after the infection has resolved and a definitive procedure is performed. The work of 11981 and 11983 never included the manual preparation and implantation of a drug delivery device during a major open operation for infection and 11982 and 11983 never included the removal of the implant during a major open operation.

- ***Evidence that incorrect assumptions were made in the previous valuation of the service, such as a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data.***

Although it may appear that this compelling evidence argument would apply to the codes in this tab, the fact is that the services represented by codes 11981-11983 (insert/removal of manufactured time-released drug implant) have not changed from the original application submitted in 2001 and subsequent review by the RUC. Orthopaedic surgeons were not part of the original application in 2001 and valuation, and orthopaedic surgeons were not aware that these codes were only meant to describe subcutaneous insertion of a manufactured time-released drug implant. This resulted

in the codes being inadvertently reported for very different deep musculoskeletal procedures. The societies recommended and the RAW agreed, that referral to CPT for creation of new codes for this new and different work was appropriate. This required submission of a code change application and supporting literature to clearly describe the musculoskeletal work for a surgeon's manual preparation of drug delivery devices to be implanted deep.

Survey Sample and Process

A survey request was sent to a random selection of members from the American Academy of Orthopaedic Surgeons, American Association of Hip and Knee Surgeons, and Orthopaedic Trauma Association. The survey included all six codes.

Work Recommendation – 20704

The survey median work RVU of 4.00 is recommended for code 20704.

Time recommendation

An expert panel reviewed the survey data and determined that there was some confusion about whether the backbench manual preparation of the implant device was pre-time or intra-time. Specifically, some respondents included significantly more time in the pre-time category than the intra-time. This is evident by the increasing median pre-time for codes 20700, 20702, and 20704 (ie, the preparation of the implant for 20704 takes longer than 20700). However, we do not agree that the pre-time represents the time to manually prepare the device and that this time is mixed between the two categories of pre- and intra-time in the data.

Our expert panel believes the median total time of 45 minutes is accurate for the entire additional work required for 20704 which includes: consent for a device implant, collection of supplies and equipment to prepare the device, manually preparing the device intra-operatively, inserting the device, and then documenting the work and device (type, lot, manufacturer, etc.). We considered requesting collapsing all time into the intra-category, similar to what the RUC allows for other societies where there is a gray zone of the components of work. For example, pathology collapses all time (including review of records and dictation and documentation of final report) into the intra-time category. Allergy and immunology has similarly collapsed all work and time into the intra-time category.

We do not know of a rule about assigning work and time to add-on codes, so we are leaving the survey times in the three categories. However, we have collapsed the service description to the intra-service work category similar to what other specialties have done.

We strongly recommend the survey total time of 45 minutes as accurate for the total work of add-on code 20704 and we present the time data as 10/30/5 per the survey statistics.

Key Reference Codes

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
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)	1.80	0.059	31	0	30	1
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)	3.00	0.075	40	0	40	0
20704	Manual preparation and insertion of drug delivery device(s), intra-articular (List separately in addition to code for primary procedure)	4.00	0.122	45	10	30	5

MPC Codes

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
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)	2.09	0.139	15	0	15	0
20704	Manual preparation and insertion of drug delivery device(s), intra-articular (List separately in addition to code for primary procedure)	4.00	0.122	45	10	30	5
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)	4.88	0.108	45	0	45	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. (Use 206X2 in conjunction with 22864, 22865, 23040, 23044, 23334, 24000, 24160, 25040, 25250, 25251, 26070, 26075, 26080, 26990, 27030, 27090, 27301, 27310, 27603, 27610, 28020)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11981, 11983, 20999, or primary procedure with modifier 22 appended

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national utilization not available

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,748

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The expert panel summed the 2017 Medicare data for 11981, 11982, 11983 attributable to orthopaedic surgeons, plastic surgeons, hand surgeons, and podiatry and added 10% to account for reporting using unlisted codes or modifier 22 appended to the primary procedure. The expert panel also estimates a 15% / 15% / 70% split within each set of codes (deep, intramedullary, intra-articular) and a 50% split for 11983 between the insert and remove set of new codes. The result is: 20700=1446; 20702=1446; 20704=6748; 20701=511; 20703=511; 20705=2388 (see separate Excel utilization file for calculations).

Specialty orthopaedic surgery	Frequency 6574	Percentage 97.42 %
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Specialty	Frequency	Percentage	%
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:

Orthopedic - other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 27310

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 20705 Tracking Number C10

Original Specialty Recommended RVU: **2.15**Presented Recommended RVU: **2.15**

Global Period: ZZZ Current Work RVU:

RUC Recommended RVU: **2.15**

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old male undergoes removal of an intra-articular antibiotic cement device during surgical treatment of an intra-articular infection. [Note: This is an add-on code. Only consider the additional work for removal of the antibiotic delivery device.]

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The surgeon reviews removal of the device with the patient and/or family; provides a brief description of the technical aspects; outlines the risks, benefits, alternatives and expected outcome; discusses the potential inability to remove the device totally, or in part, and the implications, including the need for additional surgery; and obtains informed consent.

Pre-operative radiographs, including anteroposterior and lateral views are evaluated to assess the location and integrity of the device.

The surgeon confirms the presence of the equipment and specialized instruments required for removal (e.g. long flexible osteotomes, high speed burr, nail/implant extraction kits).

Description of Intra-Service Work: The prior incision(s), in part or in total, are utilized. Exposure and dissection are completed until the device is identified, typically at the insertion site, but frequently also at the site of the infection and/or fracture.

Soft tissues are carefully stripped and a semi-circular osteotome is used to loosen the bone-device interface. An extraction tool is attached to the nail/rod/wire and attempts are made to remove the device under fluoroscopic control. However, not infrequently, the cement fractures and multiple fragments must be removed individually via the medullary canal and/or via the infection/fracture site. Fluoroscopy is used to confirm that the entire device has been removed..

Description of Post-Service Work: Removal of the device is documented in the medical record (e.g. written brief operative note and dictated complete operative note). Post-operative radiographs are reviewed..

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	William Creevy, MD; Hussein Elkousy, MD				
Specialty(s):	American Academy of Orthopaedic Surgeons; American Association of Hip and Knee Surgeons; Orthopaedic Trauma Association				
CPT Code:	20705				
Sample Size:	5070	Resp N:	140	Response: 2.7 %	
Description of Sample:	Random from each society membership databases.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	10.00	15.00	60.00
Survey RVW:	0.85	2.15	3.30	4.35	10.00
Pre-Service Evaluation Time:			5.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	5.00	20.00	25.00	32.00	105.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the **pre-service time package** that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	20705	Recommended Physician Work RVU: 2.15		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	1.00	0.00	1.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	25.00			
Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) ZZZ Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	2.00	0.00	2.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11047	ZZZ	1.80	RUC Time

CPT Descriptor 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)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
29826	ZZZ	3.00	RUC Time

CPT Descriptor Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36277	ZZZ	2.09	RUC Time	11,539

CPT Descriptor 1 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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36476	ZZZ	2.65	RUC Time	9,885

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 37 % of respondents: 26.4 %

Number of respondents who choose 2nd Key Reference Code: 17 % of respondents: 12.1 %

TIME ESTIMATES (Median)

	CPT Code: <u>20705</u>	Top Key Reference CPT Code: <u>11047</u>	2nd Key Reference CPT Code: <u>29826</u>
Median Pre-Service Time	1.00	0.00	0.00
Median Intra-Service Time	25.00	30.00	40.00
Median Immediate Post-service Time	2.00	1.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	28.00	31.00	40.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	8%	38%	41%	14%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	11%	46%	43%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	11%	43%	46%
Physical effort required	14%	51%	35%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	8%	43%	49%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	41%	41%	18%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	12%	47%	41%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	24%	29%	47%
Physical effort required	6%	24%	71%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	6%	35%	59%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In January 2018, the RAW identified code 11981 through a screen of "Different Performing Specialty from Survey." The RAW noted that this service was first surveyed in 2001 by the American Urological Association (AUA), but the 2016 Medicare utilization no shows orthopedic surgery as the primary provider. The RUC recommended that the service be referred to the CPT Panel to better define these services and to determine if musculoskeletal procedures should have separate codes to report.

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- ***Evidence that technology and patient has changed***

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- ***Evidence that incorrect assumptions were made in the previous valuation of the service, such as a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data.***

Although it may appear that this compelling evidence argument would apply to the codes in this tab, the fact is that the services represented by codes 11981-11983 (insert/removal of manufactured time-released drug implant) have not changed from the original application submitted in 2001 and subsequent review by the RUC. Orthopaedic surgeons were not part of the original application in 2001 and valuation, and orthopaedic surgeons were not aware that these codes were only meant to describe subcutaneous insertion of a manufactured time-released drug implant. This resulted in the codes being inadvertently reported for very different deep musculoskeletal procedures. The societies recommended and the RAW agreed, that referral to CPT for creation of new codes for this new and different work was appropriate. This required submission of a code change application and supporting literature to clearly describe the musculoskeletal work for a surgeon's manual preparation of drug delivery devices to be implanted deep.

Survey Sample and Process

A survey request was sent to a random selection of members from the American Academy of Orthopaedic Surgeons, American Association of Hip and Knee Surgeons, and Orthopaedic Trauma Association. The survey included all six codes.

Work Recommendation – 20705

The survey 25th percentile work RVU of 2.15 is recommended for code 20705.

Time recommendation

Unlike the codes for manual preparation and insertion of a drug delivery device, codes 20701, 20703, and 20705 are clear typical add-on codes with limited pre- and post-work related to the add-on service that is not part of the primary procedure.

Our expert panel believes the survey respondents may have overestimated the pre-service time which would include addition time related to discussion removal of the implant during the consent process and to confirm availability of equipment necessary to remove the device. We also believe the survey respondents may have overestimated the post-service time which would include addition time related to documentation of the additional work. **We recommend one minute for pre-service work and two minutes for post-service work related to the add-on code 20705 that is not included in the work of the primary procedure.**

Key Reference Codes

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
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)	1.80	0.059	31	0	30	1
20705	Removal of drug delivery device(s), intra-articular (List separately in addition to code for primary procedure)	2.15	0.083	28	1	25	2
29826	'Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)	3.00	0.075	40	0	40	0

MPC Codes

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
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)	2.09	0.139	15	0	15	0
20705	Removal of drug delivery device(s), intra-articular (List separately in addition to code for primary procedure)	2.15	0.083	28	1	25	2
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)	2.65	0.088	30	0	30	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. (Use 206X5 in conjunction with 22864, 22865, 23040, 23044, 23334, 24000, 24160, 25040, 25250, 25251, 26070, 26075, 26080, 26990, 27030, 27090, 27301, 27310, 27603, 27610, 28020)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11982, 11983, 20999, or primary procedure with modifier 22 appended

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic surgery

How often? Sometimes

Specialty

How often?

Specialty

How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national utilization not available

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,388

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The expert panel summed the 2017 Medicare data for 11981, 11982, 11983 attributable to orthopaedic surgeons, plastic surgeons, hand surgeons, and podiatry and added 10% to account for reporting using unlisted codes or modifier 22 appended to the primary procedure. The expert panel also estimates a 15% / 15% / 70% split within each set of codes (deep, intramedullary, intra-articular) and a 50% split for 11983 between the insert and remove set of new codes. The result is: 20700=1446; 20702=1446; 20704=6748; 20701=511; 20703=511; 20705=2388 (see separate Excel utilization file for calculations).

Specialty orthopaedic surgery	Frequency 2250	Percentage 94.22 %
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Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:

Orthopedic - other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 27310

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR	AS
13	ISSUE: Drug Delivery Implant Procedures																								
14	TAB: 5																								
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
19	CURRENT	11980	Subcutaneous hormone pellet implantation (implantation of estradiol		0.065			1.10			27	7	2	1			12			5					
21	REC		Subcutaneous hormone pellet implantation (implantation of estradiol		0.065			1.10			27	7	2	1			12			5					
22																									
23																									
24						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
25	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
26	1st REF	55876	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial	18	0.043			1.73			59	19	10			20			10						
27	2nd REF	57500	Biopsy of cervix, single or multiple, or local excision of lesion, with or without	14	0.060			1.20			29	7	1	1			15			5					
28	CURRENT	11981	Insertion, non-biodegradable drug delivery implant		#DIV/0!			1.48			39														
29	SVY	11981	Insertion, non-biodegradable drug delivery implant	111	0.231	0.90	1.30	1.68	2.00	4.00	31	15	2	4	1	5	5	10	30	5	0	2	10	20	150
30	SVY		AUA	40	0.109	0.90	1.43	1.67	2.06	4.00	39	15	4	5	5	8	10	13	30	5	0	0	1	3	15
31	SVY		ACOG	71	0.237	0.90	1.23	1.70	1.99	3.60	30	15	2	3	1	3	5	6	25	5	0	10	15	25	150
32	REC				0.159			1.30			30	15	1	4			5			5					
33																									
34																									
35						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
36	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
37	1st REF	54150	Circumcision, using clamp or other device with regional dorsal penile or ring	15	0.087			1.90			45	15	5	5			15			5					
38	2nd REF	52287	Cystourethroscopy, with injection(s) for chemodenervation of the bladder	12	0.120			3.20			58	7	5	10			21			15					
39	CURRENT	11982	Removal, non-biodegradable drug delivery implant		#DIV/0!			1.78			44														
40	SVY	11982	Removal, non-biodegradable drug delivery implant	110	0.152	0.90	1.70	2.00	2.34	5.20	34	13	2	4	4	8	10	15	35	5	0	1	5	12	150
41	SVY		AUA	39	0.102	0.90	1.39	1.80	2.00	3.50	41	15	4	5	4	9	12	15	35	5	0	0	1	2	10
42	SVY		ACOG	72	0.160	0.91	1.80	2.07	2.40	5.20	33	13	2	3	4	7	10	15	30	5	0	4	10	20	150
43	REC				0.124			1.70			33	13	1	4			10			5					
44																									
45																									
46						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
47	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
48	1st REF	52287	Cystourethroscopy, with injection(s) for chemodenervation of the bladder	28	0.120			3.20			58	7	5	10			21			15					
49	2nd REF	55700	Biopsy, prostate; needle or punch, single or multiple, any approach	19	0.142			2.50			35	5	5	5			15			5					
50	CURRENT	11983	Removal with reinsertion, non-biodegradable drug delivery implant		#DIV/0!			3.30			69														
51	SVY	11983	Removal with reinsertion, non-biodegradable drug delivery implant	112	0.132	1.00	2.10	2.50	3.00	6.00	41	15	2	4	5	10	15	20	45	5	0	1	4	10	150
52	SVY		AUA	40	0.099	1.15	1.79	2.29	3.08	6.00	47	16	4	5	5	12	17	21	40	5	0	0	1	4	12
53	SVY		ACOG	72	0.142	1.00	2.24	2.50	3.00	6.00	39	15	2	3	5	10	14	20	45	5	0	2	5	10	150
54	REC				0.106			2.10			40	15	1	4			15			5					

ISSUE: Drug Delivery Implant Procedures

TAB: 5

SOURCE	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE	INTRA					POST
					MIN	25th	MED	75th	MAX			MIN	25th	MED	75th	MAX	
MANUAL PREPRATION & INSERTION																	
REF1	11047	Debridement, bone (includes epidermis, dermis, subcuta	50	0.059			1.80			31	0			30			1
REF2	11046	Debridement, muscle and/or fascia (includes epidermis,	28	0.050			1.03			21	0			20			1
current	NEW			N/A						0							
SVY	20700	Manual preparation and insertion of drug delivery device(s), deep (eg, subfascial) (List separately in	139	0.089	0.85	1.50	2.00	2.78	7.00	30	5	5	14	20	30	60	5
REC		25th % Survey RVW		0.067			1.50			27	5			20			2
REF1	11047	Debridement, bone (includes epidermis, dermis, subcuta	49	0.059			1.80			31	0			30			1
REF2	22515	Percutaneous vertebral augmentation, including cavity cr	19	0.132			4.00			32	1			30			1
current	NEW			N/A						0							
SVY	20702	Manual preparation and insertion of drug delivery device(s), intramedullary (List separately in addition to	141	0.118	1.00	2.50	3.25	4.15	9.00	38	8	5	18	25	36	90	5
REC		25th % Survey RVW		0.094			2.50			32	5			25			2
REF1	11047	Debridement, bone (includes epidermis, dermis, subcuta	32	0.059			1.80			31	0			30			1
REF2	29826	Arthroscopy, shoulder, surgical; decompression of subac	21	0.075			3.00			40	0			40			0
current	NEW			N/A						0							
SVY	20704	Manual preparation and insertion of drug delivery device(s), intra-articular (List separately in addition to	141	0.122	1.00	2.60	4.00	5.75	10.50	45	10	8	20	30	45	90	5
REC		25th % Survey RVW		0.081			2.60			37	5			30			2
REMOVAL																	
REF1	11047	Debridement, bone (includes epidermis, dermis, subcuta	40	0.059			1.80			31	0			30			1
REF2	11046	Debridement, muscle and/or fascia (includes epidermis,	40	0.050			1.03			21	0			20			1
current	NEW			N/A						0							
SVY	20701	Removal of drug delivery device(s), deep (eg, subfascial) (List separately in addition to code for	133	0.106	0.85	1.13	1.75	2.05	7.00	22	5	5	10	15	20	45	2
REC				0.071			1.13			18	1			15			2
REF1	11047	Debridement, bone (includes epidermis, dermis, subcuta	53	0.059			1.80			31	0			30			1
REF2	20985	Computer-assisted surgical navigational procedure for m	13	0.114			2.50			30	10			20			0
current	NEW			N/A						0							
SVY	20703	Removal of drug delivery device, intramedullary (List separately in addition to code for primary procedure)	139	0.116	0.85	1.80	2.50	3.68	8.00	28	5	5	15	20	30	75	3
REC				0.087			1.80			23	1			20			2
REF1	11047	Debridement, bone (includes epidermis, dermis, subcuta	37	0.059			1.80			31	0			30			1
REF2	29826	Arthroscopy, shoulder, surgical; decompression of subac	17	0.075			3.00			40	0			40			0
current	NEW			N/A						0							
SVY	20705	Removal of drug delivery device(s), intra-articular (List separately in addition to code for primary procedure)	140	0.123	0.85	2.15	3.30	4.35	10.00	35	5	5	20	25	32	105	5
REC				0.083			2.15			28	1			25			2

CPT Code: 11981-11983
Specialty Society: ACOG & AUA

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

Global Period: 000 **REVISED – At Meeting** Meeting Date: October 2018

CPT Long Descriptor(s):

11981: Insertion, non-biodegradable drug delivery implant
11982: Removal, non-biodegradable drug delivery implant
11983: Removal with reinsertion, non-biodegradable drug delivery implant

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

ACOG and AUA convened a panel that included a number of experts familiar with these services to evaluate the direct practice expense inputs for these drug delivery implant procedures.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

CPT Codes 11981-11983 are current codes. As such, we included the existing direct practice expense inputs on the PE spreadsheet.

**3. Is this code(s) typically billed with an E/M service?
Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)**

These codes are not typically billed with E/M services:

- 11981 – 5%
- 11982 – 6%
- 11983 – 23%

These codes are not typically billed with an E/M service in the nonfacility:

- 11981 – 50%
- 11982 – 38%
- 11983 – 47%

**4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?**

CPT Code: 11981-11983
Specialty Society: ACOG & AUA

**Is the dominant provider in the nonfacility different then for the global?
(Please see provided data in PE Subcommittee folder)**

The current dominant provider in the nonfacility setting is orthopedic surgery:

- 11981-65%
- 11982-64%
- 11983-47%

However, the reason for the survey is that new CPT codes have been created to report the orthopedic surgery work for these services.

The current dominant provider in the global (+ tc services) setting are as follows:

- 11981-gynecology 38%
- 11982-gynecology 50%
- 11983-urology 59%

- 5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:**

N/A

- 6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.**

We are requesting an increase in aggregate current costs for supplies due to changes in technique of the services. The current implant only includes the trocar and medication, as such all the necessary items to perform need to be included.

- 7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:**

N/A

- 8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code)
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:**

We are recommending 3 minutes for obtain vital signs, based on the vital signs standards (1-3). The vital signs for these procedures include: blood pressure, height, weight. **It would not appear that the vital signs were increased to 5 minutes based on the CMS 'vital signs' initiative.*

CPT Code: 11981-11983
Specialty Society: ACOG & AUA

9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

Assist physician
Open and pass supplies/anesthetic to physician
Patient attention
Chaperone

10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

N/A

12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.

N/A

13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:

N/A

14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:

N/A

15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

EF023 Exam Table -- Default + Post Procedure Monitoring (CA022) **recognized/recommended by CMS*
EQ168 light, exam -- Default + Post Procedure Monitoring (CA022) **recognized/recommended by CMS*
EF027 table, instrument, mobile -- Default + Post Procedure Monitoring (CA022)
**recognized/recommended by CMS*

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CPT Code: 11981-11983
Specialty Society: ACOG & AUA

~~*Note: Because we are using the default equipment formula, CA022 time is not included in the equipment formulas. However, the patient does recover in the room, so that time is not being captured.~~

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:

We are requesting 5 minutes for education and consent to address issues including side effects, long term implications, confusion, etc. Discussions around use of hormones is much more complex today.

The patient recovers for approximately 10 minutes after the procedure, with the nurse coming to check in on the patient. We are requesting 2 minutes for post procedure monitoring (instead of 2.5 minutes).
*See note in #15.

Post procedure phone call is to check on bruising and ensure not having any issues with hematoma development.

17. If there is any other item on your spreadsheet that needs further explanation please include here:

The old PE spreadsheets that these codes were crosswalked to had time in the pre-service and the post-service that is not reflected in the RUC database.

The codes are changing from an XXX global period to a 000 global period.

18. Please include an explanation of each line item:

SA027	Kit, Scissors and clamp	Used in 11982&11983 in order to open the fibrosis around the existing implant
SB006	drape, non-sterile, sheet 40in x 60in	Patient cover
SB007	drape, sterile barrier	For instrument table
SB014	Drape, sterile, three-quarter sheet	For injection area
SB024	gloves, sterile	Nurse and MD
SB026	gown, patient	Patient gown
SB036	paper, exam table	Exam table paper
SB037	pillow case	Pillow case
SB044	underpad 2ft x 3ft (Chux)	Under the operative site for blood collection
SC029	needle, 18-27g	1 to aspirate the anesthetic from the anesthetic supply bottle and the other to inject the patient with.
SC051	syringe 10-12ml	
SF044	Blade, surgical, super-sharp	Initial incision for the implant
SG014	bandage, elastic, self-adherent wrap 1in (Coban)	Provides pressure to reduce bruising
SG040	dressing, 5in x 9in (Adaptic)	Placed over the gauze
SG055	gauze, sterile 4in x 4in	Folded over the incision
SG074	steri-strip (6 strip uou)	2 steri-strips to close incision
SH046	lidocaine 1% w-epi inj (Xylocaine w-epi)	Local anesthetic for procedure – w/epi for hemostasis
SJ043	povidone swabsticks (3 pack uou)	Used to prepare the arm for implant
SJ053	swab-pad, alcohol	Wipe off top off anesthetic bottle

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AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor:

+20700	Manual preparation and insertion of drug delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)
+20702	Manual preparation and insertion of drug delivery device(s), intramedullary (List separately in addition to code for primary procedure)
+20704	Manual preparation and insertion of drug delivery device(s), intra-articular (List separately in addition to code for primary procedure)
+20701	Removal of drug delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)
+20703	Removal of drug delivery device(s), intramedullary (List separately in addition to code for primary procedure)
+20705	Removal of drug delivery device(s), intra-articular (List separately in addition to code for primary procedure)

Global Period: ZZZ Meeting Date: October 2018

****No direct practice expense inputs recommended****

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:
2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:
3. Is this code(s) typically billed with an E/M service?
4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence:
6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:
7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:
8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.
9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:
11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:
12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:
13. If there is any other item on your spreadsheet that needs further explanation please include here:
14. Please include an explanation of each line item:

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor:

+20700	Manual preparation and insertion of drug delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)
+20702	Manual preparation and insertion of drug delivery device(s), intramedullary (List separately in addition to code for primary procedure)
+20704	Manual preparation and insertion of drug delivery device(s), intra-articular (List separately in addition to code for primary procedure)
+20701	Removal of drug delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)
+20703	Removal of drug delivery device(s), intramedullary (List separately in addition to code for primary procedure)
+20705	Removal of drug delivery device(s), intra-articular (List separately in addition to code for primary procedure)

Global Period: ZZZ Meeting Date: October 2018

****No direct practice expense inputs recommended****

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:
2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:
3. Is this code(s) typically billed with an E/M service?
Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)
4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different then for the global?
(Please see provided data in PE Subcommittee folder)
5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.
7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code)
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:
9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:
10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:
12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.
13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:
14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:
15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:
16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:
17. If there is any other item on your spreadsheet that needs further explanation please include here:
18. Please include an explanation of each line item:

	A	B	C	D	E	F	G	H	I
1	RUC Practice Expense Spreadsheet						CURRENT		RECOMM
2	At MTG	C. For more complete information about summaries and guidelines					11980		119
3		RUC Collaboration Website					Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)		Subcutaneos pellet imp (implantation and/or testos beneath
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 5 Specialty: AUA, ACOG	Standards/Guidelines	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute			
5		LOCATION					Non Fac	Facility	Non Fac
6		GLOBAL PERIOD					XXX	XXX	000
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME					\$ 33.52	\$ -	\$ 33.52
8		TOTAL CLINICAL STAFF TIME		L037D	RN/LPN/MTA	0.37	47	0	47
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME		L037D	RN/LPN/MTA	0.37	0	0	0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME		L037D	RN/LPN/MTA	0.37	44	0	44
11		TOTAL POST-SERVICE CLINICAL STAFF TIME		L037D	RN/LPN/MTA	0.37	3	0	3
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE					\$ 17.39	\$ -	\$ 17.39
13	PRE-SERVICE PERIOD								
14		Start: Following visit when decision for surgery or procedure made							
15	CA001	Complete pre-service diagnostic and referral forms	90 DAY: NF5, F5*	L037D	RN/LPN/MTA	0.37			
16	CA002	Coordinate pre-surgery services (including test results)	90 DAY: NF10, F20*	L037D	RN/LPN/MTA	0.37			
17	CA003	Schedule space and equipment in facility	90 DAY: NF0, F8*	L037D	RN/LPN/MTA	0.37			
18	CA004	Provide pre-service education/obtain consent	90 DAY: NF10, F20*	L037D	RN/LPN/MTA	0.37			
19	CA005	Complete pre-procedure phone calls and prescription	90 DAY: NF10, F7*	L037D	RN/LPN/MTA	0.37			
20	CA006	Confirm availability of prior images/studies	Standard time for this activity is	L037D	RN/LPN/MTA				
21	CA007	Review patient clinical extant information and questionnaire	Standard time for this activity is	L037D	RN/LPN/MTA				
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	0	L037D	RN/LPN/MTA				
26		End: When patient enters office/facility for surgery/procedure							
27	SERVICE PERIOD								
28		Start: When patient enters office/facility for surgery/procedure:							
29		Pre-Service (of service period)							
30	CA009	Greet patient, provide gowning, ensure appropriate medical records are	Standard time for this activity is	L037D	RN/LPN/MTA	0.37	3		3
31	CA010	Obtain vital signs	Vital Sign Standards	L037D	RN/LPN/MTA	0.37	5		5
32	CA011	Provide education/obtain consent	Include only the additional	L037D	RN/LPN/MTA	0.37	3		3
33	CA013	Prepare room, equipment and supplies	2 minute standard	L037D	RN/LPN/MTA	0.37	2		2
34	CA015	Setup scope (nonfacility setting only)	5 minutes standard for scope set	L037D	RN/LPN/MTA	0.37			
35	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	2 minute standard	L037D	RN/LPN/MTA	0.37	2		2
36	CA017	Sedate/apply anesthesia	2 minute standard RN/LPN/MA	L037D	RN/LPN/MTA	0.37	2		2
43		Intra-service (of service period)							
44	CA018	Assist physician or other qualified healthcare professional---directly	100% of physician or other	L037D	RN/LPN/MTA	0.37	12		12
45	CA019	Assist physician or other qualified healthcare professional---directly	67% of physician or other	L037D	RN/LPN/MTA	0.37			
46	CA020	Assist physician or other qualified healthcare professional---directly	other% of physician or other	L037D	RN/LPN/MTA	0.37			
47	CA021	Perform procedure/service---NOT directly related to physician work time	0	L037D	RN/LPN/MTA	0.37			
54		Post-Service (of service period)							
55	CA022	Monitor patient following procedure/service, multitasking 1:4	For monitoring following	L037D	RN/LPN/MTA	0.37			
56	CA023	Monitor patient following procedure/service, no multitasking	0	L037D	RN/LPN/MTA	0.37			
57	CA024	Clean room/equipment by clinical staff	3 minute standard	L037D	RN/LPN/MTA	0.37	3		3
58	CA025	Clean scope	Standards For Scope Cleaning	L037D	RN/LPN/MTA	0.37			
59	CA026	Clean surgical instrument package	Standard for cleaning	L037D	RN/LPN/MTA	0.37	10		10
60	CA029	Check dressings, catheters, wounds	Standard time for this activity is	L037D	RN/LPN/MTA	0.37	2		2
61	CA035	Review home care instructions, coordinate visits/prescriptions	Standard time for this activity is	L037D	RN/LPN/MTA	0.37			
62	CA036	Discharge day management	Dischrg mgmt same day (0.5 x	L037D	RN/LPN/MTA	0.37	n/a		n/a
69		End: Patient leaves office							
70	POST-SERVICE PERIOD								
71		Start: Patient leaves office/facility							
72	CA037	Conduct patient communications	Phone calls/emails/texts are in 3	L037D	RN/LPN/MTA	0.37	3		3
73	CA038	Coordinate post-procedure services	0	L037D	RN/LPN/MTA	0.37			
87		End: with last office visit before end of global period							

A			B			J	K		L	M		N		O	P		Q	R		S
1	RUC Practice Expense Spreadsheet					ENDED	CURRENT			RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CUR
2	At MTG	C. For more complete information about summaries and guidelines					80	11981			11981		11982		11982		11982		119	
3		RUC Collaboration Website					us hormone plantation h of estradiol terone pellets (the skin)	Insertion, non- biodegradable drug delivery implant			Insertion, non- biodegradable drug delivery implant		Removal, non- biodegradable drug delivery implant		Removal, non- biodegradable drug delivery implant		Remov reinserti biodegrad delivery			
	Clinical Activity Code	Meeting Date: October 2018 Tab: 5 Specialty: AUA, ACOG																		
4		LOCATION					Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac		
5		GLOBAL PERIOD					000	XXX	XXX	000	000	XXX	XXX	000	000	XXX	XXX	XXX		
6		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME					\$ -	\$ 32.04	\$ -	\$ 25.75	\$ -	\$ 32.04	\$ -	\$ 28.57	\$ -	\$ 32.04	\$ -	\$ 32.04		
7	TOTAL CLINICAL STAFF TIME					0	67	0	28	0	67	0	33	0	67	0	33	0	67	
8	TOTAL PRE-SERVICE CLINICAL STAFF TIME					0	13	0	0	0	13	0	0	0	13	0	0	0	13	
9	TOTAL SERVICE PERIOD CLINICAL STAFF TIME					0	51	0	25	0	51	0	30	0	51	0	30	0	51	
10	TOTAL POST-SERVICE CLINICAL STAFF TIME					0	3	0	3	0	3	0	3	0	3	0	3	0	3	
11	TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE					\$ -	\$ 24.79	\$ -	\$ 10.36	\$ -	\$ 24.79	\$ -	\$ 12.21	\$ -	\$ 24.79	\$ -	\$ 12.21	\$ -	\$ 24.79	
12	PRE-SERVICE PERIOD																			
13	Start: Following visit when decision for surgery or procedure made																			
14	CA001	Complete pre-service diagnostic and referral forms						5				5						5		
15	CA002	Coordinate pre-surgery services (including test results)						3				3						3		
16	CA003	Schedule space and equipment in facility																		
17	CA004	Provide pre-service education/obtain consent						5				5						5		
18	CA005	Complete pre-procedure phone calls and prescription																		
19	CA006	Confirm availability of prior images/studies																		
20	CA007	Review patient clinical extant information and questionnaire																		
21	CA008	Perform regulatory mandated quality assurance activity (pre-service)																		
22	End: When patient enters office/facility for surgery/procedure																			
23	SERVICE PERIOD																			
24	Start: When patient enters office/facility for surgery/procedure:																			
25	Pre-Service (of service period)																			
26	CA009	Greet patient, provide gowning, ensure appropriate medical records are						3		3		3		3		3		3		
27	CA010	Obtain vital signs						3		3		3		3		3		3		
28	CA011	Provide education/obtain consent								5				5						
29	CA013	Prepare room, equipment and supplies						2		2		2		2		2		2		
30	CA015	Setup scope (nonfacility setting only)																		
31	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient						2		2		2		2		2		2		
32	CA017	Sedate/apply anesthesia						2		2		2		2		2		2		
33	Intra-service (of service period)																			
34	CA018	Assist physician or other qualified healthcare professional---directly						26		5		26		10		26		10		
35	CA019	Assist physician or other qualified healthcare professional---directly																		
36	CA020	Assist physician or other qualified healthcare professional---directly																		
37	CA021	Perform procedure/service---NOT directly related to physician work time																		
38	Post-Service (of service period)																			
39	CA022	Monitor patient following procedure/service, multitasking 1:4								2				2						
40	CA023	Monitor patient following procedure/service, no multitasking																		
41	CA024	Clean room/equipment by clinical staff						3		3		3		3		3		3		
42	CA025	Clean scope																		
43	CA026	Clean surgical instrument package						10				10						10		
44	CA029	Check dressings, catheters, wounds																		
45	CA035	Review home care instructions, coordinate visits/prescriptions																		
46	CA036	Discharge day management						n/a		n/a		n/a		n/a		n/a		n/a		
47	End: Patient leaves office																			
48	POST-SERVICE PERIOD																			
49	Start: Patient leaves office/facility																			
50	CA037	Conduct patient communications						3		3		3		3		3		3		
51	CA038	Coordinate post-procedure services																		
52	End: with last office visit before end of global period																			

	A	B	J	K	L	M	N	O	P	Q	R	S
1	RUC Practice Expense Spreadsheet		RECOMMENDED	CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CURRENT
2	At MTG	C. For more complete information about summaries and guidelines	11980	11981		11981		11982		11982		11982
3		RUC Collaboration Website	Insertion, non-hormone plantation of estradiol terone pellets (the skin)	Insertion, non-biodegradable drug delivery implant		Insertion, non-biodegradable drug delivery implant		Removal, non-biodegradable drug delivery implant		Removal, non-biodegradable drug delivery implant		Removal, non-biodegradable drug delivery implant
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 5 Specialty: AUA, ACOG										
5		LOCATION	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac
6		GLOBAL PERIOD	000	XXX	XXX	000	000	XXX	XXX	000	000	XXX
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ -	\$ 32.04	\$ -	\$ 25.75	\$ -	\$ 32.04	\$ -	\$ 28.57	\$ -	\$ 32.04
8		TOTAL CLINICAL STAFF TIME	0	67	0	28	0	67	0	33	0	67
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0	13	0	0	0	13	0	0	0	13
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0	51	0	25	0	51	0	30	0	51
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0	3	0	3	0	3	0	3	0	3
88	Supply	MEDICAL SUPPLIES										
89		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ -	\$ 5.47	\$ -	\$ 15.26	\$ -	\$ 5.47	\$ -	\$ 16.20	\$ -	\$ 5.47
90	SA048	pack, minimum multi-specialty visit										
91	SB006	drape, non-sterile, sheet 40in x 60in		1				1				1
92	SB007	drape, sterile barrier 16in x 29in				1				1		
93	sb012	drape, sterile, for Mayo stand										
94	SB014	drape, sterile, three-quarter sheet				1				1		
95	SB022	gloves, non-sterile		2				2				2
96	SB024	gloves, sterile				2				2		
97	SB026	gown, patient		1		1		1		1		1
98	SB036	paper, exam table		7		7		7		7		7
99	SB037	pillow case		1		1		1		1		1
100	SB044	underpad 2ft x 3ft (Chux)				1				1		
101	SC029	needle, 18-27g		1		2		1		2		1
102	SC051	syringe 10-12ml		1		2		1		2		1
103	SC058	syringe w-needle, OSHA compliant (SafetyGlide)										
104	SG040	dressing, 5in x 9in (Adaptic)		1				1				1
105	SF044	blade, surgical, super-sharp				1				1		
106	SG055	gauze, sterile 4in x 4in		1		4		1		6		1
107	SG074	steri-strip (6 strip uou)				0.33				0.33		
108	SG079	tape, surgical paper 1in (Micropore)										
109	SH047	lidocaine 1%		15				15				15
110	SH046	lidocaine 1% w-epi inj (Xylocaine w-epi)				10				10		
111	SJ032	lubricating jelly (K-Y) (5gm uou)		1				1				1
112	SJ041	povidone soln (Betadine)		50				50				50
113	SJ043	povidone swabsticks (3 pack uou)				1				1		
114	SJ046	silver nitrate applicator		4				4				4
115	SJ053	swab-pad, alcohol		1		1		1		1		1
116	SK052	pad, feminine mini		1				1				1
117	SG014	bandage, elastic, self-adherent wrap 1in (Coban)				1				1		
118												
119	SA027	Kit, Scissors and clamp								1		
120		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A										
122	Equipme nt Code	EQUIPMENT										
123		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ -	\$ 1.78	\$ -	\$ 0.13	\$ -	\$ 1.78	\$ -	\$ 0.16	\$ -	\$ 1.78
124	EF031	table, power		67				67				67
125	EF023	table, exam				23				28		
126	EQ168	light, exam				23				28		
127	EF027	table, instrument, mobile				23				28		
128	EQ137	instrument pack, basic (\$500-\$1499)		67				67				67
129	EQ170	light, fiberoptic headlight w-source		67				67				67
130												
131												
132		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A										
134						up by 2 min						

	A	B	T	U	V
1		RUC Practice Expense Spreadsheet	RENT	RECOMMENDED	
2	At MTG	C. For more complete information about summaries and guidelines	983	11983	
3		RUC Collaboration Website	al with	Removal with	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 5 Specialty: AUA, ACOG	on, non- able drug implant	Reinsertion, non- biodegradable drug delivery implant	
5		LOCATION	Facility	Non Fac	Facility
6		GLOBAL PERIOD	XXX	000	000
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ -	\$ 30.45	\$ -
8		TOTAL CLINICAL STAFF TIME	0	38	0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0	0	0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0	35	0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0	3	0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	\$ -	\$ 14.06	\$ -
13		PRE-SERVICE PERIOD			
14		Start: Following visit when decision for surgery or procedure made			
15	CA001	Complete pre-service diagnostic and referral forms			
16	CA002	Coordinate pre-surgery services (including test results)			
17	CA003	Schedule space and equipment in facility			
18	CA004	Provide pre-service education/obtain consent			
19	CA005	Complete pre-procedure phone calls and prescription			
20	CA006	Confirm availability of prior images/studies			
21	CA007	Review patient clinical extant information and questionnaire			
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)			
26		End: When patient enters office/facility for surgery/procedure			
27		SERVICE PERIOD			
28		Start: When patient enters office/facility for surgery/procedure:			
29		Pre-Service (of service period)			
30	CA009	Greet patient, provide gowning, ensure appropriate medical records are		3	
31	CA010	Obtain vital signs		3	
32	CA011	Provide education/obtain consent		5	
33	CA013	Prepare room, equipment and supplies		2	
34	CA015	Setup scope (nonfacility setting only)			
35	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient		2	
36	CA017	Sedate/apply anesthesia			
43		Intra-service (of service period)			
44	CA018	Assist physician or other qualified healthcare professional---directly		15	
45	CA019	Assist physician or other qualified healthcare professional---directly			
46	CA020	Assist physician or other qualified healthcare professional---directly			
47	CA021	Perform procedure/service---NOT directly related to physician work time			
54		Post-Service (of service period)			
55	CA022	Monitor patient following procedure/service, multitasking 1:4		2	
56	CA023	Monitor patient following procedure/service, no multitasking			
57	CA024	Clean room/equipment by clinical staff		3	
58	CA025	Clean scope			
59	CA026	Clean surgical instrument package			
60	CA029	Check dressings, catheters, wounds			
61	CA035	Review home care instructions, coordinate visits/prescriptions			
62	CA036	Discharge day management		n/a	
69		End: Patient leaves office			
70		POST-SERVICE PERIOD			
71		Start: Patient leaves office/facility			
72	CA037	Conduct patient communications		3	
73	CA038	Coordinate post-procedure services			
87		End: with last office visit before end of global period			

	A	B	T	U	V
1	RUC Practice Expense Spreadsheet		RENT	RECOMMENDED	
2	At MTG	C. For more complete information about summaries and guidelines	983	11983	
3		RUC Collaboration Website	al with	Removal with	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 5 Specialty: AUA, ACOG	on, non- table drug implant	Reinsertion, non- biodegradable drug delivery implant	
5		LOCATION	Facility	Non Fac	Facility
6		GLOBAL PERIOD	XXX	000	000
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ -	\$ 30.45	\$ -
8		TOTAL CLINICAL STAFF TIME	0	38	0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0	0	0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0	35	0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0	3	0
88	Supply	MEDICAL SUPPLIES			
89		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ -	\$ 16.20	\$ -
90	SA048	pack, minimum multi-specialty visit			
91	SB006	drape, non-sterile, sheet 40in x 60in			
92	SB007	drape, sterile barrier 16in x 29in		1	
93	sb012	drape, sterile, for Mayo stand			
94	SB014	drape, sterile, three-quarter sheet		1	
95	SB022	gloves, non-sterile			
96	SB024	gloves, sterile		2	
97	SB026	gown, patient		1	
98	SB036	paper, exam table		7	
99	SB037	pillow case		1	
100	SB044	underpad 2ft x 3ft (Chux)		1	
101	SC029	needle, 18-27g		2	
102	SC051	syringe 10-12ml		2	
103	SC058	syringe w-needle, OSHA compliant (SafetyGlide)			
104	SG040	dressing, 5in x 9in (Adaptic)			
105	SF044	blade, surgical, super-sharp		1	
106	SG055	gauze, sterile 4in x 4in		6	
107	SG074	steri-strip (6 strip uou)		0.33	
108	SG079	tape, surgical paper 1in (Micropore)			
109	SH047	lidocaine 1%			
110	SH046	lidocaine 1% w-epi inj (Xylocaine w-epi)		10	
111	SJ032	lubricating jelly (K-Y) (5gm uou)			
112	SJ041	povidone soln (Betadine)			
113	SJ043	povidone swabsticks (3 pack uou)		1	
114	SJ046	silver nitrate applicator			
115	SJ053	swab-pad, alcohol		1	
116	SK052	pad, feminine mini			
117	SG014	bandage, elastic, self-adherent wrap 1in (Coban)		1	
118					
119	SA027	Kit, Scissors and clamp		1	
120		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A			
122	Equipme nt Code	EQUIPMENT			
123		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ -	\$ 0.19	\$ -
124	EF031	table, power			
125	EF023	table, exam		33	
126	EQ168	light, exam		33	
127	EF027	table, instrument, mobile		33	
128	EQ137	instrument pack, basic (\$500-\$1499)			
129	EQ170	light, fiberoptic headlight w-source			
130					
131					
132		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A			
134					

AMA/Specialty Society RVS Update Committee Summary of Recommendations
High Volume Growth screen

January 2014

Hormone Pellet Implantation

At the October 2013, meeting the Relativity Assessment Workgroup reviewed High Volume Growth Services where Medicare utilization increased by at least 100% from 2006 to 2011. The RUC requested that these services be surveyed for physician work and develop practice expense inputs for the January 2014 RUC meeting. In January 2014 the RUC questioned whether CPT code 11981 should also be reviewed since it is “CMS/Other” and has not been reviewed. **The RUC requests the specialty societies submit an action plan to the RAW in April to consider whether 11981 is part of this family and should be surveyed.**

The RUC discussed the physician time and intensity associated with CPT Code 11980 *Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)* and the appropriate work RVU relative to similar services. The specialty societies indicated and the RUC agreed that 10 minutes of pre-service time, 12 minutes of intra-service time, and 5 minutes of post-service time, adequately accounts for the physician time required to perform this service. The RUC noted that the time has decreased since this code was last reviewed in February 2000 and acknowledged that the reduction in time may be a result of the creation of pre- and post-time packages. Based on this reduction in time, rather than maintain the current work RVU, the RUC recommended a direct crosswalk to CPT Code 11730 *Avulsion of nail plate, partial or complete, simple; single* (work RVU=1.10) with identical intra service time of 12 minutes and similar intensity. To further support the value the RUC compared the surveyed code to CPT Code 51705 *Change of cystostomy tube; simple* (work RVU= 0.90) and agreed that 11980 should be valued higher since this requires more physician work. The RUC also compared CPT Code 11980 to CPT Code 67810 *Incisional biopsy of eyelid skin including lid margin* (work RVU=1.18) and agreed that this procedure requires slightly more physician time and intensity, accounting for the higher work value. **The RUC recommends a work RVU of 1.10, a direct crosswalk to CPT code 11730 for CPT code 11980.**

Practice Expense

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

Work Neutrality

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

CPT Code (●New)	CPT Descriptor	Global Period	Work RVU Recommendation
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	000	1.10

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 11980	Tracking Number	Original Specialty Recommended RVU: 1.48
		Presented Recommended RVU: 1.48
Global Period: 000		RUC Recommended RVU: 1.10

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56 year old man has a diagnosis of hypogonadism, his serum testosterone is below the lower limit of the range of normal for testosterone. After discussion with his physician, he decides to undergo implantation of testosterone pellet(s).

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Description of Pre-Service Work: An explanation of the procedure is provided and informed consent is obtained. The patient is placed in either the supine, prone or Sim's position and the patient's skin is scrubbed with betadine followed by alcohol. After draping with sterile drapes, the abdominal skin area is anesthetized by raising a skin wheal with 10 cc 1% lidocaine.

Description of Intra-Service Work: A small incision is made into the skin with a scalpel and a trocar is inserted with a pellet implanter and the trocar is withdrawn. Forceps are used to place the hormone pellets in the external opening of the cannula and implant them 6 to 10 cm from the puncture wound with the blunt trocar into the subcutaneous area. Bleeding is controlled with a few minutes of pressure with sterile 4 x 4 gauze squares.

Description of Post-Service Work: A steri-strip is placed over the wound and additional dressing is held in place with non-allergic tape. The sterile bandage is left in place overnight. The patient is instructed to replace the bandage daily with band-aids until the puncture wound is completely closed. Dictate office notes. Provides patient with instructions

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2014				
Presenter(s):	Thomas Turk, MD and Philip Wise, MD				
Specialty(s):	Urology				
CPT Code:	11980				
Sample Size:	82	Resp N:	44	Response: 53.6 %	
Description of Sample:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	10.00	20.00	42.50	500.00
Survey RVW:	1.19	1.69	2.10	2.60	4.50
Pre-Service Evaluation Time:			13.50		
Pre-Service Positioning Time:			3.00		
Pre-Service Scrub, Dress, Wait Time:			5.00		
Intra-Service Time:	5.00	10.00	12.00	15.00	20.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

5 - NF Procedure without sedation/anesthesia care

CPT Code:	11980	Recommended Physician Work RVU: 1.10		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	7.00	7.00	0.00	
Pre-Service Positioning Time:	2.00	0.00	2.00	
Pre-Service Scrub, Dress, Wait Time:	1.00	1.00	0.00	
Intra-Service Time:	12.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) 7A Local/Simple Procedure				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	5.00	16.00	-11.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
55876	000	1.73	RUC Time

CPT Descriptor Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
10060	000	1.22	RUC Time	503,463

CPT Descriptor 1 Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
57452	000	1.50	RUC Time	10,566

CPT Descriptor 2 Colposcopy of the cervix including upper/adjacent vagina;

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14 % of respondents: 31.8 %

TIME ESTIMATES (Median)

<u>CPT Code:</u>	<u>Key Reference CPT Code:</u>	<u>Source of Time</u>
11980	55876	RUC Time

Median Pre-Service Time	10.00	29.00
Median Intra-Service Time	12.00	20.00
Median Immediate Post-service Time	5.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	27.00	59.00
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)**(of those that selected Key
Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.29	2.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.21	3.07
Urgency of medical decision making	2.14	2.64

Technical Skill/Physical Effort (Mean)

Technical skill required	3.07	3.36
Physical effort required	2.71	2.79

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.71	3.21
Outcome depends on the skill and judgment of physician	3.00	3.21
Estimated risk of malpractice suit with poor outcome	2.57	2.93

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.57	2.79
Intra-Service intensity/complexity	3.00	3.14
Post-Service intensity/complexity	2.36	2.29

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The AUA sent a “do you do letter” to a random number of members. The surveys were then sent to the individual physicians who answered that they do the procedure and would complete the RUC survey. The survey was sent to 87 individuals and of those individuals, 49 responses were received for a response rate of 56.32%. In 2013, 22,910 of these procedures were performed in the Medicare population so the number of responses to this survey meets the new RUC criteria of 30 respondents as the minimum survey sample size for this code.

The AUA RUC expert panel reviewed the survey results. The expert panel added two minutes of positioning time in the pre-service time. The current intraservice time is 12.5 minutes. The survey results for intraservice time came to 12 minutes. The current work RVU is 1.48. The median work value from the survey is 2.10. The 25th percentile of the work RVU was 1.69. The survey median postservice time was five minutes and the expert panel suggests that time be considered instead of the postservice time package for this procedure.

Since there was a minimal reduction in the intraservice time, it is the recommendation of the AUA RUC expert panel that the current RVU of 1.48 be maintained for CPT code 11980.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 11980

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology

How often? Commonly

Specialty Radiation Oncology

How often? Sometimes

Specialty Diagnostic Radiology

How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 21531

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare X 125%

Specialty Urology	Frequency 16421	Percentage 76.26 %
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Specialty Radiation Oncology	Frequency 3938	Percentage 18.28 %
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Specialty Diagnostic Radiology	Frequency 776	Percentage 3.60 %
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

17,225 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Please explain the rationale for this estimate. RUC Database

Specialty Urology	Frequency 13137	Percentage 76.26 %
-------------------	-----------------	--------------------

Specialty Radiation Oncology	Frequency 3150	Percentage 18.28 %
------------------------------	----------------	--------------------

Specialty Diagnostic Radiology	Frequency 620	Percentage 3.59 %
--------------------------------	---------------	-------------------

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Minor procedure

BETOS Sub-classification Level II:

Skin

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 11980

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
12	ISSUE: 11980 Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)																			
13	TAB: 20																			
14						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
15	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
16	REF	55876	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple		0.0428			1.73			59.00	19.00	10.00				20.00			10.00
17	CURRENT	11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)		0.0826			1.48			32.50	15.00					12.50			5.00
18	SVY	11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	44		1.19	1.69	2.10	2.60	4.50	38.00	13.50	3.00	5.00	5.00	10.00	12.00	15.00	20.00	5.00
19	REC	11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)			1.10						7.00	2.00	1.00			12.00			5.00
20																				
21																				
22																				
23																				
24																				
25																				

____20, 25 &32_____
Tab Number

Issue

Code Range

Attestation Statement

This form needs to be completed by any **RUC Advisor** whose specialty society is developing a recommendation to be reviewed by the RUC.

As a RUC Advisor, I attest that the integrity of the RUC survey, summary of recommendation forms and practice expense recommendations are based on accurate and complete data to the best of my knowledge. As a RUC advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair, AMA Representative and Alternate AMA Representative.)



Signature

Norm D. Smith, MD

Printed Signature

American Urological Association

Specialty Society

Date

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs**

CPT Long Descriptor:

11980

Global Period: xxx Meeting Date: January 2014

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: RUC Advisors from each specialty society involved in this survey process reviewed the practice expense recommendations and approved them.
2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: We are using existing CPT code inputs as reference code.
3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:
4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:
5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Visit prior to procedure:

Provide pre-service education and obtain consent from patient

Day of Procedure – Pre-Service

Greet the patient

Provide gown

Ensure appropriate medical records are available

Obtain three vitals (BP, weight and temperature)

Prepare room, equipment and supplies

Intra-Service Clinical Labor Activities:

Assist physician during procedure

Post-Service Clinical Labor Activities:

Clean the room and equipment

Provide follow up information to patient.

Patient education/teaching as appropriate based upon the visit

Confers with the MD verbally for any last minute instructions for patient.

Next appointment is set up for patient while checking out.

Next day after patient leaves the office, calls patient.

	A	B	C	D	E	F
1				EXISTING INPUTS		
2	<p>more please bold the item name and CMS code.</p> <p>**Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.</p>					
3	Meeting Date: January 2014 Tab: 20 Specialty: American Urological Association	CMS Code	Staff Type	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)		Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
4	LOCATION			Non Fac	Facility	Non Fac
5	GLOBAL PERIOD			000	000	000
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	32.5	5.0	45.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			15.0	5.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			17.5	0.0	42.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	3.0
10	PRE-SERVICE					
11	Start: Following visit when decision for surgery or procedure made					
12	Complete pre-service diagnostic & referral forms					
13	Coordinate pre-surgery services					
14	Schedule space and equipment in facility				5	
15	Provide pre-service education/obtain consent			15		
16	Follow-up phone calls & prescriptions					
17	*Other Clinical Activity - <i>specify:</i>					
18	End: When patient enters office/facility for surgery/procedure					
19	SERVICE PERIOD					
20	Start: When patient enters office/facility for surgery/procedure:					
21	Greet patient, provide gowning, ensure appropriate medical records are available					3
22	Obtain vital signs					3
23	Provide pre-service education/obtain consent					3
24	Prepare room, equipment, supplies					2
25	Prepare and position patient/ monitor patient/ set up IV					2
26	Sedate/apply anesthesia					2
27	Intra-service					
28	Assist physician in performing procedure	L037D	RN/LPN/MTA	12.5		12
29	Assist physician/moderate sedation (100% of physician time)					
30	Post-Service					
31	Monitor pt. following moderate sedation					
32	Monitor pt. following service/check tubes, monitors, drains (not related to moderate sedation)					
33	Clean room/equipment by physician staff			5		3
34	Clean Surgical Instrument Package					10
35	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions					2
36	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a
37	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a
38	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a
39	End: Patient leaves office					
40	POST-SERVICE Period					
41	Start: Patient leaves office/facility					
42	Conduct phone calls/call in prescriptions					3
43	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits
44	99211 16 minutes		16			
45	99212 27 minutes		27			
46	99213 36 minutes		36			
47	99214 53 minutes		53			
48	99215 63 minutes		63			
49	Total Office Visit Time			0.0	0.0	0.0
50	*Other Clinical Activity - <i>specify:</i>					
51	End: with last office visit before end of global period					

	A	B	C	D	E	F
1				EXISTING INPUTS		
2	<p>Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.</p> <p>**Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.</p>			CPT Code # 11980		CPT Co
3	Meeting Date: January 2014 Tab: 20 Specialty: American Urological Association	CMS Code	Staff Type	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)		Subcutan pellet (implanta and/or test benea
4	LOCATION			Non Fac	Facility	Non Fac
5	GLOBAL PERIOD			000	000	000
52	MEDICAL SUPPLIES**	CODE	UNIT			
53	pack, minimum multi-specialty visit	SA048	pack	1		1
54	drape, non-sterile, sheet 40 in x 60 in	SB006	item	1		
55	gloves, sterile	SB024	item	1		2
56	gauze, sterile, 4in x 4in	SG055	item	2		2
57	tape, surgical paper 1 in (micropore)	SB079	item	12		12
58	syringe-needle, OSHA compliant	SC058	item			1
59	drape, sterile, for Mayo stand	SB012	item			1
60	drape, sterile, three-quarter sheet	SB014	item			1
61	Underpad, 2 ft x 3 ft (Chux)	SB044	item			1
62	blade, surgical, super-sharp	SF044	item			1
63	providone swabstick	SJ043	item			1
64	steri-strip	SG074	item			1
65	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	1		10
66	EQUIPMENT	CODE				
67	instrument pack, basic (\$500)	EQ137		13		24
68	table, power	EF031		40		32
69	table, instrument, mobile	EF027				22
70	light, exam	EQ168				22
71						

	A	B	C	G
1				
2	<p>more please bold the item name and CMS code.</p> <p>**Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.</p>			Code # 11980
3	<p>Meeting Date: January 2014</p> <p>Tab: 20</p> <p>Specialty: American Urological Association</p>	CMS Code	Staff Type	eous hormone implantation of estradiol osterone pellets (th the skin)
4	LOCATION			Facility
5	GLOBAL PERIOD			000
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0
10	PRE-SERVICE			
11	Start: Following visit when decision for surgery or procedure made			
12	Complete pre-service diagnostic & referral forms			
13	Coordinate pre-surgery services			
14	Schedule space and equipment in facility			
15	Provide pre-service education/obtain consent			
16	Follow-up phone calls & prescriptions			
17	*Other Clinical Activity - <i>specify</i> :			
18	End: When patient enters office/facility for surgery/procedure			
19	SERVICE PERIOD			
20	Start: When patient enters office/facility for surgery/procedure:			
21	Greet patient, provide gowning, ensure appropriate medical records are available			
22	Obtain vital signs			
23	Provide pre-service education/obtain consent			
24	Prepare room, equipment, supplies			
25	Prepare and position patient/ monitor patient/ set up IV			
26	Sedate/apply anesthesia			
27	Intra-service			
28	Assist physician in performing procedure	L037D	RN/LPN/MTA	
29	Assist physician/moderate sedation (100% of physician time)			
30	Post-Service			
31	Monitor pt. following moderate sedation			
32	Monitor pt. following service/check tubes, monitors, drains (not related to moderate sedation)			
33	Clean room/equipment by physician staff			
34	Clean Surgical Instrument Package			
35	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			
36	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			
37	Dischrg mgmt (1.0 x 99238) (enter 12 min)			
38	Dischrg mgmt (1.0 x 99239) (enter 15 min)			
39	End: Patient leaves office			
40	POST-SERVICE Period			
41	Start: Patient leaves office/facility			
42	Conduct phone calls/call in prescriptions			
43	Office visits: List Number and Level of Office Visits			# visits
44	99211 16 minutes		16	
45	99212 27 minutes		27	
46	99213 36 minutes		36	
47	99214 53 minutes		53	
48	99215 63 minutes		63	
49	Total Office Visit Time			0.0
50	*Other Clinical Activity - <i>specify</i> :			
51	End: with last office visit before end of global period			

	A	B	C	G
1				
2	<p>more please bold the item name and CMS code.</p> <p>**Please note: If you are including clinical labor tasks that are not listed on this spreadsheet please list them as subcategories of established clinical labor tasks whenever possible. Please see the <i>PE Spreadsheet Instructions</i> document for an example.</p>			code # 11980
3	<p>Meeting Date: January 2014</p> <p>Tab: 20</p> <p>Specialty: American Urological Association</p>	CMS Code	Staff Type	eous hormone implantation ion of estradiol osterone pellets (th the skin)
4	LOCATION			Facility
5	GLOBAL PERIOD			000
52	MEDICAL SUPPLIES**	CODE	UNIT	
53	pack, minimum multi-specialty visit	SA048	pack	
54	drape, non-sterile, sheet 40 in x 60 in	SB006	item	
55	gloves, sterile	SB024	item	
56	gauze, sterile, 4in x 4in	SG055	item	
57	tape, surgical paper 1 in (micropore)	SB079	item	
58	syringe-needle, OSHA compliant	SC058	item	
59	drape, sterile, for Mayo stand	SB012	item	
60	drape, sterile, three-quarter sheet	SB014	item	
61	Underpad, 2 ft x 3 ft (Chux)	SB044	item	
62	blade, surgical, super-sharp	SF044	item	
63	providone swabstick	SJ043	item	
64	steri-strip	SG074	item	
65	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	
66	EQUIPMENT	CODE		
67	instrument pack, basic (\$500)	EQ137		
68	table, power	EF031		
69	table, instrument, mobile	EF027		
70	light, exam	EQ168		
71				

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2018

Aortic Graft Procedures

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 those 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.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery Cardiovascular System Heart and Pericardium Electrophysiologic Operative Procedures Incision				
33255		<i>Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass</i>		
33256		<i>with cardiopulmonary bypass</i>		
		(Do not report 33254-33256 in conjunction with 32100, 32551, 33120, 33130, 33210, 33211, 33390, 33391, 33404-33507, 33510-33523, 33533-33548, 33600-33853, 33860 33858-33864, 33910-33920)		
+33259		<i>Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass (List separately in addition to code for primary procedure)</i>		
		(Use 33259 in conjunction with 33120, 33251, 33261, 33305, 33315, 33322, 33335, 33390, 33391, 33404, 33405, 33406, 33410,		

33411, 33412, 33413, 33414, 33415, 33416, 33417, 33422-33468, 33474, ~~33475, 33476, 33478~~, 33496, 33500, 33504-33507, 33510-33516, 33533-33548, 33600-33688, 33692-~~33722~~33726, 33730, 33732, 33736, ~~33750-33766~~, 33767, 33770-~~33781~~33783, 33786-33788, 33814, 33853, ~~33860~~33858-33877, 33910, 33916-33922, 33926, ~~33935, 33945~~, 33975-33980, 33983 when the procedure is performed with cardiopulmonary bypass)

Thoracic Aortic Aneurysm

When ascending aortic disease involves the aortic arch, an aortic hemiarch graft may be necessary in conjunction with the ascending aortic graft and may be reported with add-on code 33866 in conjunction with the appropriate ascending aortic graft code (~~33860~~ 33858, 33859, 33863, or 33864). Aortic hemiarch graft requires all of the following components:

1. either total circulatory arrest or isolated cerebral perfusion (retrograde or antegrade);
2. incision into the transverse arch extending under one or more of the arch vessels (eg, innominate, left common carotid, or left subclavian arteries); and
3. extension of the ascending aortic graft under the aortic arch by construction of a beveled anastomosis to the distal ascending aorta and aortic arch without a cross-clamp (an open anastomosis).

An ascending aortic repair with a beveled anastomosis into the arch with a cross-clamp may not be reported separately as a hemiarch graft using 33866. Use 33866 for aortic hemiarch graft when performed in conjunction with the ascending aortic graft codes ~~33860~~ 33858, 33859, 33863, 33864.

Code 33871 describes a complete transverse arch graft placement, and is not used to report an aortic hemiarch graft procedure.

D 33860	-	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed <u>(Do not report 33860 in conjunction with 33870)</u> <u>(33860 has been deleted. To report, see 33858, 33859)</u>	090	N/A (2018 work RVU = 59.46)
•33858	D1	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic dissection	090	65.00

•33859	D2	for aortic disease other than dissection (eg, aneurysm)	090	50.00
(f)33863	D3	Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall) (Do not report 33863 in conjunction with 33405, 33406, 33410, 33411, 33412, 33413, 33860 , <u>33858</u> , <u>33859</u> , 33870)	090	59.00
(f)33864	D4	Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub procedure) (Do not report 33864 in conjunction with 33860 , 33858, <u>33859</u> , 33863, 33870)	090	63.00
+•33866	D5 (CPT - 2019)	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) (Use 33866 for aortic hemiarch graft when performed in conjunction with the ascending aortic graft codes 33858, 33859, 33863, 33864) (Do not report 33866 in conjunction with 33871)	ZZZ	17.75
D33870	-	Transverse arch graft, with cardiopulmonary bypass <u>(33870 has been deleted. To report, use 33871)</u>	090	N/A (2018 work RVU = 46.06)

•33871	D6	<p>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)</p> <p>(For aortic hemiarch graft performed in conjunction with the ascending aortic graft codes 33858, 33859,-33863, 33864, use 33866)</p> <p>(Do not report 33871 for aortic hemiarch graft)</p> <p>(Do not report 33871 in conjunction with 33866)</p>	090	65.75
Arteries and Veins Endovascular Repair of Abdominal Aorta and/or Iliac Arteries +34714 <i>Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (List separately in addition to code for primary procedure)</i> (Use 34714 in conjunction with 32852, 32854, 33031, 33120, 33251, 33256, 33259, 33261, 33305, 33315, 33322, 33335, 33390, 33391, 33404-33417, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33468, 33474, 33475, 33476, 33478, 33496, 33500, 33502, 33504, 33505, 33506, 33507, 33510, 33511, 33512, 33513, 33514, 33516, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33600-33688, 33692, 33694, 33697, 33702, 33710, 33720, 33722, 33724, 33726, 33730, 33732, 33736, 33750, 33755, 33762, 33764, 33766, 33767, 33770-33783, 33786, 33788, 33802, 33803, 33814, 33820, 33822, 33824, 33840, 33845, 33851, 33853, 33860 , 33858, 33859, 33863, 33864, 33870 , 33871, 33875, 33877, 33880, 33881, 33883, 33884, 33886, 33910, 33916, 33917, 33920, 33922, 33926, 33935, 33945, 33975, 33976, 33977, 33978, 33979, 33980, 33983, 33990, 33991, 34701, 34702, 34703, 34704, 34705, 34706, 34707, 34708, 34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848, 0254T) (34714 may only be reported once per side. For bilateral procedure, report 34714 twice) (Do not report 34714 in conjunction with 33362, 33953, 33954, 33959, 33962, 33969, 33984, 34812 when performed on the same side) +34716 <i>Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)</i> (Use 34716 in conjunction with 32852, 32854, 33031, 33120, 33251, 33256, 33259-33261, 33305, 33315, 33322, 33335, 33390, 33391, 33404-33417, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33468, 33474, 33475, 33476, 33478, 33496, 33500, 33502, 33504, 33505, 33506, 33507, 33510, 33511, 33512, 33513, 33514, 33516, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33600-33688, 33692, 33694, 33697, 33702-33722, 33724, 33726, 33730, 33732, 33736, 33750, 33755,				

	<p>33762, 33764, 33766, 33767, 33770-33783, 33786, 33788, 33802, 33803, 33814, 33820, 33822, 33824, 33840, 33845, 33851, 33853, 33860, 33858, 33859, 33863, 33864, 33870, 33871, 33875, 33877, 33880, 33881, 33883, 33884, 33886, 33910, 33916, 33917, 33920, 33922, 33926, 33935, 33945, 33975, 33976, 33977, 33978, 33979, 33980, 33983, 33990, 33991, 34701, 34702, 34703, 34704, 34705, 34706, 34707, 34708, 34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848, 0254T)</p> <p><i>(34716 may only be reported once per side. For bilateral procedure, report 34716 twice)</i></p> <p><i>(Do not report 34716 in conjunction with 33953, 33954, 33959, 33962, 33969, 33984, 0451T, 0452T, 0455T, 0456T)</i></p> <p><i>(34800, 34802, 34803, 34804, 34805, 34806 have been deleted. To report, see 34701, 34702, 34703, 34704, 34705, 34706, 34707, 34708)</i></p>
# + 34833	<p><i>Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)</i></p> <p>(Use 34833 in conjunction with 32852, 32854, 33031, 33120, 33251, 33256, 33259, 33261, 33305, 33315, 33322, 33335, 33390, 33391, 33404-33417, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33468, 33474, 33475, 33476, 33478, 33496, 33500, 33502, 33504, 33505, 33506, 33507, 33510, 33511, 33512, 33513, 33514, 33516, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33600-33688, 33692, 33694, 33697, 33702, 33710, 33720, 33722, 33724, 33726, 33730, 33732, 33736, 33750, 33755, 33762, 33764, 33766, 33767, 33770-33783, 33786, 33788, 33802, 33803, 33814, 33820, 33822, 33824, 33840, 33845, 33851, 33853, 33860, <u>33858</u>, <u>33859</u>, 33863, 33864, 33870, <u>33871</u>, 33875, 33877, 33880, 33881, 33883, 33884, 33886, 33910, 33916, 33917, 33920, 33922, 33926, 33935, 33945, 33975, 33976, 33977, 33978, 33979, 33980, 33983, 33990, 33991, 34701, 34702, 34703, 34704, 34705, 34706, 34707, 34708, 34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848, 0254T)</p> <p><i>(34833 may only be reported once per side. For bilateral procedure, report 34833 twice)</i></p> <p><i>(Do not report 34833 in conjunction with 33364, 33953, 33954, 33959, 33962, 33969, 33984, 34820 when performed on the same side)</i></p>
<p>Arteries and Veins Direct Repair of Aneurysm or Excision (Partial or Total) and Graft Insertion for Aneurysm, Pseudoaneurysm, Ruptured Aneurysm, and Associated Occlusive Disease</p> <p><i>Procedures 35001-35152 include preparation of artery for anastomosis including endarterectomy.</i></p>	

(For direct repairs associated with occlusive disease only, see 35201-35286)

(For intracranial aneurysm, see 61700 et seq)

(For endovascular repair of abdominal aortic and/or iliac artery aneurysm, see 34701-34716)

(For thoracic aortic aneurysm, see ~~33860~~33858-33875)

(For endovascular repair of descending thoracic aorta, involving coverage of left subclavian artery origin, use 33880)

35001

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, carotid, subclavian artery, by neck incision

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 33858	Tracking Number	D1	Original Specialty Recommended RVU: 65.00
			Presented Recommended RVU: 65.00
Global Period: 090	Current Work RVU: 59.46		RUC Recommended RVU: 65.00

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old male presents to the emergency room with severe tearing pain in the chest. Transesophageal echocardiogram confirms an aortic dissection and the patient is taken to the operating room for ascending aortic graft repair.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 97% , In the ASC 0%, In the office 3%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 61%

Description of Pre-Service Work: This service is typically performed as an emergency for Type I aortic dissection, with the pre-service period beginning on the day of surgery. Perform rapid trauma system directed evaluation and physical exam. Obtain history from patient or from EMT's and treating ED physicians. Pay specific attention to end-organ damage due to malperfusion syndromes (paraplegia, stroke, renal artery occlusion, and other peripheral artery perfusion). Preoperative orders are written. Preoperative imaging studies including chest x-rays, CT Scan, MRI, aortogram and TEE are reviewed if available. Preoperative laboratory studies (CBC, electrolytes, renal and liver function, coagulation) are reviewed if available. The surgical procedure is reviewed and explained to the patient and/or family if possible and informed consent is obtained. The OR start time is confirmed. Availability of the surgical assistant is confirmed. The patient is identified, the surgical site is marked per hospital policy, and any questions from the family are answered. Availability of blood and/or cross match and any special instruments or medical devices is ensured. Review planned incision and procedure. Review the length and type of anesthesia with anesthesiologist alerting the anesthesiologist of the potential for cardiac tamponade physiology, and the need to adjust induction techniques accordingly. Ensure anesthesiology and perfusionist are prepared for circulatory arrest if needed. Plan invasive monitoring including use of arterial line (right radial only) and pulmonary artery catheter. Review trans-esophageal echocardiogram with anesthesiologist and/or cardiologist with special attention to quality of ascending aorta, location and extent of false lumen, degree and nature of aortic insufficiency and assessment of ventricular function. The surgeon scrubs and puts on a gown and gloves. Prep and drape the skin of the chest, abdomen, and legs from the neck to the ankles including both groin areas. Ensure that the patient is properly positioned for the procedure

Description of Intra-Service Work: Following a standard median sternotomy incision, the sternum is divided with a saw. A determination of which artery will be used for arterial access while on cardiopulmonary bypass is made following median sternotomy and exposure of the heart and great vessels. This may require exposure and use of the aortic arch, the innominate artery, the subclavian artery, the brachial artery, or even the femoral artery depending on the extent of the dissection and the condition of the ascending aorta. If necessary, an eight-millimeter Dacron graft is anastomosed to a peripheral artery in order to facilitate cardiopulmonary bypass (reported separately). A venous cannula is placed directly into the right atrium. The patient is heparinized and cardiopulmonary bypass is initiated with immediate systemic cooling.

Since the ascending aorta is dissected to a variable and unpredictable degree, use of a standard antegrade cannula for cardioplegia solution delivery is not possible. A retrograde cardioplegia cannula is inserted into the coronary sinus to administer cardioplegia and induce cardiac arrest. The heart is continually assessed for distention, myocardial cooling and sustained cardioplegic arrest.

The aorta is cross-clamped just below the innominate artery. The heart is arrested with retrograde cardioplegia. The dissected aorta is transected. The two coronary ostia are identified, and direct cannulation allows for delivery of additional cardioplegia in antegrade fashion as necessary. The location and complete extent of the aortic intimal entry tear is determined and must be included in the resection specimen. Following resection of the ascending aorta, the remaining aorta is sized for an appropriate Dacron tube graft. The integrity of the aortic valve is assessed and, if necessary, the valve is re-suspended within the proximal ascending aorta. The cut end of the proximal ascending aorta is reinforced with a circumferential Teflon felt strip. The tube graft is sutured to this reinforced proximal aorta with a running 5-0 polypropylene stitch. The tube graft is measured to length distally and sutured to the distal aorta below the aortic cross clamp using running 5-0 polypropylene stitch. In some cases, the distal suture line is reinforced with Teflon felt prior to performing the anastomosis. In some cases the distal anastomosis may not be possible with the cross clamp in place due to the extent of dissection and/or quality of the aortic tissue. In these situations, the patient is cooled to a nasopharyngeal or bladder temp in the range of 15-20 degrees Centigrade. Once the patient is cooled to the desired temperature, the cardiopulmonary bypass machine circuit is turned off and circulation to the entire body is interrupted. Retrograde and/or antegrade cerebral perfusion is established in some cases. Upon achieving total circulatory arrest, any cross clamp, if present, can be removed allowing unobstructed view of the intimal integrity of the ascending aorta and transverse arch within a bloodless aorta. The entire extent of the entry aortic tear must be confirmed and resected. The aorta is then cut and prepared with Teflon felt reinforcement prior to performing the distal anastomosis to the dacron tube graft. Rewarming of the patient is started during this anastomosis.

Upon completion of the distal aortic anastomosis, the patient is placed in Trendelenburg. Air is evacuated from the graft as cardiopulmonary bypass is slowly re-established. Once full cardiopulmonary bypass is re-established, an aortic cross clamp can be re-applied to the prosthetic graft and antegrade/retrograde cardioplegia can be re-administered as needed during the rewarming period. When the patient has been rewarmed to an acceptable temperature, the cross-clamp is removed, cardioplegia is discontinued and the heart is allowed to resume normal electrical activity. The aortic root is vented until LV ejection has been present for 5-10 minutes. Confirmation of air evaluation from the left side of heart, as well as from the dacron tube graft together with assessment for any aortic valve insufficiency is accomplished using transesophageal echocardiogram (separately reported). Continued resuscitation of the heart is accomplished by allowing it to beat while unloaded on cardiopulmonary bypass. Establishing meticulous hemostasis is critical since the patients are most often profoundly coagulopathic following profound hypothermia and total circulatory arrest. Temporary pacing wires are placed and electrical pacing is initiated if necessary. The patient is carefully weaned from cardiopulmonary bypass. Arterial, venous and cardioplegia cannulas are removed and cannulation sites are secured/repared. Chest tubes are placed, and the sternum is re-approximated. The sternal wound is closed.

Description of Post-Service Work: Postoperative same day work through admission to intensive care: An operating room debriefing is performed. Sterile dressings are applied to the incision. Drapes are removed, with close attention to pacing wires (if any), tubes, and lines to ensure that none are dislodged or disconnected. This attention continues as the patient is moved to the intensive care unit (ICU) bed for transfer. In a coordinated team manner, the patient's overall condition is monitored as the anesthesia team converts the monitoring equipment (arterial blood pressure, pulmonary artery pressures, electrocardiogram [EKG]) to a portable monitor. The chest drainage system is observed periodically to assess interval bleeding, to ascertain that negative pressure is not lost, and to ensure that the tubes are not obstructed. The OR transporting team and the ICU receiving team confirm initiation of transfer. The patient is accompanied to the ICU, and the team is directed should the patient's condition change en route. Operating room forms, indicating pre- and postoperative diagnoses and the operation performed, are signed. A postoperative chest X ray is obtained and examined to assess expansion of the lungs and placement of the chest and nasogastric tubes (if inserted). Orders for postoperative laboratory tests, films, medications, diet, and patient activity are written. A brief operative note is written for the patient's chart. Daily progress notes of the pre- and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, and specimens sent to pathology (if any) are documented. Intensive care and medications are reviewed with the staff. The patient's short-term goals are established with the ICU nursing staff. Procedure outcomes, including the procedure performed, any variance from the planned procedure, the general findings, an initial assessment of the degree of procedural success, and expectations for the remainder of the day of surgery and the longer term, are discussed with the family. The procedure outcome is discussed with the patient's family or caregiver after patient's emergence from anesthesia. A postoperative report is dictated, and the procedure outcome is discussed with the referring

physician. Care is coordinated with other physicians. A procedure outcome and expected recovery letter is dictated for the referring physician and/or the insurance company. A careful assessment of end-organ and extremity perfusion is mandatory at this point after any aortic dissection surgery.

Postoperative intensive care: Pharmacologic agents are initiated as needed to achieve strict blood pressure control. The patient's neurological state is assessed, and emergence from anesthesia is monitored. Sedatives, paralyzing agents, and analgesics are administered as needed. Gross neurologic function, including level of consciousness, behavioral appropriateness, and presence and nature of focal neurological defect if present, is evaluated. The evaluation is repeated until intraoperative neurologic injury is ruled out. The patient's hemodynamic condition, including cardiac rhythm, is assessed. Rate and conduction abnormalities are assessed. Temporary pacing is initiated as needed. A suitable mode is determined, and the output and sensitivity of the device are adjusted. The assessment of hemodynamic effects is repeated. Arrhythmias are assessed. Atrial extrasystoles or runs are differentiated from ventricular extrasystoles or runs and correlated with operative events and hemodynamic effects; antiarrhythmic therapy (treatment or prophylaxis) is considered. The 12-lead EKG is evaluated for signs or ischemia or injury and compared to the preoperative tracing. Blood pressure, central venous pressure, pulmonary artery pressures, and cardiac output and index are assessed. Filling pressures are correlated at baseline, calibration of transducers with zero level at the level of the right heart are confirmed, and waveforms are assessed. Crystalloid fluids or blood products are administered depending on cardiac index, mixed venous oxygen saturation, hemoglobin, and central filling pressures. Inotropic and vasoactive agents given by continuous infusion are adjusted to optimize oxygen delivery and minimize adverse end-organ effects. Peripheral perfusion is carefully evaluated by observation and physical exam, correlating findings with invasive monitoring results. Chest tube bleeding is monitored. The character of the mediastinal drainage (rate, amount, stability of clot) is assessed. The patency of the mediastinal tubes is assessed to ensure that a cardiac tamponade state is avoided. Bleeding quantity and character are correlated with chest X ray, laboratory tests, hemodynamics, urine output, and physical exam. Laboratory results are assessed and correlated with other findings to determine the need for blood and/or blood products, including platelets, cryoprecipitate, and fresh frozen plasma. Other adjunctive pharmacologic therapies are considered for coagulopathy. The need for re-exploration is considered if the chest tube output exceeds acceptable limits or if tamponade is present. The respiratory system is assessed. Breath sounds are examined, chest mechanics observed, and mid-line tracheal position is ensured by physical exam. Ventilator settings are assessed; underlying respiratory pattern, baseline airway pressures generated, and minute gas flow are observed. The postoperative chest X ray is reevaluated if necessary. Endotracheal tube placement is confirmed by review of the postoperative chest X ray. Lungs are monitored for infiltrate/atelectasis. Pleural spaces are assessed for fluid collection. Blood gases are assessed, and the ventilator is adjusted as needed. Readiness for extubation is assessed. The patient is weaned from the ventilator. The patient is extubated, and airway and adequacy of ventilation are ensured. Adequacy of urine output is assessed, and postoperative creatinine in light of preoperative renal function is checked. Volume status is assessed, and fluids are administered as needed. The need for a diuretic is determined and, if indicated, the dose is determined, and response is monitored. Urine flow is correlated with blood pressure and compared to preoperative status. Interaction of cardiac output and vasoactive agents with renal function is assessed. Distal extremity perfusion is monitored, and peripheral pulses are assessed and compared to preoperative findings. A comprehensive evaluation is integrated with the patient's history, expected status based on conduct of the operation, and response to critical care interventions. The extent of inflammatory state is assessed, and treatment with antipyretics or steroids is considered as indicated. The patient's chart notes are reviewed with the nursing staff and other staff. Interval plans are discussed with the nursing staff. Parameters for interval adjustments in patient treatment are set, and the interval to the next patient evaluation, if expected goals have been met, is established. Questions from the nursing staff, other staff, and the patient's family are answered. Orders are written. The patient's progress notes are charted.

Postoperative other hospital work—beginning on postoperative day 4 until discharge day: A comprehensive history and physical exam are performed. All wounds are inspected for drainage, underlying hematoma, and inflammation. The patient's chart notes are reviewed with nursing and other staff. Postoperative pain, use of analgesics, and adequacy of response are assessed. Strict control of the patient's blood pressure is continued. Adequacy of respiration, character of breathing, relationship to surgical pain, and intravascular volume status are assessed. Character of pulmonary secretions and the patient's ability to clear his airway are assessed. Vital signs, intake and output, laboratory results, and patient daily weight are reviewed. The chest radiograph is reviewed, and the cardiac monitor is evaluated for rate, rhythm, and presence or absence of arrhythmia. The stored EKG monitoring history is evaluated if indicated. Progress of the system recovery and risk for development of complications are assessed. Ambulation and vigorous pulmonary physiotherapy are encouraged. Postoperative nutritional status, as maintained by both enteral (if necessary) and oral feedings, is carefully assessed and monitored. The chest tube is removed when appropriate (usually 24 to 48 hours postoperatively). Chest X-rays after tube removal and at least one more time before discharge as indicated by patient's condition are obtained and reviewed. The temporary pacemaker wires are removed if present. Questions from the patient, family, and nursing or other staff (verbal and written) are answered. An interval plan of care that includes drug therapy for underlying conditions (eg, diabetes),

surgically induced conditions, actual or anticipated complications (eg, beta blockers for atrial fibrillation, antibiotics for prophylaxis or treatment), and preventive care is developed. Insurance staff questions are answered. Orders for postoperative laboratory tests, films, medications, diet, and patient activity are written. The postoperative echocardiogram is evaluated and reviewed. The patient's progress is discussed (oral and written) with the referring physician. Care is coordinated with other physicians. Evaluation, patient progress, and the care plan are documented in the medical record.

Discharge day work: A history and physical exam are performed. The final pathology/laboratory/film reports are checked and discussed with the patient's the family or caregiver. Wounds and patient progress are checked. Dietary management, activities permitted, bathing, handling of wound, return appointment to office, and similar items are carefully explained to the patient's family. Expectations for recovery are outlined and adjusted to specific underlying cardiac state, associated chronic diseases, operative findings, and character of postoperative recovery. Potential complications, how to recognize them, and what to do if recovery is not as anticipated are described. Care is coordinated with other physicians. The patient's chart notes are reviewed with nursing and other staff. Post discharge wound care and activity limitations are reviewed with the family. Questions from the patient, family, and nursing and other staff are answered. Insurance staff questions are answered. Orders for post discharge laboratory tests, films, and medications are written. The patient's discharge notes are charted, and prescriptions and discharge instructions are written. The nature, purpose, and expected duration of use of new medications are explained. The importance of secondary prevention of cardiac disease through risk factor reduction is explained to the family. Specific instructions on the need to notify other treating physicians and dentists of the presence of a surgically implanted dacron prosthetic graft and the need for prophylactic periprocedural antibiotics are given. The patient's home medications and homeopathic agents are explained to ensure that additional agents are compatible or will not be used. A discharge summary is dictated. Communication is made with patient's primary care physician(s).

Postoperative office work: After discharge from the hospital, a detailed history and physical exam are performed. Medications are reviewed, and compliance is determined. Interval encounters are reviewed with other care providers. Wounds and patient progress are checked. Sutures/drains are removed. Post discharge laboratory tests/films are reviewed, specifically echo studies to assess myocardial and valve function and compare to preoperative studies. Medications are reviewed and orders for medications are written. Questions from the patient and family are answered. Insurance staff questions are answered. The patient's progress is discussed (verbal and written) with the referring physician. The patient's care is coordinated with other physicians. Progress is discussed with the patient and family. A patient progress note is dictated for the medical chart, and letters are sent to referring physicians. A detailed schedule for routine follow-up CT scans to evaluate the remainder of the descending and abdominal aorta is discussed with the patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		10/2018				
Presenter(s):	Jim Levett, MD; Kirk Kanter, MD; Joseph Turek, MD; Jacob Schroder, MD					
Specialty Society(ies):	STS, AATS					
CPT Code:	33858					
Sample Size:	800	Resp N:	41	Response: 5.1 %		
Description of Sample:	Random sample of 650 self-identified cardiac surgeons and 150 self-identified congenital heart surgeons					
		Low	25 th pctl	Median*	75 th pctl	High
Service Performance Rate		0.00	4.00	6.00	11.00	25.00
Survey RVW:		41.32	60.00	65.00	80.00	100.00
Pre-Service Evaluation Time:				40.00		
Pre-Service Positioning Time:				15.00		
Pre-Service Scrub, Dress, Wait Time:				15.00		
Intra-Service Time:		120.00	240.00	300.00	360.00	540.00
Immediate Post Service-Time:	60.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	210.00	99291x 3.00 99292x 0.00				
Other Hospital time/visit(s):	170.00	99231x 1.00 99232x 1.00 99233x 2.00				
Discharge Day Mgmt:	38.00	99238x 1.00 99239x 0.00 99217x 0.00				
Office time/visit(s):	80.00	99211x 0.00 12x 0.00 13x 0.00 14x 2.00 15x 0.00				
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00				
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33858	Recommended Physician Work RVU: 65.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		15.00	20.00	-5.00
Intra-Service Time:		300.00		
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
9B General Anes or Complex Regional Blk/Cmplx Proc				
		Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:		60.00	33.00	27.00

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	<u>210.00</u>	99291x 3.00 99292x 0.00
Other Hospital time/visit(s):	<u>170.00</u>	99231x 1.00 99232x 1.00 99233x 2.00
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0 99217x 0.00
Office time/visit(s):	<u>63.00</u>	99211x 0.00 12x 0.00 13x 1.00 14x 1.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33412	090	59.00	RUC Time

CPT Descriptor Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33877	090	69.03	RUC Time

CPT Descriptor Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 14 % of respondents: 36.8 %

Number of respondents who choose 2nd Key Reference Code: 7 % of respondents: 17.0 %

TIME ESTIMATES (Median)

	CPT Code: <u>33858</u>	Top Key Reference CPT Code: <u>33412</u>	2nd Key Reference CPT Code: <u>33877</u>
Median Pre-Service Time	70.00	63.00	110.00
Median Intra-Service Time	300.00	300.00	324.00
Median Immediate Post-service Time	60.00	60.00	60.00
Median Critical Care Time	210.0	140.00	210.00
Median Other Hospital Visit Time	170.0	225.00	282.00
Median Discharge Day Management Time	38.0	38.00	38.00
Median Office Visit Time	63.0	40.00	86.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	911.00	866.00	1,110.0
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	14%	50%	36%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
0%	36%	64%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	14%	36%	50%
Physical effort required	7%	43%	50%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%

36%

64%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

0%

50%

0%

50%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

17%

33%

50%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

0%

50%

50%

Physical effort required

17%

50%

33%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%

50%

57%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

OVERALL RATIONALE

Tab 6 includes 6 codes that represent grafting procedures on the ascending aorta and the aortic arch. A new add-on code +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) that was developed to account for the additional work that is involved when the ascending aortic disease extends into the proximal portion of the transverse aortic arch was approved by the CPT Editorial Panel and surveyed for the January 2018 RUC meeting. The Expert Panel decided not to survey the ascending aortic replacement codes 33860, 33863 or 33864 for the January 2018 RUC meeting because they felt that the work involved in the aortic hemiarch replacement procedure represented an advancement in surgical technique representing new work that is not reflected in the work that is currently accounted for in the ascending aortic procedures. The specialties indicated that the aortic hemiarch replacement is more closely related to the work involved with the transverse aortic arch replacement code 33870 than to the work of the ascending aortic codes. At the January 2018 RUC meeting, the RUC determined that the specialties had to re-survey the family of aortic repair procedures including codes 33860, 33863, 33864, 33866, 33870 for the April 2018 RUC meeting. As the specialty reviewed the codes with consideration of re-surveying them, they determined that they 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 felt that there is a sufficient difference in the work associated with these procedures and now there is enough 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 CCA was submitted to the CPT Editorial Panel for consideration at the May 2018 CPT meeting. The CPT Editorial Panel approved the deletion of two existing codes, 33860 and 33870. Code 33860 will be replaced with two new codes, 33858 and 33859 for ascending aortic aneurysm repair for dissection and for other aortic disease respectively. Due to the extensive changes of the descriptor for code 33870 to further differentiate that code from the aortic hemiarch code 33866, the Panel decided to delete code 33870 and renumber it to the new code 33871. As a result, 4 ascending aortic grafting codes 33858, 33859, 33863 and 33864 and two aortic arch grafting codes 33866 and 33871 were surveyed for the October 2018 meeting.

The recommended values for these procedures result in an overall budget savings for Medicare as represented in the table below:

CPT Source	Deleted	Source 2017 Utilization	New/ Revised Code	New/ Revised Code Utilization (reference 2017)	Percent	Source RVU	STS Rec RVU	New/ Revised Total RVUs	Total Source RVUs	Difference New/Rev - Source
33860	D	3800	33858	1140	0.3	59.46	65.00	74100	67784	6316
33860	D	3800	33859	2660	0.7	59.46	50.00	133000	158164	-25164
33863		1875	33863	1875	1	58.79	59.00	110625	110231	394
33864		282	33864	282	1	60.08	63.00	17766	16943	823
33870	D	999	33871	300	0.3	46.06	65.75	19725	13818	5907
33870	D	999	33866	699	0.7	46.06	19.74	13798	32196	-18398
Totals								369014	399136	-30122

Code 33860 which is split into two new codes 33858 and 33859 results in a recommended increase in value for code 33858 (recommended RVW 65.00, current RVW 59.46) and a decrease in value for the more commonly performed code 33859 (recommended RVW 50.00, current RVW 59.46) resulting is an overall budget savings for that code. Code 33870 is also split into two new codes 33866 and 33871, which results in a recommended increase in value for code 33871 (recommended RVW 65.75, current RVW 46.06) and a decrease in value for the more commonly performed code 33866 (recommended RVW 19.74, current RVW 46.06) resulting is an overall budget savings for that code. The RVW recommendations for the other two codes, 33863 and 33864 result in slight increases for each code, but these increases are offset by the savings from the changes to the other codes. Additional information regarding the recommended revisions are included for each code.

Rationale 33858

Code 33858 is a new code for ascending aortic graft for aortic dissection. This procedure used to be reported with code 33860, which combined ascending aortic procedures for dissection and other aortic disease, such as aneurysms. The current Medicare volume for 33860 is 3800, which has been relatively consistent over the years per the RUC database. It is estimated that 30% of the ascending aortic repairs will be performed for aortic dissections, resulting in an estimated Medicare volume of 1140 procedures per year. 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.

Pre-Time Package 4**Pre-Time Changes:**

The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel is recommending increases in time for the evaluation of the patient and for the positioning of the patient. The survey only supported 15 minutes for scrub dress and wait time, so the Expert Panel is recommending a 5-minute reduction for a total of 15 minutes for the scrub dress and wait time for the procedure per the survey.

Evaluation (total = 40 minutes):

The survey supported 60 minutes of pre-service time. However, due to the emergent nature of this procedure, the Expert Panel determined that the package evaluation time of 40 minutes was more appropriate. 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. 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 ascending aorta, location and extent of false lumen, degree and nature of aortic insufficiency and assessment of ventricular function. The Expert Panel felt that the package 4 evaluation time of 40 minutes was reasonable and would cover all aspects of the pre-service work involved with the procedure.

Positioning (total = 15 minutes):

The Expert Panel is recommending a 12-minute increase in time over the package for a total positioning time of 15 minutes, which is common for cardiac procedures and there are numerous examples in the RUC database supporting this time. The survey supported 15-minutes for positioning of the patient. The additional 12-minutes above the package time can be attributed to the time spent for careful protection of pressure points on the patient with this prolonged operation.

Scrub, Dress and Wait (total = 15 minutes):

There is a 5-minute decrease from the package time, which represents the scrub dress and wait time from the survey.

Post-time Package 9b**Total = 60 minutes:**

The expert panel selected post-time package 9B for a general anesthesia or complex regional block/complex procedure. The Expert Panel is recommending a 27-minute increase in time over the package for a total immediate post time of 60 minutes and there are numerous examples in the RUC database and the cardiothoracic surgery codes supporting this time. The survey supported 60 minutes of immediate post time. The additional 27-minutes above the package time can be attributed to additional time for patient stabilization due to cardiopulmonary bypass, monitoring for bleeding, evaluation of neurologic status, assessment of peripheral circulation, and more extensive documentation and communication requirements due to the complex aspects of the procedure including the final type of repair that was accomplished.

Critical Care Visits

97% of the survey respondents replied that the procedure was performed in the hospital, and that 100% of the patients stayed overnight for more than 24 hours. 61% of the respondents indicated that they provided an E&M Visit on the same day of surgery.

The survey respondents indicated that they spent over 40 minutes providing critical care services to the patient once the patient arrives in the ICU on the day of the procedure and an additional 40 minutes of critical care for two days after the procedure for a total of three critical care visits for the procedure. The critical care visits cover that time that the physician spends with the patient directly related to the procedure providing critical care services. Critical care extends to the 3rd 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 survey supported three critical care visits for the procedure and the Expert Panel agreed.

Intensity and complexity of the procedure

41 surveys were completed by a random pool of 800 cardiac surgeons which consisted of 650 self-identified adult cardiac surgeons and 150 self-identified congenital cardiac surgeons. 14 respondents selected code 33412, aortic valve replacement as a reference code making it the 1st key reference service (KRS). That code has a lower value, the same intraservice time and a lower total time than the survey code. The survey respondents found that the survey code was more or much more complex than 33412 for all of the intensity/complexity measures. 7 respondents selected code 33877, thoracoabdominal aneurysm repair as a reference code making it the 2nd KRS. This code has a higher value with a longer intraservice and total service time. The respondents ranged in their intensity/complexity comparison saying that the survey code 33858 is identical to or much more intense/complex than 33877 for all of the intensity/complexity measures.

Recommended RVW

The survey data for code 33858 (ascending aortic graft or dissection) shows that the median intra-operative time is 300 minutes. The current intra-service time for this procedure is 305 minutes. The STS Database shows a mean intra-service time of 301 minutes and a median time of 281 minutes, however the database data that Expert Panel has available at this time does not distinguish the time for dissections versus aortic repair for other aortic disease such as aneurysm. The median intra-service time from the survey at 300 minutes is slightly less than the intra-time for the current code 33860. The surveys also supported three critical care visits during the post-operative period over two critical care visits included in the current code. The hospital LOS from the survey represents one day less than the LOS in the current code and the total time from the survey is slightly less at 911 minutes than that for the current code at 931 minutes. The Expert Panel felt that the survey accurately represented some of the work variances that exist between the ascending aortic repair for dissection versus ascending aortic repair for other aortic disease. Since code 33860 represents a blend of ascending aortic grafting for dissection and repairs for other aortic disease the time inputs from the existing code cannot be compared directly to those from the survey. The Recommended RVW and the total time for the survey code falls between the RVWs for the two KRS codes. The intraservice time of the survey code is the same as the 1st KRS and slightly lower than that of the 2nd KRS. The intensity (0.130) for the survey code is higher than the intensity for 1st (0.122) and 2nd (0.114) KRS codes. The Expert panel felt that this is appropriate and is supported by the intensity and complexity measures.

The Expert Panel is recommending the median work RVW of 65.00, with an intra-service time of 300 minutes, and total time of 911 minutes. Pre-time package 4 was selected with adjustments made to the positioning time for a total pre-service time of 70 minutes. Immediate post-service time package 9b with additional time added for a total time of 60 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33860

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiothoracic surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2117

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

The 2017 Medicare frequency for 33860 is 3,800. The STS database shows that 65% of the patients that undergo an ascending aortic graft are non-Medicare patients.

It is estimated that 30% of ascending aortic grafts reported for 33860 are for dissection. This results in the following:

For code 33858, it is estimated that 2117 procedures per year will be provided nationally and 1140 procedures per year will be provided to Medicare patients.

Specialty cardiothoracic surgery Frequency 2117 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,140

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2017 Medicare frequency for 33860 is 3,800. The STS database shows that 65% of the patients that undergo an ascending aortic graft are non-Medicare patients.

It is estimated that 30% of ascending aortic grafts reported for 33860 are for dissection. This results in the following:

For code 33858, it is estimated that 2117 procedures per year will be provided nationally and 1140 procedures per year will be provided to Medicare patients.

Specialty cardiothoracic surgery	Frequency 1140	Percentage 100.00 %
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Specialty	Frequency	Percentage	%
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:

Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33860

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 33859	Tracking Number D2	Original Specialty Recommended RVU: 50.00
		Presented Recommended RVU: 50.00
Global Period: 090	Current Work RVU: 59.46	RUC Recommended RVU: 50.00

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old male is followed with serial echocardiograms looking for increasing aortic dimensions. Echocardiogram shows a 5.5 cm ascending aorta that has increased in size by 1 cm in 1 year. The patient is referred for surgical repair.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 95% , In the ASC 0%, In the office 5%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 57%

Description of Pre-Service Work: A complete or interval history and physical examination (comprehensive) are performed. Preoperative orders are written, and the work-up and notes from referring and primary physicians are reviewed if available. Preoperative imaging studies including chest x-rays, CT Scan, MRI, Aortogram and TEE are reviewed. Preoperative laboratory studies (CBC, electrolytes, renal and liver function, coagulation test values) are reviewed. Obtain cardiology assessment and pulmonary assessment as indicated. Indications, surgical procedure, expected recovery, and expected outcomes, including potential complications, are reviewed with the family. The family's questions are answered, and informed consent is obtained. The OR start time is confirmed and the patient and family are notified. Availability of the surgical assistant is confirmed. The patient is identified, the surgical site is marked per hospital policy, and any questions from the family are answered. Availability of blood and/or cross match and any special instruments or medical devices is ensured. Review planned incision and procedure. Review the length and type of anesthesia with anesthesiologist. Ensure anesthesiology and perfusionist are prepared for circulatory arrest if needed. Plan invasive monitoring including use of arterial line (right radial only) and pulmonary artery catheter. Review trans-esophageal echocardiogram with anesthesiologist and/or cardiologist with special attention to quality of ascending aorta, degree and nature of aortic insufficiency as well as assessment of ventricular function. The surgeon scrubs and puts on a gown and gloves. Prep and drape the skin of the chest, abdomen, and legs from the neck to the ankles including both groin areas. Ensure that the patient is properly positioned for the procedure

Description of Intra-Service Work: Perform standard median sternotomy skin incision, divide the sternum in the midline with a saw, place arterial cardiopulmonary bypass cannula above the aneurysmal portion of the aorta. A venous cannula is placed directly into the right atrium, Assesses ascending aorta. Administer heparin and determine level of heparinization, establish cardiopulmonary bypass, initiate systemic cooling, place antegrade and retrograde cardioplegia cannulas. The aorta is cross-clamped just below the innominate artery. The heart is arrested with antegrade and retrograde cardioplegia and assess heart for distention, cooling and efficacy of cardioplegic arrest.

The aorta is transected where the ascending aortic dilatation begins, most commonly at the sinotubular junction. The cut end of the aorta is sized for the appropriate tube graft. The tube graft is sutured to the proximal aorta with a running 5-0 polypropylene stitch. The tube graft is measured to length distally and sutured to the distal ascending aorta below the aortic

cross clamp using running 5-0 polypropylene stitch, thereby, excluding the entire aneurysmal portion of the ascending aorta.

The patient is placed in Trendelenburg. Air is evacuated from the left ventricle and ascending tube graft. The cross-clamp removed, and the aortic root is vented until LV ejection has been present for 5-10 minutes. Confirm evaluate air in left side of heart and assess for any aortic valve insufficiency using transesophageal echocardiogram (separately reported). Resuscitate the heart by allowing it to beat while unloaded on cardiopulmonary bypass. Ensure hemostasis, place temporary pacing wires and begin pacing if necessary. Discontinue cardiopulmonary bypass, remove cannulas and repair cannulation sites. Ensure hemostasis, place chest tubes, re-approximate the sternum and close chest wound.

Description of Post-Service Work: Postoperative same day work through admission to intensive care: An operating room debriefing is performed. Sterile dressings are applied to the incision. Drapes are removed, with close attention to pacing wires (if any), tubes, and lines, including possible epidural anesthesia catheter if present, to ensure that none are dislodged or disconnected. This attention continues as the patient is moved to the intensive care unit (ICU) bed for transfer. In a coordinated team manner, the patient's overall condition is monitored as the anesthesia team converts the monitoring equipment (arterial blood pressure, pulmonary artery pressures, electrocardiogram [EKG]) to a portable monitor. The chest drainage system is observed periodically to assess interval bleeding, to ascertain that negative pressure is not lost, and to ensure that the tubes are not obstructed. The OR transporting team and the ICU receiving team confirm initiation of transfer. The patient is accompanied to the ICU, and the team is directed should the patient's condition change en route. Operating room forms, indicating pre- and postoperative diagnoses and the operation performed, are signed. A postoperative chest X ray is obtained and examined to assess expansion of the lungs and placement of the chest and nasogastric tubes (if inserted). Orders for postoperative laboratory tests, films, medications, diet, and patient activity are written. A brief operative note is written for the patient's chart. Daily progress notes of the pre- and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, and specimens sent to pathology (if any) are documented. Intensive care and medications are reviewed with the staff. The patient's short-term goals are established with the ICU nursing staff. Procedure outcomes, including the procedure performed, any variance from the planned procedure, the general findings, an initial assessment of the degree of procedural success, and expectations for the remainder of the day of surgery and the longer term, are discussed with the family. The procedure outcome is discussed with the patient's family or caregiver after patient's emergence from anesthesia. A postoperative report is dictated, and the procedure outcome is discussed with the referring physician. Care is coordinated with other physicians. A procedure outcome and expected recovery letter is dictated for the referring physician and/or the insurance company.

Postoperative intensive care: The patient's neurological state is assessed, and emergence from anesthesia is monitored. Sedatives, paralyzing agents, and analgesics are administered as needed. Gross neurologic function, including level of consciousness, behavioral appropriateness, and presence and nature of focal neurological defect if present, is evaluated. The evaluation is repeated until intraoperative neurologic injury is ruled out. The patient's hemodynamic condition, including cardiac rhythm, is assessed. Rate and conduction abnormalities are assessed. A temporary pacemaker is considered, and temporary pacing is initiated as needed. A suitable mode is determined, and the output and sensitivity of the device are adjusted. The assessment of hemodynamic effects is repeated. Arrhythmias are assessed. Atrial extrasystoles or runs are differentiated from ventricular extrasystoles or runs and correlated with operative events and hemodynamic effects; antiarrhythmic therapy (treatment or prophylaxis) is considered. The 12-lead EKG is evaluated for signs or ischemia or injury and compared to the preoperative tracing. Blood pressure, central venous pressure, pulmonary artery pressures, and cardiac output and index are assessed. Filling pressures are correlated at baseline, calibration of transducers with zero level at the level of the right heart are confirmed, and waveforms are assessed. Crystalloid fluids or blood products are administered depending on cardiac index, mixed venous oxygen saturation, hemoglobin, and central filling pressures. Inotropic and vasoactive agents given by continuous infusion are adjusted to optimize oxygen delivery and minimize adverse end-organ effects. Peripheral perfusion is carefully evaluated by observation and physical exam, correlating findings with invasive monitoring results. Chest tube bleeding is monitored. The character of the mediastinal drainage (rate, amount, stability of clot) is assessed. The patency of the mediastinal tubes is assessed to ensure that a cardiac tamponade state is avoided. Bleeding quantity and character are correlated with chest X ray, laboratory tests, hemodynamics, urine output, and physical exam. Laboratory results are assessed and correlated with other findings to determine the need for blood and/or blood products, including platelets, cryoprecipitate, and fresh frozen plasma. Other adjunctive pharmacologic therapies are considered for coagulopathy. The need for reexploration is considered if the chest tube output exceeds acceptable limits or if tamponade physiology is present. The respiratory system is assessed. Breath sounds are examined, chest mechanics observed, and mid-line tracheal position is ensured by physical exam. Ventilator settings are assessed; underlying respiratory pattern, baseline airway pressures generated, and minute gas flow are observed. The postoperative chest X ray is reevaluated if necessary. Endotracheal tube placement is confirmed by review of the postoperative chest X ray. Lungs are monitored for infiltrate/atelectasis. Pleural spaces are assessed for fluid

collection. Blood gases are assessed, and the ventilator is adjusted as needed. The patient is weaned from the ventilator. Readiness for extubation is assessed. The patient is extubated, and airway and adequacy of ventilation are ensured. Adequacy of urine output is assessed, and postoperative creatinine in light of preoperative renal function is checked. Volume status is assessed, and fluids are administered as needed. The need for a diuretic is determined and, if indicated, the dose is determined, and response is monitored. Urine flow is correlated with blood pressure and compared to preoperative status. Interaction of cardiac output and vasoactive agents with renal function is assessed. Distal extremity perfusion is monitored, and peripheral pulses are assessed and compared to preoperative findings. A comprehensive evaluation is integrated with the patient's history, expected status based on conduct of the operation, and response to critical care interventions. The extent of inflammatory state is assessed, and treatment with antipyretics or steroids is considered as indicated. The patient's chart notes are reviewed with the nursing staff and other staff. Interval plans are discussed with the nursing staff. Parameters for interval adjustments in patient treatment are set, and the interval to the next patient evaluation, if expected goals have been met, is established. Questions from the nursing staff, other staff, and the patient's family are answered. Orders are written. The patient's progress notes are charted.

Postoperative other hospital work—beginning on postoperative day 3 until discharge day: A comprehensive history and physical exam are performed. All wounds are inspected for drainage, underlying hematoma, and inflammation. The patient's chart notes are reviewed with nursing and other staff. Postoperative pain, use of analgesics, and adequacy of response are assessed. Adequacy of respiration, character of breathing, relationship to surgical pain, and intravascular volume status are assessed. Character of pulmonary secretions and the patient's ability to clear his airway are assessed. Vital signs, intake and output, laboratory results, and patient daily weight are reviewed. The chest radiograph is reviewed, and the cardiac monitor is evaluated for rate, rhythm, and presence or absence of arrhythmia. The stored EKG monitoring history is evaluated if indicated. Progress of the system recovery and risk for development of complications are assessed. Ambulation and vigorous pulmonary physiotherapy are encouraged. Postoperative nutritional status, as maintained by both enteral (if necessary) and oral feedings, is carefully assessed and monitored. The chest tube is removed when appropriate (usually 24 to 48 hours postoperatively). Chest X-rays after tube removal and at least one more time before discharge as indicated by patient's condition are obtained and reviewed. The temporary pacemaker wires are removed if present. Questions from the patient, family, and nursing or other staff (verbal and written) are answered. An interval plan of care that includes drug therapy for underlying conditions (eg, diabetes), surgically induced conditions, actual or anticipated complications (eg, beta blockers for atrial fibrillation, antibiotics for prophylaxis or treatment), and preventive care is developed. Insurance staff questions are answered. Orders for postoperative laboratory tests, films, medications, diet, and patient activity are written. The postoperative echocardiogram is evaluated and reviewed. The patient's progress is discussed (oral and written) with the referring physician. Care is coordinated with other physicians. Evaluation, patient progress, and the care plan are documented in the medical record.

Discharge day work: A history and physical exam are performed. The final pathology/laboratory/film reports are checked and discussed with the patient's the family or caregiver. Wounds and patient progress are checked. Dietary management, activities permitted, bathing, handling of wound, return appointment to office, and similar items are carefully explained to the patient's family. Expectations for recovery are outlined and adjusted to specific underlying cardiac state, associated chronic diseases, operative findings, and character of postoperative recovery. Potential complications, how to recognize them, and what to do if recovery is not as anticipated are described. Care is coordinated with other physicians. The patient's chart notes are reviewed with nursing and other staff. Post discharge wound care and activity limitations are reviewed with the family. Questions from the patient, family, and nursing and other staff are answered. Insurance staff questions are answered. Orders for post discharge laboratory tests, films, and medications are written. The patient's discharge notes are charted, and prescriptions and discharge instructions are written. The nature, purpose, and expected duration of use of new medications are explained. The importance of secondary prevention of cardiac disease through risk factor reduction is explained to the family. Specific instructions on the need to notify other treating physicians and dentists of the presence of a surgically implanted ascending aortic prosthetic graft and the need for prophylactic periprocedural antibiotics are given. The patient's home medications and homeopathic agents are explained to ensure that additional agents are compatible or will not be used. A discharge summary is dictated. Communication is made with patient's primary care physician(s).

Postoperative office work: After discharge from the hospital, a detailed history and physical exam are performed. Medications are reviewed, and compliance is determined. Interval encounters are reviewed with other care providers. Wounds and patient progress are checked. Sutures/drains that remained in the patient on the day of discharge are removed. Post discharge laboratory tests/films are reviewed to confirm that no mediastinal enlargement compared to immediate postoperative chest x-ray, has occurred. Medications are reviewed and orders for medications are written. Questions from the patient and family are answered. Insurance staff questions are answered. The patient's progress is discussed (verbal and written) with the referring physician. The patient's care is coordinated with other physicians. Progress is discussed with the patient and family. A patient progress note is dictated for the medical chart, and letters are sent to referring physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		10/2018				
Presenter(s):	Jim Levett, MD; Kirk Kanter, MD; Joseph Turek, MD; Jacob Schroder, MD					
Specialty Society(ies):	STS, AATS					
CPT Code:	33859					
Sample Size:	800	Resp N:	40	Response: 5.0 %		
Description of Sample:	Random sample of 650 self-identified cardiac surgeons and 150 self-identified congenital heart surgeons					
		Low	25 th pctl	Median*	75 th pctl	High
Service Performance Rate		0.00	4.00	7.00	12.00	50.00
Survey RVW:		35.00	50.00	59.00	65.81	95.00
Pre-Service Evaluation Time:				65.00		
Pre-Service Positioning Time:				15.00		
Pre-Service Scrub, Dress, Wait Time:				15.00		
Intra-Service Time:		120.00	199.00	240.00	279.00	360.00
Immediate Post Service-Time:	60.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	140.00	99291x 2.00 99292x 0.00				
Other Hospital time/visit(s):	170.00	99231x 1.00 99232x 1.00 99233x 2.00				
Discharge Day Mgmt:	38.00	99238x 1.00 99239x 0.00 99217x 0.00				
Office time/visit(s):	40.00	99211x 0.00 12x 0.00 13x 0.00 14x 1.00 15x 0.00				
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00				
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33859	Recommended Physician Work RVU: 50.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time
Pre-Service Evaluation Time:		60.00	40.00	20.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		15.00	20.00	-5.00
Intra-Service Time:		240.00		
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) 9B General Anes or Complex Regional Blk/Complex Proc				
		Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:		60.00	33.00	27.00

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>140.00</u>	99291x 2.00	99292x 0.00		
Other Hospital time/visit(s):	<u>170.00</u>	99231x 1.00	99232x 1.00	99233x 2.00	
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>40.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 1.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33430	090	50.93	RUC Time

CPT Descriptor Replacement, mitral valve, with cardiopulmonary bypass**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33877	090	69.03	RUC Time

CPT Descriptor Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 12 % of respondents: 30.0 %

Number of respondents who choose 2nd Key Reference Code: 8 % of respondents: 20.0 %

TIME ESTIMATES (Median)

	CPT Code: <u>33859</u>	Top Key Reference CPT Code: <u>33430</u>	2nd Key Reference CPT Code: <u>33877</u>
Median Pre-Service Time	90.00	95.00	110.00
Median Intra-Service Time	240.00	232.00	324.00
Median Immediate Post-service Time	60.00	40.00	60.00
Median Critical Care Time	140.0	140.00	210.00
Median Other Hospital Visit Time	170.0	282.00	282.00
Median Discharge Day Management Time	38.0	38.00	38.00
Median Office Visit Time	40.0	86.00	86.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	778.00	913.00	1,110.0
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	9%	55%	36%	0%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
0%	55%	45%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	18%	64%	18%
Physical effort required	18%	73%	9%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%

82%

18%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

17%

33%

33%

17%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

50%

17%

33%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

0%

33%

67%

Physical effort required

17%

33%

50%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

17%

17%

67%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

OVERALL RATIONALE

Tab 6 includes 6 codes that represent grafting procedures on the ascending aorta and the aortic arch. A new add-on code +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) that was developed to account for the additional work that

is involved when the ascending aortic disease extends into the proximal portion of the transverse aortic arch was approved by the CPT Editorial Panel and surveyed for the January 2018 RUC meeting. The Expert Panel decided not to survey the ascending aortic replacement codes 33860, 33863 or 33864 for the January 2018 RUC meeting because they felt that the work involved in the aortic hemiarch replacement procedure represented an advancement in surgical technique representing new work that is not reflected in the work that is currently accounted for in the ascending aortic procedures. The specialties indicated that the aortic hemiarch replacement is more closely related to the work involved with the transverse aortic arch replacement code 33870 than to the work of the ascending aortic codes. At the January 2018 RUC meeting, the RUC determined that the specialties had to re-survey the family of aortic repair procedures including codes 33860, 33863, 33864, 33866, 33870 for the April 2018 RUC meeting. As the specialty reviewed the codes with consideration of re-surveying them, they determined that they 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 felt that there is a sufficient difference in the work associated with these procedures and now there is enough 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 CCA was submitted to the CPT Editorial Panel for consideration at the May 2018 CPT meeting. The CPT Editorial Panel approved the deletion of two existing codes, 33860 and 33870. Code 33860 will be replaced with two new codes, 33858 and 33859 for ascending aortic aneurysm repair for dissection and for other aortic disease respectively. Due to the extensive changes of the descriptor for code 33870 to further differentiate that code from the aortic hemiarch code 33866, the Panel decided to delete code 33870 and renumber it to the new code 33871. As a result, 4 ascending aortic grafting codes 33858, 33859, 33863 and 33864 and two aortic arch grafting codes 33866 and 33871 were surveyed for the October 2018 meeting.

The recommended values for these procedures result in an overall budget savings for Medicare as represented in the table below:

CPT Source	Deleted	Source 2017 Utilization	New/ Revised Code	New/ Revised Code Utilization (reference 2017)	Percent	Source RVU	STS Rec RVU	New/ Revised Total RVUs	Total Source RVUs	Difference New/Rev - Source
33860	D	3800	33858	1140	0.3	59.46	65.00	74100	67784	6316
33860	D	3800	33859	2660	0.7	59.46	50.00	133000	158164	-25164
33863		1875	33863	1875	1	58.79	59.00	110625	110231	394
33864		282	33864	282	1	60.08	63.00	17766	16943	823
33870	D	999	33871	300	0.3	46.06	65.75	19725	13818	5907
33870	D	999	33866	699	0.7	46.06	19.74	13798	32196	-18398
Totals								369014	399136	-30122

Code 33860 which is split into two new codes 33858 and 33859 results in a recommended increase in value for code 33858 (recommended RVW 65.00, current RVW 59.46) and a decrease in value for the more commonly performed code 33859 (recommended RVW 50.00, current RVW 59.46) resulting in an overall budget savings for that code. Code 33870 is also split into two new codes 33866 and 33871, which results in a recommended increase in value for code 33871 (recommended RVW 65.75, current RVW 46.06) and a decrease in value for the more commonly performed code 33866 (recommended RVW 19.74, current RVW 46.06) resulting in an overall budget savings for that code. The RVW recommendations for the other two codes, 33863 and 33864 result in slight increases for each code, but these increases are offset by the savings from the changes to the other codes. Additional information regarding the recommended revisions are included for each code.

Rationale 33859

Code 33859 is a new code for ascending aortic graft for other aortic disease such as aneurysm. This procedure used to be reported with code 33860, which combined ascending aortic procedures for dissection and other aortic disease, such as aneurysms. The current Medicare volume for 33860 is 3800, which has been relatively consistent over the years per the RUC database. It is estimated that 70% of the ascending aortic repairs will be performed for other aortic disease such as aneurysm, resulting in an estimated Medicare volume of 2660 procedures per year. Ascending aortic grafting for other aortic disease such as aneurysm is a procedure that requires a median sternotomy and cardiopulmonary bypass with cardiac arrest. The ascending aorta involved in the aneurysm is transected and replaced with a graft. Depending on the patient and the repair, re-suspension of the aortic valve may also be necessary.

Pre-Time Package 4

Pre-Time Changes:

The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel is recommending increases in time for the evaluation of the patient and for the positioning of the patient. The survey only supported 15 minutes for scrub dress and wait time, so the Expert Panel is recommending a 5-minute reduction for a total of 15 minutes for the scrub dress and wait time for the procedure per the survey.

Evaluation (total = 60 minutes): For the evaluation, the Expert Panel is recommending a 20-minute increase in time over the package for a total evaluation time of 60 minutes. This is supported by the survey data with 60 minutes of pre-service evaluation. The total evaluation time accounts for the review of the patient, by the surgeon and the collaborative efforts that go into each case. The additional evaluation time of 20 minutes accounts 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, cath report, CT scan 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 Expert Panel felt that adding 20 minutes of evaluation time to package 4 was reasonable and would cover all aspects of the pre-service work involved with the procedure.

Positioning (total = 15 minutes): The Expert Panel is recommending a 12-minute increase in time over the package for a total positioning time of 15 minutes, which is common for cardiac procedures and there are numerous examples in the RUC database supporting this time. The survey supported 15-minutes for positioning of the patient. The additional 12-minutes above the package time can be attributed to the time spent for careful protection of pressure points on the patient with this prolonged operation.

Scrub, Dress and Wait (total = 15 minutes): There is a 5-minute decrease from the package time, which represents the scrub dress and wait time from the survey.

Post-time Package 9b

Total = 60 minutes: The expert panel selected post-time package 9B for a general anesthesia or complex regional block/complex procedure. The Expert Panel is recommending a 27-minute increase in time over the package for a total immediate post time of 60 minutes. There are numerous examples in the RUC database and the cardiothoracic surgery codes supporting this time. The survey supported 60 minutes of immediate post time. The additional 27-minutes above the package time can be attributed to additional time 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.

Critical Care Visits: 95% of the survey respondents replied that the procedure was performed in the hospital, and that 100% of the patients stayed overnight for more than 24 hours. 57% of the respondents indicated that they provided an E&M Visit on the same day of surgery.

The survey respondents indicated that they spent over 40 minutes providing critical care services to the patient once the patient arrives in the ICU on the day of the procedure and an additional 40 minutes of critical care the day after the procedure for a total of two critical care visits for the procedure. The critical care visit covers that time that the physician spends with the patient directly related to the procedure providing critical care services. The survey supported two critical care visits for the procedure and the Expert Panel agreed.

Intensity and complexity of the procedure: 40 surveys were completed by a random pool of 800 cardiac surgeons which consisted of 650 self-identified adult cardiac surgeons and 150 self-identified congenital cardiac surgeons. 12 respondents selected code 33430, mitral valve replacement as a reference code making it the 1st key reference service (KRS). That code has a slightly lower value, a shorter intraservice time and a longer total time than the survey code. The survey respondents ranged in their intensity/complexity comparison saying that the survey code was identical or somewhat more complex than 33430 for all of the intensity/complexity measures. 8 respondents selected code 33877, thoracoabdominal aneurysm repair as a reference code making it the 2nd KRS. This code has a higher value with a longer intraservice and total service time. The respondents ranged in their intensity/complexity comparison saying that the survey code is identical to, somewhat or much more intense/complex than 33877 for all of the intensity/complexity measures except for the mental effort where 50% of the respondents indicated that the survey code was less complex than 33877.

Recommended RVW: The survey data for code 33859 (ascending aortic graft for other aortic disease) shows that the median intra-operative time is 240 minutes. The current intra-service time for this procedure is 305 minutes. The STS Database intra-service time shows a mean time of 301 minutes and a median time of 281 minutes. However, the database time data available to the Expert Panel at this time does not distinguish between dissections and other aortic disease such as aneurysms. The median intra-service time from the survey at 240 minutes is less than the intra-time for the current code 33860. The surveys also supported two critical care visits during the post-operative period which is the same number included in the current code. The hospital LOS from the survey represents one day less than the LOS in the current code and the total time from the survey is less at 778 minutes than that for the current code at 931 minutes. The Expert Panel felt that the survey accurately represented some of the work variances that exist between the ascending aortic repair for dissection versus ascending aortic repair for other aortic disease. Since code 33860 represents a blend of ascending aortic grafting for dissection and repairs for other aortic disease, the time inputs from the existing code cannot be compared directly to those from the survey. The Recommended RVW and the total time for the survey code falls on just above the RVW for the 1st KRS. The intraservice time of the survey code is slightly more than the intra-service time of the 1st KRS and lower than that of the 2nd KRS. The intensity (0.121) for the survey code is higher than the intensity for 1st (0.105) and 2nd (0.114) KRS codes. The Expert panel felt that this is appropriate and is supported by the intensity and complexity measures.

The Expert Panel is recommending the 25th percentile work RVW of 50.00, with a median intra-service time of 240 minutes, and total time of 778 minutes. Pre-time package 4 was selected with adjustments made to the evaluation and positioning time for a total pre-service time of 90 minutes. Immediate post-service time package 9b with additional time added for a total time of 60 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33860

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiothoracic surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4940

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2017 Medicare frequency for 33860 is 3,800. The STS database shows that 65% of the patients that undergo an ascending aortic graft are non-Medicare patients.

It is estimated that 70% of the ascending aortic grafts reported for 33860 are for aortic disease other than dissection. This results in the following:

For code 33859, it is estimated that 4940 procedures per year will be provided nationally and 2660 procedures per year will be provided to Medicare patients.

Specialty cardiothoracic surgery Frequency 4940 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,660

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2017 Medicare frequency for 33860 is 3,800. The STS database shows that 65% of the patients that undergo an ascending aortic graft are non-Medicare patients.

It is estimated that 70% of the ascending aortic grafts reported for 33860 are for aortic disease other than dissection. This results in the following:

For code 33859, it is estimated that 4940 procedures per year will be provided nationally and 2660 procedures per year will be provided to Medicare patients.

Specialty cardiothoracic surgery Frequency 2660 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33860

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 33863 Tracking Number D3

Original Specialty Recommended RVU: **59.00**Global Period: 090 Current Work RVU: **58.79**Presented Recommended RVU: **59.00**RUC Recommended RVU: **59.00**

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male with a history of a dilated aortic root and ascending aorta has been followed yearly. Transthoracic echo now shows the ascending aorta to be 6.5 cm in diameter with severe aortic insufficiency. The patient undergoes graft replacement of the ascending aorta, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg Bentall)

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 95% , In the ASC 0%, In the office 5%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 58%

Description of Pre-Service Work: A complete or interval history and physical examination (comprehensive) are performed with special attention to dental condition or other possible future sources of prosthetic or native endocarditis. Identify absolute or relative contraindications to lifetime anticoagulation with Warfarin, including an assessment of patient compliance, lifestyle, work environment and coexistent diseases that predispose to hemorrhagic complications. If female, discuss possibility of future pregnancy. Preoperative orders are written, and the work-up and notes from referring and primary physicians are reviewed if available. Preoperative imaging studies including chest x-rays, coronary angiogram, echocardiogram, cath report, CT scan and echo report are reviewed. Preoperative laboratory studies (CBC, electrolytes, renal and liver function, coagulation) are reviewed. Obtain cardiology assessment and pulmonary assessment as indicated. Indications, surgical procedure, expected recovery, and expected outcomes, including potential complications, are reviewed with the family. Discuss alternative valve selection criteria, relative risks in short and long term of bioprosthesis vs mechanical prostheses, intraoperative findings that may force the decision. Discuss the possibility of complete heart block and the need for permanent pacing, as well as the standard risks of cardiac surgery. The family's questions are answered, and informed consent is obtained. The OR start time is confirmed and the patient and family are notified. Confirm surgical assistant. The patient is identified, the surgical site is marked per hospital policy, and any questions from the family are answered. Availability of blood and/or cross match and any special instruments or medical devices, including a full range of valve-conduits by size, is ensured. Review planned incision and procedure. Review the length and type of anesthesia with anesthesiologist alerting the anesthesiologist of the potential for cardiac tamponade physiology. Ensure anesthesiology and perfusionist are prepared for circulatory arrest if needed. Plan invasive monitoring including use of arterial line and pulmonary artery catheter. Review trans-esophageal echocardiogram with anesthesiologist and/or cardiologist with special attention to quality of ascending aorta, degree and nature of aortic valve pathology and ventricular function. Position patient supine and carefully pad the extremities to prevent pressure injury. The surgeon scrubs and puts on a gown and gloves. Prep and drape the skin of the chest, abdomen, and legs from the neck to the ankles including both groin areas. Ensure that the patient is properly positioned for the procedure

Description of Intra-Service Work: Perform standard median sternotomy skin incision, divide the sternum in the midline with a saw.

Assess ascending aorta and level of aneurysm. Determine if a period of total circulatory arrest will be necessary for distal graft anastomosis and plan systemic cooling accordingly. A determination of which artery will be used for arterial access while on cardiopulmonary bypass is made following median sternotomy and exposure of the heart and great vessels. This may require exposure and use of the aortic arch, the innominate artery, the subclavian artery, the brachial artery, or even the femoral artery depending on condition of the ascending aorta and the extent of pathology. Administer systemic heparin. Determine appropriate cannulas to use based on anatomy and patient BSA. Place purse string sutures in right atrium. Check with anesthesiologist and/or perfusionist regarding activated clotting time value to assess level of heparinization. If peripheral arterial cannulation is planned proceed with the following steps: assess size of arterial vessel and select cannula based on vessel diameter and patient's BSA. Apply vascular clamps to proximal and distal portions of exposed artery. Perform small transverse arteriotomy. If necessary, an eight-millimeter Dacron graft is anastomosed to the artery in order to facilitate cardiopulmonary bypass (reported separately). Atraumatically insert arterial cannula by removing proximal clamp verifying by echocardiography its position in the descending thoracic aorta if a long cannula is used. Change gloves after completing cannulation and before returning to chest incision. Insert venous right atrial cannula, vent left atrium. Initiate cardiopulmonary bypass, inspect aorta for signs of dissection. Initiate systemic cooling. Place antegrade and retrograde (if necessary) cardioplegia cannulas. Cross clamp the aorta and administer cardioplegia and topical hypothermia. Assess effectiveness of cardioplegia based on arrest of heart and temperature probe in ventricular septum; maintain septal temperature below 15 degrees Centigrade. Repeat cardioplegia every 20 minutes or as necessary while cross clamp in place. Assess heart for distention, cooling and cardioplegic arrest.

Open ascending aorta evaluate aneurysm (or dissection), the aortic root and aortic valve. Measure root. Dissect left coronary artery free with cuff of surrounding aortic wall to serve as a button. Dissect free the right coronary artery in similar fashion. Resect the aortic valve and entire ascending aorta. Size the aortic annulus to determine appropriate size for the prosthetic valve. If a composite graft (prosthetic valve attached to a Dacron tube graft) is used: select the appropriately sized composite graft. Place interrupted, braided valve sutures around native valve annulus. Place sutures into prosthetic valve sewing ring. Seat and secure the valve with each of annular sutures. To re-establish continuity between aortic blood flow and coronary circulation, both the right and left coronary arteries must be anastomosed to the side walls of the Dacron valve-conduit tube graft. Determine suitable position for left coronary anastomosis to the graft. Mark this location and create an opening in graft. Perform the left coronary artery/button anastomosis to the side wall of the graft with running polypropylene using thin felt strips on cuff of coronary artery. Perform a similar maneuver for the right coronary/button anastomosis to the side wall of the graft. Measure length of aortic prosthetic graft for distal aortic anastomosis and the cut graft to the appropriate length. Perform distal anastomosis with running polypropylene.

Rewarm at appropriate time. Place patient in Trendelenberg, evacuate air, remove cross-clamp. Vent aortic root until LV ejection present for 5-10 minutes. Check all suture lines, with particular attention to coronary anastomoses to graft. Evaluate air in left side of heart using transesophageal echocardiogram. Resuscitate the heart by allowing it to beat while unloaded on cardiopulmonary bypass. Recheck all suture lines. Place temporary pacing wires and begin atrial, atrio-ventricular, or ventricular pacing if indicated. Assess need for inotropic agents or intra-aortic balloon pump. Discontinue cardiopulmonary bypass by reducing arterial flow and retarding venous return to pump while continuously monitoring hemodynamics with arterial and pulmonary artery lines. Evaluate the post-procedure, intra-operative echocardiogram specifically examining for ventricular function, regional wall motion abnormalities, and valve function. When the patient is stable, give protamine to reverse heparin and remove the arterial and venous cannulas. If necessary, close peripheral artery cannulation site with running polypropylene suture. Arterial, venous, right superior pulmonary vein and cardioplegia cannulas are removed and cannulation sites are secured/repared. Chest tubes are placed, and the sternum is re-approximated. The sternal wound is closed.

Description of Post-Service Work: Postoperative same day work through admission to intensive care: An operating room debriefing is performed. Sterile dressings are applied to the incision. Drapes are removed, with close attention to pacing wires (if any), tubes, lines and possible epidural anesthesia catheter to ensure that none are dislodged or disconnected. This attention continues as the patient is moved to the intensive care unit (ICU) bed for transfer. In a coordinated team manner, the patient's overall condition is monitored as the anesthesia team converts the monitoring equipment (arterial blood pressure, pulmonary artery pressures, electrocardiogram [EKG]) to a portable monitor. The chest drainage system is observed periodically to assess interval bleeding, to ascertain that negative pressure is not lost, and to ensure that the tubes are not obstructed. The OR transporting team and the ICU receiving team confirm initiation of transfer. The patient is accompanied to the ICU, and the team is directed should the patient's condition change en route. Operating room forms, indicating pre- and postoperative diagnoses and the operation performed, are signed. A postoperative chest X ray is

obtained and examined to assess expansion of the lungs and placement of the chest and nasogastric tubes (if inserted). Orders for postoperative laboratory tests, films, medications, diet, and patient activity are written. A brief operative note is written for the patient's chart. Daily progress notes of the pre- and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, and specimens sent to pathology (if any) are documented. Intensive care and medications are reviewed with the staff. The patient's short-term goals are established with the ICU nursing staff. Procedure outcomes, including the procedure performed, any variance from the planned procedure, the general findings, an initial assessment of the degree of procedural success, and expectations for the remainder of the day of surgery and the longer term, are discussed with the family. The procedure outcome is discussed with the patient's family or caregiver after patient's emergence from anesthesia. A postoperative report is dictated, and the procedure outcome is discussed with the referring physician. Care is coordinated with other physicians. A procedure outcome and expected recovery letter is dictated for the referring physician and/or the insurance company.

Postoperative intensive care: The patient's neurological state is assessed, and emergence from anesthesia is monitored. Sedatives, paralyzing agents, and analgesics are administered as needed. Gross neurologic function, including level of consciousness, behavioral appropriateness, and presence and nature of focal neurological defect if present, is evaluated. The evaluation is repeated until intraoperative neurologic injury is ruled out. The patient's hemodynamic condition, including cardiac rhythm, is assessed. Rate and conduction abnormalities are assessed. Temporary pacing is initiated as needed. A suitable mode is determined, and the output and sensitivity of the device are adjusted. The assessment of hemodynamic effects is repeated. Arrhythmias are assessed. Atrial extrasystoles or runs are differentiated from ventricular extrasystoles or runs and correlated with operative events and hemodynamic effects; antiarrhythmic therapy (treatment or prophylaxis) is considered. The 12-lead EKG is evaluated for signs of ischemia or injury and compared to the preoperative tracing. Blood pressure, central venous pressure, pulmonary artery pressures, and cardiac output and index are assessed. Filling pressures are correlated at baseline, calibration of transducers with zero level at the level of the right heart are confirmed, and waveforms are assessed. Crystalloid fluids or blood products are administered depending on cardiac index, mixed venous oxygen saturation, hemoglobin, and central filling pressures. Inotropic and vasoactive agents given by continuous infusion are adjusted to optimize oxygen delivery and minimize adverse end-organ effects. Peripheral perfusion is carefully evaluated by observation and physical exam, correlating findings with invasive monitoring results. Chest tube bleeding is monitored. The character of the mediastinal drainage (rate, amount, stability of clot) is assessed. The patency of the mediastinal tubes is assessed to ensure that a cardiac tamponade state is avoided. Bleeding quantity and character are correlated with chest X ray, laboratory tests, hemodynamics, urine output, and physical exam. Laboratory results are assessed and correlated with other findings to determine the need for blood and/or blood products, including platelets, cryoprecipitate, and fresh frozen plasma. Other adjunctive pharmacologic therapies are considered for coagulopathy. The need for reexploration is considered if the chest tube output exceeds acceptable limits or if tamponade is present. The respiratory system is assessed. Breath sounds are examined, chest mechanics observed, and mid-line tracheal position is ensured by physical exam. Ventilator settings are assessed; underlying respiratory pattern, baseline airway pressures generated, and minute gas flow are observed. The postoperative chest X ray is reevaluated if necessary. Endotracheal tube placement is confirmed by review of the postoperative chest X ray. Lungs are monitored for infiltrate/atelectasis. Pleural spaces are assessed for fluid collection. Blood gases are assessed, and the ventilator is adjusted as needed. Readiness for extubation is assessed. When appropriate, the patient is extubated, and airway and adequacy of ventilation are ensured. Adequacy of urine output is assessed, and postoperative creatinine in light of preoperative renal function is checked. Volume status is assessed, and fluids are administered as needed. The need for a diuretic is determined and, if indicated, the dose is determined, and response is monitored. Urine flow is correlated with blood pressure and compared to preoperative status. Interaction of cardiac output and vasoactive agents with renal function is assessed. Distal extremity perfusion is monitored, and peripheral pulses are assessed and compared to preoperative findings. A comprehensive evaluation is integrated with the patient's history, expected status based on conduct of the operation, and response to critical care interventions. The extent of inflammatory state is assessed, and treatment with antipyretics or steroids is considered as indicated. The patient's chart notes are reviewed with the nursing staff and other staff. Interval plans are discussed with the nursing staff. Parameters for interval adjustments in patient treatment are set, and the interval to the next patient evaluation, if expected goals have been met, is established. Questions from the nursing staff, other staff, and the patient's family are answered. Orders are written. The patient's progress notes are charted.

Postoperative other hospital work—beginning on postoperative day 3 until discharge day: A comprehensive history and physical exam are performed. All wounds are inspected for drainage, underlying hematoma, and inflammation. The patient's chart notes are reviewed with nursing and other staff. Postoperative pain, use of analgesics, and adequacy of response are assessed. Adequacy of respiration, character of breathing, relationship to surgical pain, and intravascular volume status are assessed. Character of pulmonary secretions and the patient's ability to clear his airway are assessed. Vital signs, intake and output, laboratory results, and patient daily weight are reviewed. The chest radiograph is reviewed, and the cardiac monitor is evaluated for rate, rhythm, and presence or absence of arrhythmia. The stored EKG monitoring history is evaluated if indicated. Progress of the system recovery and risk for development of complications are assessed.

Ambulation and vigorous pulmonary physiotherapy are encouraged. Postoperative nutritional status, as maintained by both enteral (if necessary) and oral feedings, is carefully assessed and monitored. The chest tubes, if still present, are removed when appropriate. Chest X-rays after tube removal and at least one more time before discharge as indicated by patient's condition are obtained and reviewed. The temporary pacemaker wires are removed if present. Questions from the patient, family, and nursing or other staff (verbal and written) are answered. An interval plan of care that includes drug therapy for underlying conditions (e.g., diabetes), surgically induced conditions, actual or anticipated complications (e.g., beta blockers for atrial fibrillation, antibiotics for prophylaxis or treatment), and preventive care is developed. Insurance staff questions are answered. Orders for postoperative laboratory tests, films, medications, diet, and patient activity are written. The postoperative echocardiogram is evaluated and reviewed. The patient's progress is discussed (oral and written) with the referring physician. Care is coordinated with other physicians. Evaluation, patient progress, and the care plan are documented in the medical record.

Discharge day work: A history and physical exam are performed. The final pathology/laboratory/film reports are checked and discussed with the patient's the family or caregiver. Wounds and patient progress are checked. Dietary management, activities permitted, bathing, handling of wound, return appointment to office, and similar items are carefully explained to the patient's family. Expectations for recovery are outlined and adjusted to specific underlying cardiac state, associated chronic diseases, operative findings, and character of postoperative recovery. Potential complications, how to recognize them, and what to do if recovery is not as anticipated are described. Care is coordinated with other physicians. The patient's chart notes are reviewed with nursing and other staff. Post discharge wound care and activity limitations are reviewed with the family. Questions from the patient, family, and nursing and other staff are answered. Insurance staff questions are answered. Orders for post discharge laboratory tests, films, and medications are written. The patient's discharge notes are charted, and prescriptions and discharge instructions are written. The nature, purpose, and expected duration of use of new medications are explained. The importance of secondary prevention of cardiac disease through risk factor reduction is explained to the family. Specific instructions on the need to notify other treating physicians and dentists of the presence of a prosthetic heart valve and Dacron graft replacing the ascending aorta, as well as the need for prophylactic periprocedural antibiotics are given. The patient's home medications and homeopathic agents are explained to ensure that additional agents are compatible or will not be used. A discharge summary is dictated. Communication is made with patient's primary care physician(s). A schedule for anticoagulation testing is formulated for the patient.

Postoperative office work: After discharge from the hospital, a detailed history and physical exam are performed. Medications are reviewed, and compliance is determined. Interval encounters are reviewed with other care providers. Wounds and patient progress are checked. Sutures/drains are removed. Post discharge laboratory tests/films are reviewed, specifically echo studies to assess valve function and compare to preoperative studies. Medications are reviewed and orders for medications are written. Questions from the patient and family are answered. Insurance staff questions are answered. The patient's progress is discussed (verbal and written) with the referring physician. The patient's care is coordinated with other physicians. Progress is discussed with the patient and family. A patient progress note is dictated for the medical chart, and letters are sent to referring physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		10/2018				
Presenter(s):	Jim Levett, MD; Kirk Kanter, MD; Joseph Turek, MD; Jacob Schroder, MD					
Specialty Society(ies):	STS, AATS					
CPT Code:	33863					
Sample Size:	800	Resp N:	41	Response: 5.1 %		
Description of Sample:	Random sample of 650 self-identified cardiac surgeons and 150 self-identified congenital heart surgeons					
		Low	25 th pctl	Median*	75 th pctl	High
Service Performance Rate		0.00	3.00	5.00	10.00	70.00
Survey RVW:		41.32	59.00	62.00	78.00	100.00
Pre-Service Evaluation Time:				67.50		
Pre-Service Positioning Time:				13.50		
Pre-Service Scrub, Dress, Wait Time:				15.00		
Intra-Service Time:		180.00	240.00	280.00	300.00	480.00
Immediate Post Service-Time:	60.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	140.00	99291x 2.00 99292x 0.00				
Other Hospital time/visit(s):	170.00	99231x 1.00 99232x 1.00 99233x 2.00				
Discharge Day Mgmt:	38.00	99238x 1.00 99239x 0.00 99217x 0.00				
Office time/visit(s):	40.00	99211x 0.00 12x 0.00 13x 0.00 14x 1.00 15x 0.00				
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00				
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33863	Recommended Physician Work RVU: 59.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time
Pre-Service Evaluation Time:		60.00	40.00	20.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		15.00	20.00	-5.00
Intra-Service Time:		300.00		
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) 9B General Anes or Complex Regional Blk/Cmplx Proc				
		Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:		60.00	33.00	27.00

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	<u>140.00</u>	99291x 2.00 99292x 0.00
Other Hospital time/visit(s):	<u>170.00</u>	99231x 1.00 99232x 1.00 99233x 2.00
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0 99217x 0.00
Office time/visit(s):	<u>40.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 1.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33412	090	59.00	RUC Time

CPT Descriptor Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33877	090	69.03	RUC Time

CPT Descriptor Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 12 % of respondents: 29.2 %

Number of respondents who choose 2nd Key Reference Code: 8 % of respondents: 19.5 %

TIME ESTIMATES (Median)

	CPT Code: <u>33863</u>	Top Key Reference CPT Code: <u>33412</u>	2nd Key Reference CPT Code: <u>33877</u>
Median Pre-Service Time	90.00	63.00	110.00
Median Intra-Service Time	300.00	300.00	324.00
Median Immediate Post-service Time	60.00	60.00	60.00
Median Critical Care Time	140.0	140.00	210.00
Median Other Hospital Visit Time	170.0	225.00	282.00
Median Discharge Day Management Time	38.0	38.00	38.00
Median Office Visit Time	40.0	40.00	86.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	838.00	866.00	1,110.0
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	8%	50%	33%	8%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
25%	50%	25%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	25%	33%	42%
Physical effort required	17%	25%	58%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

17%

42%

42%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

0%

43%

29%

29%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

0%

43%

57%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

0%

43%

57%

Physical effort required

0%

43%

57%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%

0%

100%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

OVERALL RATIONALE

Tab 6 includes 6 codes that represent grafting procedures on the ascending aorta and the aortic arch. A new add-on code +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) that was developed to account for the additional work that

is involved when the ascending aortic disease extends into the proximal portion of the transverse aortic arch was approved by the CPT Editorial Panel and surveyed for the January 2018 RUC meeting. The Expert Panel decided not to survey the ascending aortic replacement codes 33860, 33863 or 33864 for the January 2018 RUC meeting because they felt that the work involved in the aortic hemiarch replacement procedure represented an advancement in surgical technique representing new work that is not reflected in the work that is currently accounted for in the ascending aortic procedures. The specialties indicated that the aortic hemiarch replacement is more closely related to the work involved with the transverse aortic arch replacement code 33870 than to the work of the ascending aortic codes. At the January 2018 RUC meeting, the RUC determined that the specialties had to re-survey the family of aortic repair procedures including codes 33860, 33863, 33864, 33866, 33870 for the April 2018 RUC meeting. As the specialty reviewed the codes with consideration of re-surveying them, they determined that they 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 felt that there is a sufficient difference in the work associated with these procedures and now there is enough 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 CCA was submitted to the CPT Editorial Panel for consideration at the May 2018 CPT meeting. The CPT Editorial Panel approved the deletion of two existing codes, 33860 and 33870. Code 33860 will be replaced with two new codes, 33858 and 33859 for ascending aortic aneurysm repair for dissection and for other aortic disease respectively. Due to the extensive changes of the descriptor for code 33870 to further differentiate that code from the aortic hemiarch code 33866, the Panel decided to delete code 33870 and renumber it to the new code 33871. As a result, 4 ascending aortic grafting codes 33858, 33859, 33863 and 33864 and two aortic arch grafting codes 33866 and 33871 were surveyed for the October 2018 meeting.

The recommended values for these procedures result in an overall budget savings for Medicare as represented in the table below:

CPT Source	Deleted	Source 2017 Utilization	New/ Revised Code	New/ Revised Code Utilization (reference 2017)	Percent	Source RVU	STS Rec RVU	New/ Revised Total RVUs	Total Source RVUs	Difference New/Rev - Source
33860	D	3800	33858	1140	0.3	59.46	65.00	74100	67784	6316
33860	D	3800	33859	2660	0.7	59.46	50.00	133000	158164	-25164
33863		1875	33863	1875	1	58.79	59.00	110625	110231	394
33864		282	33864	282	1	60.08	63.00	17766	16943	823
33870	D	999	33871	300	0.3	46.06	65.75	19725	13818	5907
33870	D	999	33866	699	0.7	46.06	19.74	13798	32196	-18398
Totals								369014	399136	-30122

Code 33860 which is split into two new codes 33858 and 33859 results in a recommended increase in value for code 33858 (recommended RVW 65.00, current RVW 59.46) and a decrease in value for the more commonly performed code 33859 (recommended RVW 50.00, current RVW 59.46) resulting in an overall budget savings for that code. Code 33870 is also split into two new codes 33866 and 33871, which results in a recommended increase in value for code 33871 (recommended RVW 65.75, current RVW 46.06) and a decrease in value for the more commonly performed code 33866 (recommended RVW 19.74, current RVW 46.06) resulting in an overall budget savings for that code. The RVW recommendations for the other two codes, 33863 and 33864 result in slight increases for each code, but these increases are offset by the savings from the changes to the other codes. Additional information regarding the recommended revisions are included for each code.

Rationale 33863

Code 33863 is a code for ascending aortic disease that extends into the aortic root producing dilatation of the root and insufficiency of the aortic valve. The current Medicare volume for 33863 is 1875, and this low volume procedure has been relatively steady over the years per the RUC database. The specialties do not expect any changes in the volume. Ascending aortic grafting that involves the aortic root the aortic valve is a procedure that requires a median sternotomy and cardiopulmonary bypass with cardiac arrest. The ascending aorta involved in the aneurysm is transected and replaced with a graft, the right and left coronary arteries are dissected with cuffs, and the aortic root and aortic valve are resected. The aortic annulus is sized, and the aortic root and valve are replaced with a prosthetic valve/composite graft and the right and left coronary/buttons are re-implanted into the graft.

Pre-Time Package 4

Pre-Time Changes:

The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel is recommending increases in time for the evaluation of the patient and for the positioning of the patient. The survey only supported 15 minutes for scrub dress and wait time, so the Expert Panel is recommending a 5-minute reduction for a total of 15 minutes for the scrub dress and wait time for the procedure per the survey.

Evaluation (total = 60 minutes): For the evaluation, the Expert Panel is recommending a 20-minute increase in time over the package for a total evaluation time of 60 minutes. This is supported by the survey data with 60 minutes of pre-service evaluation. The total evaluation time accounts for the review of the patient, by the surgeon and the collaborative efforts that go into each case. The additional evaluation time of 20 minutes accounts 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 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 trans-esophageal echocardiogram 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 Expert Panel felt that adding 20 minutes of evaluation time to package 4 was reasonable and would cover all aspects of the pre-service work involved with the procedure.

Positioning (total = 15 minutes): The Expert Panel is recommending a 12-minute increase in time over the package for a total positioning time of 15 minutes, which is common for cardiac procedures and there are numerous examples in the RUC database supporting this time. The survey supported 15-minutes for positioning of the patient. The additional 12-minutes above the package time can be attributed to the time spent for careful protection of pressure points on the patient with this prolonged operation.

Scrub, Dress and Wait (total = 15 minutes): There is a 5-minute decrease from the package time, which represents the scrub dress and wait time from the survey.

Post-time Package 9b

Total = 60 minutes: The expert panel selected post-time package 9B for a general anesthesia or complex regional block/complex procedure. The Expert Panel is recommending a 27-minute increase in time over the package for a total immediate post time of 60 minutes and there are numerous examples in the RUC database and the cardiothoracic surgery codes supporting this time. The survey supported 60 minutes of immediate post time. The additional 27-minutes above the package time can be attributed to additional time 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.

Critical Care Visits: 95% of the survey respondents replied that the procedure was performed in the hospital, and that 100% of the patients stayed overnight for more than 24 hours. 58% of the respondents indicated that they provided an E&M Visit on the same day of surgery.

The survey respondents indicated that they spent over 40 minutes providing critical care services to the patient once the patient arrives in the ICU on the day of the procedure and an additional 40 minutes of critical care the day after the procedure for a total of two critical care visits for the procedure. The critical care visit covers that time that the

physician spends with the patient directly related to the procedure providing critical care services. The survey supported two critical care visits for the procedure and the Expert Panel agreed.

Intensity and complexity of the procedure: 41 surveys were completed by a random pool of 800 cardiac surgeons which consisted of 650 self-identified adult cardiac surgeons and 150 self-identified congenital cardiac surgeons. 12 respondents selected code 33412, aortic valve replacement with transventricular aortic annulus enlargement as a reference code making it the 1st key reference service (KRS). That code has the same value and intraservice time and a slightly longer total time than the survey code. The survey respondents ranged in their intensity/complexity comparison saying that the survey code was identical or somewhat more complex than 33412 for all of the intensity/complexity measures. 8 respondents selected code 33877, thoracoabdominal aneurysm repair as a reference code making it the 2nd KRS. This code has a higher value with a longer intraservice and total service time. The respondents ranged in their intensity/complexity comparison saying that the survey code is identical to, somewhat or much more intense/complex than 33877 for all of the intensity/complexity measures except for the psychological stress where 100% of the respondents indicated that the survey code more complex than 33877.

Recommended RVW: The survey data for code 33863 (Ascending aorta graft with aortic root replacement using valved conduit and coronary reconstruction) shows that the median intra-operative time is 280 minutes. The current intra-service time for this procedure is 287 minutes. 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 Expert Panel felt that the survey respondents underestimated the intra-service time of the procedure and are recommending the 75th percentile of intra-service time from the survey, which is 300 minutes. The 75th percentile of 300 minutes is supported by the STS database times with the surveyed 75th percentile time falling between the STS Database mean and median intra-service times. The survey also supported two critical care visits during the post-operative period which is the same number included in the current code. The hospital LOS from the survey represents two days less than the LOS in the current code and the total time from the survey is less at 838 minutes than that for the current code at 905 minutes. The Recommended RVW and the total time for the survey code are very close to the values for the 1st KRS. The intraservice time of the survey code is the same as the intra-service time of the 1st KRS and lower than that of the 2nd KRS. The intensity (0.126) for the survey code is slightly higher than the intensity for 1st (0.122) and 2nd (0.114) KRS codes. The Expert panel felt that this is appropriate and is supported by the intensity and complexity measures.

The Expert Panel is recommending the 25th percentile work RVW of 59.00, with the 75th percentile intra-service time of 300 minutes, and total time of 838 minutes. Pre-time package 4 was selected with adjustments made to the evaluation and positioning time for a total pre-service time of 90 minutes. Immediate post-service time package 9b with additional time added for a total time of 60 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these

data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33863

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiothoracic surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2604

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2017 Medicare frequency for 33863 is 1875. The STS database shows that 72% of the patients that undergo Bentall are Medicare patients.

Specialty cardiothoracic surgery Frequency 2604 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,875

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2017 Medicare frequency for 33863 is 1875. The STS database shows that 72% of the patients that undergo Bentall are Medicare patients. The specialties do not expect any changes in the Medicare volume.

Specialty cardiothoracic surgery Frequency 1875 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 33863

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 33864	Tracking Number D4	Original Specialty Recommended RVU: 63.00
		Presented Recommended RVU: 63.00
Global Period: 090	Current Work RVU: 60.08	RUC Recommended RVU: 63.00

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 32-year-old male with Marfan's syndrome is followed with serial echocardiograms looking for increasing aortic root dimensions. Echocardiogram now shows a 5.5 cm ascending aorta with aortic annulus dilatation without aortic valve insufficiency. He is referred for a valve sparing root reconstruction

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 95% , In the ASC 0%, In the office 5%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 65%

Description of Pre-Service Work: A complete or interval history and physical examination (comprehensive) are performed. Preoperative orders are written, and the work-up and notes from referring and primary physicians are reviewed if available. Preoperative imaging studies including chest x-rays, coronary angiogram, echocardiogram, cath report, CT scan and echo report are reviewed with special attention to the feasibility of a valve-sparing operation. Preoperative laboratory studies (CBC, electrolytes, renal and liver function, coagulation) are reviewed. Obtain cardiology assessment and pulmonary assessment as indicated. Indications, surgical procedure, expected recovery, and expected outcomes, including potential complications, are reviewed with the family. Discuss the possibility of complete heart block and the need for permanent pacing, as well as the standard risks of cardiac surgery. In addition, the patient is informed of the possibility that valve-sparing cannot be accomplished, in which case the patient may require a more conventional valve-conduit type procedure (e.g., Bentall Procedure). The family's questions are answered, and informed consent is obtained. The OR start time is confirmed and the patient and family are notified. Confirm surgical assistant. The patient is identified, the surgical site is marked per hospital policy, and any questions from the family are answered. Availability of blood and/or cross match and any special instruments or medical devices, such as the availability of prosthetic valve conduits if valve-sparing cannot be accomplished, is ensured. Review planned incision and procedure. Review the length and type of anesthesia with anesthesiologist alerting the anesthesiologist of the potential for cardiac tamponade physiology, and the need to adjust induction techniques accordingly. Ensure anesthesiology and perfusionist are prepared for circulatory arrest if needed. Plan invasive monitoring including use of arterial line (right radial only) and pulmonary artery catheter. Review trans-esophageal echocardiogram with 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. Position patient supine and carefully pad the extremities to prevent pressure injury. The surgeon scrubs and puts on a gown and gloves. Prep and drape the skin of the chest, abdomen, and legs from the neck to the ankles including both groin areas. Ensure that the patient is properly positioned for the procedure.

Description of Intra-Service Work: Following a standard median sternotomy incision, the sternum is divided with a saw. A determination of which artery will be used for arterial access while on cardiopulmonary bypass is made following median sternotomy and exposure of the heart and great vessels. This may require exposure and use of the aortic arch, the

innominate artery, the distal ascending aorta, the subclavian artery, the brachial artery, or even the femoral artery depending on condition of the ascending aorta and the extent of pathology. Administer systemic heparin. Determine appropriate cannulas to use based on anatomy and patient BSA. Place purse string sutures in right atrium

Check with anesthesiologist and/or perfusionist regarding activated clotting time value to assess level of heparinization. If peripheral arterial cannulation is planned proceed with the following steps: Assess size of arterial vessel and select cannula based on vessel diameter and patient's BSA; Apply vascular clamps to proximal and distal portions of exposed artery; Perform small transverse arteriotomy; If necessary, an eight-millimeter Dacron graft is anastomosed to the artery in order to facilitate cardiopulmonary bypass (reported separately); If direct arterial cannulation is used, atraumatically insert arterial cannula by removing proximal clamp. If a long femoral artery cannula is used, verify its position by echocardiography in the descending thoracic aorta. Change gloves after completing cannulation and before returning to chest incision. Insert venous right atrial cannula. A pledgeted mattress suture is placed on the anterior surface of the right superior pulmonary vein through which a venting cannula is placed into the left atrium. Cardiopulmonary bypass is initiated, and the patient is systemically cooled. Antegrade and retrograde cardioplegia cannulas are inserted. The aorta is cross clamped and cardioplegia is administered to achieve cardiac arrest. The heart is assessed for distention. The ascending aorta is opened and the aortic root and aortic valve are evaluated.

The aortic valve and annulus are assessed and sized. The proximal aortic root is excised mobilizing the right and left coronary artery ostia with cuffs of residual aortic tissue and leaving the native aortic valve and commissures intact. Multiple interrupted pledgetted sutures are placed beneath the aortic valve from the left ventricle to the base of the aortic root. These are passed through the proximal portion of a suitably sized Dacron graft. The graft is seated down and the sutures tied, thus fixing/remodeling the aortic annulus. The aortic valve and commissures are reattached at the appropriate height to the inside of the Dacron graft resuspending the valve using continuous running sutures. Oval shaped openings are created in the side walls of the Dacron graft and the right and left coronary "buttons" are reimplanted into the Dacron graft to re-establish continuity of aortic blood flow and coronary circulation. The distal portion of the Dacron graft is cut to the appropriate length and sewn to the normal distal ascending aorta, evacuating air from the left side of the heart before tying down the last stitch.

The patient is placed in Trendelenberg. The aortic cross-clamp is removed. The aortic root is vented during Left Ventricular ejection for 5-10 minutes. The absence of residual air in left side of heart is confirmed and the degree of any aortic valve insufficiency is evaluated using transesophageal echocardiogram. Resuscitate the heart by allowing it to beat while unloaded on cardiopulmonary bypass. Place temporary pacing wires and begin atrial, atrio-ventricular, or ventricular pacing if indicated. Assess need for inotropic agents or intra-aortic balloon pump. Discontinue cardiopulmonary bypass by reducing arterial flow and retarding venous return to pump while continuously monitoring hemodynamics with arterial and pulmonary artery lines. Meticulous hemostasis is achieved. Evaluate the post-procedure, intra-operative echocardiogram specifically examining for ventricular function, regional wall motion abnormalities, and aortic valve function. When the patient is stable, give protamine to reverse heparin and remove the arterial and venous cannulas. If necessary, close peripheral artery cannulation site with running polypropylene suture. Arterial, venous, right superior pulmonary vein and cardioplegia cannulas are removed and cannulation sites are secured/repared. Chest tubes are placed, and the sternum is re-approximated. The sternal wound is closed.

Description of Post-Service Work: Postoperative same day work through admission to intensive care: An operating room debriefing is performed. Sterile dressings are applied to the incision. Drapes are removed, with close attention to pacing wires (if any), tubes, lines and possible epidural anesthesia catheter to ensure that none are dislodged or disconnected. This attention continues as the patient is moved to the intensive care unit (ICU) bed for transfer. In a coordinated team manner, the patient's overall condition is monitored as the anesthesia team converts the monitoring equipment (arterial blood pressure, pulmonary artery pressures, electrocardiogram [EKG]) to a portable monitor. The chest drainage system is observed periodically to assess interval bleeding, to ascertain that negative pressure is not lost, and to ensure that the tubes are not obstructed. The OR transporting team and the ICU receiving team confirm initiation of transfer. The patient is accompanied to the ICU, and the team is directed should the patient's condition change en route. Operating room forms, indicating pre- and postoperative diagnoses and the operation performed, are signed. A postoperative chest X ray is obtained and examined to assess expansion of the lungs and placement of the chest and nasogastric tubes (if inserted). Orders for postoperative laboratory tests, films, medications, diet, and patient activity are written. A brief operative note is written for the patient's chart. Daily progress notes of the pre- and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, and specimens sent to pathology (if any) are documented. Intensive care and medications are reviewed with the staff. The patient's short-term goals are established with the ICU nursing staff. Procedure outcomes, including the procedure performed, any variance from the planned procedure, the general findings, an initial assessment of the degree of procedural success, and expectations for the remainder of the day of

surgery and the longer term, are discussed with the family. The procedure outcome is discussed with the patient's family or caregiver after patient's emergence from anesthesia. A postoperative report is dictated, and the procedure outcome is discussed with the referring physician. Care is coordinated with other physicians. A procedure outcome and expected recovery letter is dictated for the referring physician and/or the insurance company.

Postoperative intensive care: The patient's neurological state is assessed, and emergence from anesthesia is monitored. Sedatives, paralyzing agents, and analgesics are administered as needed. Gross neurologic function, including level of consciousness, behavioral appropriateness, and presence and nature of focal neurological defect if present, is evaluated. The evaluation is repeated until intraoperative neurologic injury is ruled out. The patient's hemodynamic condition, including cardiac rhythm, is assessed. Rate and conduction abnormalities are assessed. A temporary pacemaker is considered, and temporary pacing is initiated as needed. A suitable mode is determined, and the output and sensitivity of the device are adjusted. The assessment of hemodynamic effects is repeated. Arrhythmias are assessed. Atrial extrasystoles or runs are differentiated from ventricular extrasystoles or runs and correlated with operative events and hemodynamic effects; antiarrhythmic therapy (treatment or prophylaxis) is considered. The 12-lead EKG is evaluated for signs or ischemia or injury and compared to the preoperative tracing. Blood pressure, central venous pressure, pulmonary artery pressures, and cardiac output and index are assessed. Filling pressures are correlated at baseline, calibration of transducers with zero level at the level of the right heart are confirmed, and waveforms are assessed. Crystalloid fluids or blood products are administered depending on cardiac index, mixed venous oxygen saturation, hemoglobin, and central filling pressures. Inotropic and vasoactive agents given by continuous infusion are adjusted to optimize oxygen delivery and minimize adverse end-organ effects. Peripheral perfusion is carefully evaluated by observation and physical exam, correlating findings with invasive monitoring results. Chest tube bleeding is monitored. The character of the mediastinal drainage (rate, amount, stability of clot) is assessed. The patency of the mediastinal tubes is assessed to ensure that a cardiac tamponade state is avoided. Bleeding quantity and character are correlated with chest X ray, laboratory tests, hemodynamics, urine output, and physical exam. Laboratory results are assessed and correlated with other findings to determine the need for blood and/or blood products, including platelets, cryoprecipitate, and fresh frozen plasma. Other adjunctive pharmacologic therapies are considered for coagulopathy. The need for reexploration is considered if the chest tube output exceeds acceptable limits or if tamponade is present. The respiratory system is assessed. Breath sounds are examined, chest mechanics observed, and mid-line tracheal position is ensured by physical exam. Ventilator settings are assessed; underlying respiratory pattern, baseline airway pressures generated, and minute gas flow are observed. The postoperative chest X ray is reevaluated if necessary. Endotracheal tube placement is confirmed by review of the postoperative chest X ray. Lungs are monitored for infiltrate/atelectasis. Pleural spaces are assessed for fluid collection. Blood gases are assessed, and the ventilator is adjusted as needed. The patient is weaned from the ventilator. Readiness for extubation is assessed. The patient is extubated, and airway and adequacy of ventilation are ensured. Adequacy of urine output is assessed, and postoperative creatinine in light of preoperative renal function is checked. Volume status is assessed, and fluids are administered as needed. The need for a diuretic is determined and, if indicated, the dose is determined, and response is monitored. Urine flow is correlated with blood pressure and compared to preoperative status. Interaction of cardiac output and vasoactive agents with renal function is assessed. Distal extremity perfusion is monitored, and peripheral pulses are assessed and compared to preoperative findings. A comprehensive evaluation is integrated with the patient's history, expected status based on conduct of the operation, and response to critical care interventions. The extent of inflammatory state is assessed, and treatment with antipyretics or steroids is considered as indicated. The patient's chart notes are reviewed with the nursing staff and other staff. Interval plans are discussed with the nursing staff. Parameters for interval adjustments in patient treatment are set, and the interval to the next patient evaluation, if expected goals have been met, is established. Questions from the nursing staff, other staff, and the patient's family are answered. Orders are written. The patient's progress notes are charted.

Postoperative other hospital work—beginning on postoperative day 3 until discharge day: A comprehensive history and physical exam are performed. All wounds are inspected for drainage, underlying hematoma, and inflammation. The patient's chart notes are reviewed with nursing and other staff. Postoperative pain, use of analgesics, and adequacy of response are assessed. Adequacy of respiration, character of breathing, relationship to surgical pain, and intravascular volume status are assessed. Character of pulmonary secretions and the patient's ability to clear his airway are assessed. Vital signs, intake and output, laboratory results, and patient daily weight are reviewed. The chest radiograph is reviewed, and the cardiac monitor is evaluated for rate, rhythm, and presence or absence of arrhythmia. The stored EKG monitoring history is evaluated if indicated. Progress of the system recovery and risk for development of complications are assessed. Ambulation and vigorous pulmonary physiotherapy are encouraged. Postoperative nutritional status, as maintained by both enteral (if necessary) and oral feedings, is carefully assessed and monitored. The chest tubes, if still present are removed when appropriate. Chest X-rays after tube removal and at least one more time before discharge as indicated by patient's condition are obtained and reviewed. The temporary pacemaker wires are removed if present. Questions from the patient, family, and nursing or other staff (verbal and written) are answered. An interval plan of care that includes drug therapy for underlying conditions (e.g., diabetes), surgically induced conditions, actual or anticipated complications (e.g., beta blockers

for atrial fibrillation, antibiotics for prophylaxis or treatment), and preventive care is developed. Insurance staff questions are answered. Orders for postoperative laboratory tests, films, medications, diet, and patient activity are written. The postoperative echocardiogram is evaluated and reviewed. The patient's progress is discussed (oral and written) with the referring physician. Care is coordinated with other physicians. Evaluation, patient progress, and the care plan are documented in the medical record.

Discharge day work: A history and physical exam are performed. The final pathology/laboratory/film reports are checked and discussed with the patient's the family or caregiver. Wounds and patient progress are checked. Dietary management, activities permitted, bathing, handling of wound, return appointment to office, and similar items are carefully explained to the patient's family. Expectations for recovery are outlined and adjusted to specific underlying cardiac state, associated chronic diseases, operative findings, and character of postoperative recovery. Potential complications, how to recognize them, and what to do if recovery is not as anticipated are described. Care is coordinated with other physicians. The patient's chart notes are reviewed with nursing and other staff. Post discharge wound care and activity limitations are reviewed with the family. Questions from the patient, family, and nursing and other staff are answered. Insurance staff questions are answered. Orders for post discharge laboratory tests, films, and medications are written. The patient's discharge notes are charted, and prescriptions and discharge instructions are written. The nature, purpose, and expected duration of use of new medications are explained. The importance of secondary prevention of cardiac disease through risk factor reduction is explained to the family. Specific instructions on the need to notify other treating physicians and dentists of the presence of a prosthetic aortic graft and the need for prophylactic periprocedural antibiotics are given. Primary care physicians involved with the patients long-term care should be alerted to the need for frequent assessment of the patient's aortic valve function and the possibility of sudden or gradual aortic insufficiency. The patient's home medications and homeopathic agents are explained to ensure that additional agents are compatible or will not be used. A discharge summary is dictated. Communication is made with patient's primary care physician(s).

Postoperative office work: After discharge from the hospital, a detailed history and physical exam are performed. Medications are reviewed, and compliance is determined. Interval encounters are reviewed with other care providers. Wounds and patient progress are checked. Sutures/drains are removed. Post discharge laboratory tests/films are reviewed, specifically echo studies to assess valve function and compare to preoperative studies. Medications are reviewed and orders for medications are written. Questions from the patient and family are answered. Insurance staff questions are answered. The patient's progress is discussed (verbal and written) with the referring physician. The patient's care is coordinated with other physicians. Progress is discussed with the patient and family. A patient progress note is dictated for the medical chart, and letters are sent to referring physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Jim Levett, MD; Kirk Kanter, MD; Joseph Turek, MD; Jacob Schroder, MD				
Specialty Society(ies):	STS, AATS				
CPT Code:	33864				
Sample Size:	800	Resp N:	40	Response: 5.0 %	
Description of Sample:	Random sample of 650 self-identified cardiac surgeons and 150 self-identified congenital heart surgeons				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	2.00	5.00	60.00
Survey RVW:	41.32	63.00	69.03	80.00	100.00
Pre-Service Evaluation Time:			70.00		
Pre-Service Positioning Time:			15.00		
Pre-Service Scrub, Dress, Wait Time:			15.00		
Intra-Service Time:	120.00	240.00	300.00	353.00	480.00
Immediate Post Service-Time:	60.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	140.00	99291x 2.00 99292x 0.00			
Other Hospital time/visit(s):	170.00	99231x 1.00 99232x 1.00 99233x 2.00			
Discharge Day Mgmt:	38.00	99238x 1.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	40.00	99211x 0.00 12x 0.00 13x 0.00 14x 1.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33864	Recommended Physician Work RVU: 63.00		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	60.00	40.00	20.00	
Pre-Service Positioning Time:	15.00	3.00	12.00	
Pre-Service Scrub, Dress, Wait Time:	15.00	20.00	-5.00	
Intra-Service Time:	300.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) 9B General Anes or Complex Regional Blk/Cmplx Proc				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	60.00	33.00	27.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	<u>140.00</u>	99291x 2.00 99292x 0.00
Other Hospital time/visit(s):	<u>170.00</u>	99231x 1.00 99232x 1.00 99233x 2.00
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0 99217x 0.00
Office time/visit(s):	<u>40.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 1.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33412	090	59.00	RUC Time

CPT Descriptor Replacement, aortic valve; with transventricular aortic annulus enlargement (Konno procedure)**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33877	090	69.03	RUC Time

CPT Descriptor Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 9 % of respondents: 22.5 %

Number of respondents who choose 2nd Key Reference Code: 7 % of respondents: 17.5 %

TIME ESTIMATES (Median)

	CPT Code: <u>33864</u>	Top Key Reference CPT Code: <u>33412</u>	2nd Key Reference CPT Code: <u>33877</u>
Median Pre-Service Time	90.00	63.00	110.00
Median Intra-Service Time	300.00	300.00	324.00
Median Immediate Post-service Time	60.00	60.00	60.00
Median Critical Care Time	140.0	140.00	210.00
Median Other Hospital Visit Time	170.0	225.00	282.00
Median Discharge Day Management Time	38.0	38.00	38.00
Median Office Visit Time	40.0	40.00	86.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	838.00	866.00	1,110.0
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	22%	67%	11%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
0%	44%	56%

Technical Skill/Physical Effort

<u>Less</u>	<u>Identical</u>	<u>More</u>
0%	56%	44%
0%	56%	44%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%

22%

78%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

0%

14%

29%

57%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

0%

14%

86%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

0%

14%

86%

Physical effort required

14%

14%

71%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%

14%

86%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

OVERALL RATIONALE

Tab 6 includes 6 codes that represent grafting procedures on the ascending aorta and the aortic arch. A new add-on code +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) that was developed to account for the additional work that

is involved when the ascending aortic disease extends into the proximal portion of the transverse aortic arch was approved by the CPT Editorial Panel and surveyed for the January 2018 RUC meeting. The Expert Panel decided not to survey the ascending aortic replacement codes 33860, 33863 or 33864 for the January 2018 RUC meeting because they felt that the work involved in the aortic hemiarch replacement procedure represented an advancement in surgical technique representing new work that is not reflected in the work that is currently accounted for in the ascending aortic procedures. The specialties indicated that the aortic hemiarch replacement is more closely related to the work involved with the transverse aortic arch replacement code 33870 than to the work of the ascending aortic codes. At the January 2018 RUC meeting, the RUC determined that the specialties had to re-survey the family of aortic repair procedures including codes 33860, 33863, 33864, 33866, 33870 for the April 2018 RUC meeting. As the specialty reviewed the codes with consideration of re-surveying them, they determined that they 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 felt that there is a sufficient difference in the work associated with these procedures and now there is enough 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 CCA was submitted to the CPT Editorial Panel for consideration at the May 2018 CPT meeting. The CPT Editorial Panel approved the deletion of two existing codes, 33860 and 33870. Code 33860 will be replaced with two new codes, 33858 and 33859 for ascending aortic aneurysm repair for dissection and for other aortic disease respectively. Due to the extensive changes of the descriptor for code 33870 to further differentiate that code from the aortic hemiarch code 33866, the Panel decided to delete code 33870 and renumber it to the new code 33871. As a result, 4 ascending aortic grafting codes 33858, 33859, 33863 and 33864 and two aortic arch grafting codes 33866 and 33871 were surveyed for the October 2018 meeting.

The recommended values for these procedures result in an overall budget savings for Medicare as represented in the table below:

CPT Source	Deleted	Source 2017 Utilization	New/ Revised Code	New/ Revised Code Utilization (reference 2017)	Percent	Source RVU	STS Rec RVU	New/ Revised Total RVUs	Total Source RVUs	Difference New/Rev - Source
33860	D	3800	33858	1140	0.3	59.46	65.00	74100	67784	6316
33860	D	3800	33859	2660	0.7	59.46	50.00	133000	158164	-25164
33863		1875	33863	1875	1	58.79	59.00	110625	110231	394
33864		282	33864	282	1	60.08	63.00	17766	16943	823
33870	D	999	33871	300	0.3	46.06	65.75	19725	13818	5907
33870	D	999	33866	699	0.7	46.06	19.74	13798	32196	-18398
Totals								369014	399136	-30122

Code 33860 which is split into two new codes 33858 and 33859 results in a recommended increase in value for code 33858 (recommended RVW 65.00, current RVW 59.46) and a decrease in value for the more commonly performed code 33859 (recommended RVW 50.00, current RVW 59.46) resulting in an overall budget savings for that code. Code 33870 is also split into two new codes 33866 and 33871, which results in a recommended increase in value for code 33871 (recommended RVW 65.75, current RVW 46.06) and a decrease in value for the more commonly performed code 33866 (recommended RVW 19.74, current RVW 46.06) resulting in an overall budget savings for that code. The RVW recommendations for the other two codes, 33863 and 33864 result in slight increases for each code, but these increases are offset by the savings from the changes to the other codes. Additional information regarding the recommended revisions are included for each code.

Rationale 33864

Code 33864 is a code for ascending aortic disease that extends into the aortic root. The current Medicare volume for 33864 is 282 and has been relatively steady over the years per the RUC database. The specialties do not expect any changes to the volume. Ascending aorta grafting with valve-sparing aortic root remodeling and coronary reconstruction is a procedure that requires a median sternotomy and cardiopulmonary bypass with cardiac arrest. The ascending aorta involved in the aneurysm is transected and replaced with a graft. The right and left coronary arteries are dissected with cuffs. The proximal aortic root is excised. The aortic annulus is remodeled by seating the graft down and placing sutures beneath the native aortic valve from the left ventricle to the base of the aortic root. The right and left coronary buttons are reimplanted into the graft.

Pre-Time Package 4

Pre-Time Changes: The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel is recommending increases in time for the evaluation of the patient and for the positioning of the patient. The survey only supported 15 minutes for scrub dress and wait time, so the Expert Panel is recommending a 5-minute reduction for a total of 15 minutes for the scrub dress and wait time for the procedure per the survey.

Evaluation (total = 60 minutes): For the evaluation, the Expert Panel is recommending a 20-minute increase in time over the package for a total evaluation time of 60 minutes. This is supported by the survey data with 60 minutes of pre-service evaluation. The total evaluation time accounts for the review of the patient, by the surgeon and the collaborative efforts that go into each case. The additional evaluation time of 20 minutes accounts 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, cath 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 Expert Panel felt that adding 20 minutes of evaluation time to package 4 was reasonable and would cover all aspects of the pre-service work involved with the procedure.

Positioning (total = 15 minutes): The Expert Panel is recommending a 12-minute increase in time over the package for a total positioning time of 15 minutes, which is common for cardiac procedures and there are numerous examples in the RUC database supporting this time. The survey supported 15-minutes for positioning of the patient. The additional 12-minutes above the package time can be attributed to the time spent for careful protection of pressure points on the patient with this prolonged operation.

Scrub, Dress and Wait (total = 15 minutes): There is a 5-minute decrease from the package time, which represents the scrub dress and wait time from the survey.

Post-time Package 9b

Total = 60 minutes: The expert panel selected post-time package 9B for a general anesthesia or complex regional block/complex procedure. The Expert Panel is recommending a 27-minute increase in time over the package for a total immediate post time of 60 minutes and there are numerous examples in the RUC database and the cardiothoracic surgery codes supporting this time. The survey supported 60 minutes of immediate post time. The additional 27-minutes above the package time can be attributed to additional time 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.

Critical Care Visits: 95% of the survey respondents replied that the procedure was performed in the hospital, and that 100% of the patients stayed overnight for more than 24 hours. 65% of the respondents indicated that they provided an E&M Visit on the same day of surgery.

The survey respondents indicated that they spent over 40 minutes providing critical care services to the patient once the patient arrives in the ICU on the day of the procedure and an additional 40 minutes of critical care the day after the procedure for a total of two critical care visits for the procedure. The critical care visit covers that time that the

physician spends with the patient directly related to the procedure providing critical care services. The survey supported two critical care visits for the procedure and the Expert Panel agreed.

Intensity and complexity of the procedure: 40 surveys were completed by a random pool of 800 cardiac surgeons which consisted of 650 self-identified adult cardiac surgeons and 150 self-identified congenital cardiac surgeons. 9 respondents selected code 33412, aortic valve replacement with transventricular aortic annulus enlargement as a reference code making it the 1st key reference service (KRS). That code has a lower value, the same intraservice time and a longer total time than the survey code. The survey respondents ranged in their intensity/complexity comparison saying that the survey code was identical or somewhat more complex than 33412 for all of the intensity/complexity measures. 7 respondents selected code 33877, thoracoabdominal aneurysm repair as a reference code making it the 2nd KRS. This code has a higher value with a longer intraservice and total service time. The respondents indicated that the survey code was more or much more intense/complex than 33877 for all of the intensity/complexity measures.

Recommended RVW: The survey data for code 33864 (ascending aortic graft with valve sparing root remodeling and coronary reconstruction) shows that the median intra-operative time is 300 minutes. The current intra-service time for this procedure is 300 minutes. The STS Database intra-service time shows a mean time of 308 minutes and a median time of 320 minutes. The median intra-service time from the survey at the 300 minutes is equivalent to the intra service time for the current code. The surveys also supported two critical care visits during the post-operative period which is the same number included in the current code. The hospital LOS from the survey is the same in the current code and the total time from the survey is slightly less at 838 minutes than that for the current code at 853 minutes, which is due to changes in the pre-service time. The Recommended RVW and the total time for the survey code is higher than the RVW for the 1st KRS. The intraservice time of the survey code is the same as the intra-service time of the 1st KRS and lower than that of the 2nd KRS. The intensity (0.140) for the survey code is higher than the intensity for the 1st (0.122) and 2nd (0.114) KRS codes. The Expert panel felt that this is appropriate and is supported by the intensity and complexity measures.

The Expert Panel is recommending the 25th percentile work RVW of 63.00, with a median intra-service time of 300 minutes, and total time of 838 minutes. Pre-time package 4 was selected with adjustments made to the evaluation and positioning time for a total pre-service time of 90 minutes. Immediate post-service time package 9b with additional time added for a total time of 60 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
-

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33864

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiothoracic surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 535

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2017 Medicare frequency for 33864 is 282. The STS database shows that 90% of the patients that undergo a valve-sparing root remodeling are non-Medicare patients.

Specialty cardiothoracic surgery Frequency 313 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 282

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2017 Medicare frequency for 33864 is 282. The STS database shows that 90% of the patients that undergo a valve-sparing root remodeling are non-Medicare patients. The specialties do not expect any changes to the Medicare volume.

Specialty cardiothoracic surgery Frequency 282 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:

Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 33864

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 33866 Tracking Number D5

Original Specialty Recommended RVU: **19.74**Presented Recommended RVU: **17.75**

Global Period: ZZZ Current Work RVU:

RUC Recommended RVU: **17.75**

CPT Descriptor: 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)

(Use 33X01 for aortic hemiarch graft when performed in conjunction with the ascending aortic graft codes 338XX, 338X1, 33863, 33864)

(Do not report 33X01 in conjunction with 338X2)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58-year-old male with aortic disease extending from the sino-tubular junction of the aorta to the transverse aortic arch undergoes an ascending aortic graft repair (reported separately). Since the aortic disease extends into the transverse aortic arch, a hemiarch graft repair is also indicated.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Circumferentially dissect around the base of both the innominate and left common carotid arteries and place tapes around both arteries. Initiate hypothermia, once target temperature is obtained, discontinue cardiopulmonary bypass and tighten the tapes around the innominate and common carotid arteries. Hypothermic circulatory arrest is initiated and cerebral perfusion if performed. Remove the cross-clamp and transect the aorta. Inspect the inside of the aorta and determine the extent of the intimal tear. Resect the entirety of the intimal tear. Prepare the distal end of the cut aorta for anastomosis employ additional reinforcing techniques if necessary. Perform anastomosis of the open distal aortic anastomosis to the cut end of the aorta utilizing synthetic graft with a running suture at the origin of the transverse aortic arch superiorly. Inferiorly, the suture line extends obliquely across the lesser curvature of the transverse arch of the aorta. After ensuring hemostasis of this distal anastomosis, a cross-clamp is placed on the aortic graft and full cardiopulmonary bypass is reinstituted. An extended period of re-warming is required.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Jim Levett, MD; Kirk Kanter, MD; Joseph Turek, MD; Jacob Schroder, MD				
Specialty Society(ies):	STS, AATS				
CPT Code:	33866				
Sample Size:	800	Resp N:	32	Response: 4.0 %	
Description of Sample:	Random sample of 650 self-identified cardiac surgeons and 150 self-identified congenital heart surgeons				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	10.00	20.00	50.00
Survey RVW:	10.00	17.75	21.00	30.00	90.00
Pre-Service Evaluation Time:			0.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	50.00	60.00	123.00	255.00	480.00
Immediate Post Service-Time:	0.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	33866	Recommended Physician Work RVU: 17.75		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	0.00	0.00	0.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	123.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) ZZZ Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	0.00	0.00	0.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33369	ZZZ	19.00	RUC Time

CPT Descriptor 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)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33523	ZZZ	16.08	RUC Time

CPT Descriptor Coronary artery bypass, using venous graft(s) and arterial graft(s); 6 or more venous grafts (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 12 % of respondents: 37.5 %

Number of respondents who choose 2nd Key Reference Code: 6 % of respondents: 18.7 %

TIME ESTIMATES (Median)

	CPT Code: <u>33866</u>	Top Key Reference CPT Code: <u>33369</u>	2nd Key Reference CPT Code: <u>33523</u>
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	123.00	160.00	110.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	28.00
Median Other Hospital Visit Time	0.0	0.00	55.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	123.00	160.00	193.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	0%	8%	92%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
0%	0%	100%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	0%	0%	100%

Physical effort required	0%	0%	100%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%	0%	100%
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2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	17%	0%	33%	50%
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Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

17%	0%	83%
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Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	17%	17%	67%
--------------------------	-----	-----	-----

Physical effort required	17%	33%	50%
--------------------------	-----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
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17%	0%	83%
-----	----	-----

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

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OVERALL RATIONALE

Tab 6 includes 6 codes that represent grafting procedures on the ascending aorta and the aortic arch. A new add-on code +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) that was developed to account for the additional work that is involved when the ascending aortic disease extends into the proximal portion of the transverse aortic arch was approved by the CPT Editorial Panel and surveyed for the January 2018 RUC meeting. The Expert Panel decided not to survey the ascending aortic replacement codes 33860, 33863 or 33864 for the January 2018 RUC meeting because they felt that the work involved in the aortic hemiarch replacement procedure represented an advancement in surgical technique representing new work that is not reflected in the work that is currently accounted for in the ascending aortic procedures. The specialties indicated that the aortic hemiarch replacement is more closely related to the work involved with the transverse aortic arch replacement code 33870 than to the work of the ascending aortic codes. At the January 2018 RUC meeting, the RUC determined that the specialties had to re-survey the family of aortic repair procedures including codes 33860, 33863, 33864, 33866, 33870 for the April 2018 RUC meeting. As the specialty reviewed the codes with consideration of re-surveying them, they determined that they 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 felt that there is a sufficient difference in the work associated with these procedures and now there is enough 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 CCA was submitted to the CPT Editorial Panel for consideration at the May 2018 CPT meeting. The CPT Editorial Panel approved the deletion of two existing codes, 33860 and 33870. Code 33860 will be replaced with two new codes, 33858 and 33859 for ascending aortic aneurysm repair for dissection and for other aortic disease respectively. Due to the extensive changes of the descriptor for code 33870 to further differentiate that code from the aortic hemiarch code 33866, the Panel decided to delete code 33870 and renumber it to the new code 33871. As a result, 4 ascending aortic grafting codes 33858, 33859, 33863 and 33864 and two aortic arch grafting codes 33866 and 33871 were surveyed for the October 2018 meeting.

The recommended values for these procedures result in an overall budget savings for Medicare as represented in the table below:

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33860	D	3800	33858	1140	0.3	59.46	65.00	74100	67784	6316
33860	D	3800	33859	2660	0.7	59.46	50.00	133000	158164	-25164
33863		1875	33863	1875	1	58.79	59.00	110625	110231	394
33864		282	33864	282	1	60.08	63.00	17766	16943	823
33870	D	999	33871	300	0.3	46.06	65.75	19725	13818	5907
33870	D	999	33866	699	0.7	46.06	19.74	13798	32196	-18398
Totals								369014	399136	-30122

Code 33860 which is split into two new codes 33858 and 33859 results in a recommended increase in value for code 33858 (recommended RVW 65.00, current RVW 59.46) and a decrease in value for the more commonly performed code 33859 (recommended RVW 50.00, current RVW 59.46) resulting in an overall budget savings for that code. Code 33870 is also split into two new codes 33866 and 33871, which results in a recommended increase in value for code 33871 (recommended RVW 65.75, current RVW 46.06) and a decrease in value for the more commonly performed code 33866 (recommended RVW 19.74, current RVW 46.06) resulting in an overall budget savings for that code. The RVW recommendations for the other two codes, 33863 and 33864 result in slight increases for each code, but these increases are offset by the savings from the changes to the other codes. Additional information regarding the recommended revisions are included for each code.

Rationale 33866

Code 33866 is a new code that accounts for the additional work that is involved when the ascending aortic disease extends into the proximal portion of the transverse aortic arch. This procedure has been predominantly reported with code 33870 over the past few years. The current Medicare volume for 33870 is 999. The RUC database shows an increase in volume of this code starting in 2014, which is around the time that hemiarch grafting started to become more prevalent. An increased understanding of isolated cerebral perfusion/cooling and its protective effects has made it safer to perform procedures with total circulatory arrest and deep hypothermia. Due to the increased familiarity, safety and knowledge surrounding circulatory arrest and cerebral perfusion procedures, the hemiarch procedure is now safer to perform and better for the patient resulting in reduced risk to the patient by avoiding subsequent reoperation that that might be required without the aortic hemiarch replacement or the increased risk associated with a total transverse aortic arch replacement. It is estimated that 70% of the transverse aortic arch repairs will be performed using this hemiarch code 33866, resulting in an estimated Medicare volume of 699 procedures per year. 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 aortic hemiarch code was surveyed for the January 2018 RUC meeting. That survey had 61 respondents with a 25th percentile work RVW of 19.74 and a median intra-service time of 165 minutes, which were recommended to the RUC.

Per the direction of the RUC, the aortic hemiarch code was resurveyed with the ascending aortic and transverse aortic arch grafting codes for this meeting.

In the initial submission, there were only 28 respondents to the second survey for code 33866, which is under the RUC required minimum sample size for codes with less than 100,000 Medicare claims. The RUC staff contacted the specialties and asked that they re-open the survey to try and get the minimal sample size. The specialties were able to get 4 additional responses for a total of 32 responses which meets the minimal sample size. This is compared to 61 respondents from the survey conducted for the January 2018 RUC meeting.

Intensity and complexity of the procedure: 32 surveys were completed by a random pool of 800 cardiac surgeons which consisted of 650 self-identified adult cardiac surgeons and 150 self-identified congenital cardiac surgeons. 12 respondents selected code 33369, cardiopulmonary bypass support with central cannulation for transcatheter aortic valve replacement (TAVR) as a reference code making it the 1st key reference service (KRS). That code has a slightly lower value and longer intraservice and total times than the survey code. The respondents indicated that the survey code is more or much more intense/complex than 33369 for all of the intensity/complexity measures. 6 respondents selected code 33523, arterial and venous CABG with 6 or more venous grafts as a reference code making it the 2nd KRS. This code has a lower value with longer intraservice and total times. The respondents indicated that the survey code is somewhat or much more intense/complex than 33523 for all of the intensity/complexity measures.

From the 1st survey, 61 survey respondents indicated that the survey code was significantly more intense than both KRS codes. 36 respondents selected code 33369 as the 1st KRS and 11 respondents selected code 33523 as the 2nd KRS. For both of the KRS codes over 90% of the survey respondents indicated that the survey code was more or much more complex than both KRS codes for all of the intensity/complexity factors.

Recommended RVW: The October 2018 survey data for code 33866 (aortic hemiarch graft) shows a median intra-service time of 123 minutes and a 25th percentile RVW of 17.75 and a median RVW of 21.00. The January 2018 survey had a median intra-service time of 165 minutes and a 25th percentile RVW of 19.74 and a median RVW of 22.00. The Expert Panel feels that that the data from the 1st survey should be used to value code 33866. Even though 32 responses were received for the 2nd survey after it was re-opened and the RUC's minimum sample survey size was met. The 1st survey had 61 responses which is double the minimum sample size and the specialties feel that data is more statistically valid. The recommended 25th percentile RVW of 19.74 from the 1st survey is slightly higher than the RVWs for both KRS codes and the total time for the survey code falls between the total times of the KRS codes. The

intraservice time of the survey code is longer than the intra-service time of both the KRS codes. The intensity (0.120) for the survey code is higher than the intensity for the 1st (0.119) and 2nd (0.112) KRS codes. The Expert panel felt that this is appropriate and is supported by the intensity and complexity measures.

The Expert Panel is recommending the 25th percentile work RVW of 19.74, with the median intra-service time of 165 minutes, and total time of 165 minutes from the 1st survey.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33870, 33999, modifier -22 or it was not separately reported

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiothoracic surgery How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1049

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2017 Medicare frequency for 33870 is 999. The STS database shows that 60% of patients that receive a transverse aortic arch graft are non-Medicare patients.

It is estimated that 70% of aortic arch procedures for 33870 are for aortic hemiarch grafts. This results in the following:

For code 33X01, it is estimated that 1049 procedures per year will be provided nationally and 699 procedures per year will be provided to Medicare patients.

Specialty cardiothoracic surgery Frequency 1049 Percentage 100.00 %

Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 699
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2017 Medicare frequency for 33870 is 999. The STS database shows that 60% of patients that receive a transverse aortic arch graft are non-Medicare patients.

It is estimated that 70% of aortic arch procedures for 33870 are for aortic hemiarch grafts. This results in the following:

For code 33X01, it is estimated that 1049 procedures per year will be provided nationally and 699 procedures per year will be provided to Medicare patients.

Specialty cardiothoracic surgery	Frequency 699	Percentage 100.00 %
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Specialty	Frequency	Percentage	%
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:

Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33369

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 33871 Tracking Number D6

Original Specialty Recommended RVU: **65.75**Presented Recommended RVU: **65.75**Global Period: 090 Current Work RVU: **46.06**RUC Recommended RVU: **65.75**

CPT Descriptor: 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)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Upon routine chest x-ray, a 60-year-old male is found to have an enlarged aortic arch with an aortic aneurysm and is referred for additional workup. Echocardiogram, computed tomography (CT), magnetic resonance imaging (MRI), and angiogram are obtained, and although the patient is asymptomatic, the findings show that the aneurysm involves the entire aortic arch. The patient is scheduled for a transverse aortic arch graft placement.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 94% , In the ASC 0%, In the office 6%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 100%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 61%

Description of Pre-Service Work: A complete or interval history and physical examination (comprehensive) are performed.

Preoperative orders are written, and the work-up and notes from referring and primary physicians are reviewed if available. Preoperative imaging studies including chest x-rays, CT Scan, MRI, Aortogram and TEE are reviewed. Preoperative laboratory studies (CBC, electrolytes, renal and liver function, coagulation) are reviewed. Obtain cardiology assessment and pulmonary assessment as indicated. Indications, surgical procedure, expected recovery, and expected outcomes, including potential complications, are reviewed with the family. The family's questions are answered, and informed consent is obtained. The OR start time is confirmed and the patient and family are notified. Availability of the surgical assistant is confirmed. The patient is identified, the surgical site is marked per hospital policy, and any questions from the family are answered. Availability of blood and/or cross match and any special instruments or medical devices is ensured. Review planned incision and procedure. Review the length and type of anesthesia with anesthesiologist. Ensure anesthesiology and perfusionist are prepared for circulatory arrest. Plan invasive monitoring including use of arterial line (right radial only) and pulmonary artery catheter. Review trans-esophageal echocardiogram with anesthesiologist and/or cardiologist. The surgeon scrubs and puts on a gown and gloves. Prep and drape the skin of the chest, abdomen, and legs from the neck to the ankles including both groin areas. Ensure that the patient is properly positioned for the procedure which may include extending the customary median sternotomy incision to include a left infra-clavicular incision/approach.

Description of Intra-Service Work: Perform standard median sternotomy skin incision, divide the sternum in the midline with a saw. A determination of which artery will be used for arterial access while on cardiopulmonary bypass is made following median sternotomy and exposure of the heart and great vessels. This may require exposure and use of the innominate artery, the right subclavian artery, the brachial artery, or even the femoral artery. If necessary, an eight-millimeter Dacron graft is anastomosed to a peripheral artery in order to facilitate cardiopulmonary bypass (reported separately). A venous cannula is inserted. The entire transverse arch including the innominate artery, the left carotid artery and the left subclavian artery are dissected free and isolated with vascular tapes. The recurrent laryngeal nerve, as it crosses

under the distal aortic arch, must be identified and protected. The patient is heparinized systemically and the level of heparinization is determined. Establish cardiopulmonary bypass, systemic cooling is initiated to establish deep hypothermia. Retrograde and/or antegrade cerebral perfusion is established with appropriate cannulae for delivery of cardioplegia when appropriate. An aortic cross clamp is applied to the ascending aorta and the aorta is transected above the cross clamp. An appropriately sized Dacron tube graft is anastomosed to the cut end of the ascending aorta. Once the patient is cooled to the desired temperature, the cardiopulmonary bypass machine circuit is turned off and circulation to the entire body is interrupted.

The arch vessels are transected at the base and the transverse arch is opened and resected. An appropriately sized tubular Dacron arch graft is anastomosed to the cut end of the proximal descending aorta. The remaining arch vessels (innominate artery, left carotid artery and left subclavian artery) may be individually anastomosed to the arch tube graft or the three arch vessels can be left attached to a remnant of the resected arch (configured as an island) which is then anastomosed to the newly constructed arch tube graft. A prolonged period of systemic warming is started as the anastomoses are being completed. This includes the final graft-to-graft (ascending aortic graft and transverse arch graft) anastomosis.

As the patient approaches normothermia and bleeding has been sufficiently controlled, the patient is placed in Trendelenburg and cardiopulmonary bypass is re-established slowly in order to evacuate air from the ascending aortic and transverse arch grafts. The aortic root is vented until LV ejection has been present for 5-10 minutes. Assessment of residual air (if any) in the left side of heart as well as assessing myocardial contractility is accomplished using transesophageal echocardiogram (separately reported). The heart is resuscitated by allowing it to beat while unloaded on cardiopulmonary bypass. Establishing meticulous hemostasis is critical since the patients are most often profoundly coagulopathic following profound hypothermia and total circulatory arrest. Temporary pacing wires are placed, and electrical pacing is initiated if necessary. The patient is carefully weaned from cardiopulmonary bypass. Arterial, venous and cardioplegia cannulas are removed and cannulation sites are secured/repared. Chest tubes are placed, and the sternum is re-approximated. The sternal wound is closed.

Description of Post-Service Work: Postoperative same day work through admission to intensive care: An operating room debriefing is performed. Sterile dressings are applied to the incision. Drapes are removed, with close attention to pacing wires (if any), tubes, and lines to ensure that none are dislodged or disconnected. This attention continues as the patient is moved to the intensive care unit (ICU) bed for transfer. In a coordinated team manner, the patient's overall condition is monitored as the anesthesia team converts the monitoring equipment (arterial blood pressure, pulmonary artery pressures, electrocardiogram [EKG]) to a portable monitor. The chest drainage system is observed periodically to assess interval bleeding, to ascertain that negative pressure is not lost, and to ensure that the tubes are not obstructed. The OR transporting team and the ICU receiving team confirm initiation of transfer. The patient is accompanied to the ICU, and the team is directed should the patient's condition change en route. Operating room forms, indicating pre- and postoperative diagnoses and the operation performed, are signed. A postoperative chest X ray is obtained and examined to assess expansion of the lungs and placement of the chest and nasogastric tubes (if inserted). Orders for postoperative laboratory tests, films, medications, diet, and patient activity are written. A brief operative note is written for the patient's chart. Daily progress notes of the pre- and postoperative diagnoses, operation performed, findings, blood loss, intraoperative IV fluids administered, complications, and specimens sent to pathology (if any) are documented. Intensive care and medications are reviewed with the staff. The patient's short-term goals are established with the ICU nursing staff. Procedure outcomes, including the procedure performed, any variance from the planned procedure, the general findings, an initial assessment of the degree of procedural success, and expectations for the remainder of the day of surgery and the longer term, are discussed with the family. The procedure outcome is discussed with the patient's family or caregiver after patient's emergence from anesthesia. A postoperative report is dictated, and the procedure outcome is discussed with the referring physician. Care is coordinated with other physicians. A procedure outcome and expected recovery letter is dictated for the referring physician and/or the insurance company.

Postoperative intensive care: The patient's neurological state is assessed, and emergence from anesthesia is monitored. Sedatives, paralyzing agents, and analgesics are administered as needed. Gross neurologic function, including level of consciousness, behavioral appropriateness, and presence and nature of focal neurological defect if present, is evaluated. The evaluation is repeated until intraoperative neurologic injury is ruled out. The patient's hemodynamic condition, including cardiac rhythm, is assessed. Rate and conduction abnormalities are assessed. Temporary pacing is initiated as needed. A suitable mode is determined, and the output and sensitivity of the device are adjusted. The assessment of hemodynamic effects is repeated. Arrhythmias are assessed. Atrial extrasystoles or runs are differentiated from ventricular extrasystoles or runs and correlated with operative events and hemodynamic effects; antiarrhythmic therapy (treatment or prophylaxis) is considered. The 12-lead EKG is evaluated for signs of ischemia or injury and compared to the preoperative tracing. Blood pressure, central venous pressure, pulmonary artery pressures, and cardiac output and index are assessed.

Filling pressures are correlated at baseline, calibration of transducers with zero level at the level of the right heart are confirmed, and waveforms are assessed. Crystalloid fluids or blood products are administered depending on cardiac index, mixed venous oxygen saturation, hemoglobin, and central filling pressures. Inotropic and vasoactive agents given by continuous infusion are adjusted to optimize oxygen delivery and minimize adverse end-organ effects. Peripheral perfusion is carefully evaluated by observation and physical exam, correlating findings with invasive monitoring results. Chest tube bleeding is monitored. The character of the mediastinal drainage (rate, amount, tenacity, stability of clot) is assessed. The patency of the mediastinal tubes is assessed to ensure that a cardiac tamponade state is avoided. Bleeding quantity and character are correlated with chest X ray, laboratory tests, hemodynamics, urine output, and physical exam. Laboratory results are assessed and correlated with other findings to determine the need for blood and/or blood products, including platelets, cryoprecipitate, and fresh frozen plasma. Other adjunctive pharmacologic therapies are considered for coagulopathy. The need for re-exploration is considered if the chest tube output exceeds acceptable limits or if tamponade is present. The respiratory system is assessed. Breath sounds are examined, chest mechanics observed, and mid-line tracheal position is ensured by physical exam. Ventilator settings are assessed; underlying respiratory pattern, baseline airway pressures generated, and minute gas flow are observed. The postoperative chest X ray is reevaluated if necessary. Endotracheal tube placement is confirmed by review of the postoperative chest X ray. Lungs are monitored for infiltrate/atelectasis. Pleural spaces are assessed for fluid collection. Blood gases are assessed, and the ventilator is adjusted as needed. The patient is weaned from the ventilator. Readiness for extubation is assessed. The patient is extubated, and airway and adequacy of ventilation are ensured. Particular attention is paid to assessing possible post-extubation stridor secondary to left vocal cord dysfunction. Adequacy of urine output is assessed, and postoperative creatinine in light of preoperative renal function is checked. Volume status is assessed, and fluids are administered as needed. The need for a diuretic is determined and, if indicated, the dose is determined, and response is monitored. Urine flow is correlated with blood pressure and compared to preoperative status. Interaction of cardiac output and vasoactive agents with renal function is assessed. Distal extremity perfusion is monitored, and peripheral pulses are assessed and compared to preoperative findings. A comprehensive evaluation is integrated with the patient's history, expected status based on conduct of the operation, and response to critical care interventions. The extent of inflammatory state is assessed, and treatment with antipyretics or steroids is considered as indicated. The patient's chart notes are reviewed with the nursing staff and other staff. Interval plans are discussed with the nursing staff. Parameters for interval adjustments in patient treatment are set, and the interval to the next patient evaluation, if expected goals have been met, is established. Questions from the nursing staff, other staff, and the patient's family are answered. Orders are written. The patient's progress notes are charted.

Postoperative other hospital work—beginning on postoperative day 3 until discharge day: A comprehensive history and physical exam are performed. All wounds are inspected for drainage, underlying hematoma, and inflammation. The patient's chart notes are reviewed with nursing and other staff. Postoperative pain, use of analgesics, and adequacy of response are assessed. Adequacy of respiration, character of breathing, relationship to surgical pain, and intravascular volume status are assessed. Character of pulmonary secretions and the patient's ability to clear his airway are assessed. Vital signs, intake and output, laboratory results, and patient daily weight are reviewed. The chest radiograph is reviewed, and the cardiac monitor is evaluated for rate, rhythm, and presence or absence of arrhythmia. The stored EKG monitoring history is evaluated if indicated. Progress of the system recovery and risk for development of complications are assessed. Ambulation and vigorous pulmonary physiotherapy are encouraged. Postoperative nutritional status, as maintained by both enteral (if necessary) and oral feedings, is carefully assessed and monitored. Drainage from chest tubes (if still present) is assessed daily and removed when appropriate. Chest X-rays after tube removal and at least one more time before discharge as indicated by patient's condition are obtained and reviewed. The temporary pacemaker wires are removed if present. Questions from the patient, family, and nursing or other staff (verbal and written) are answered. An interval plan of care that includes drug therapy for underlying conditions (eg, diabetes), surgically induced conditions, actual or anticipated complications (eg, beta blockers for atrial fibrillation, antibiotics for prophylaxis or treatment), and preventive care is developed. Insurance staff questions are answered. Orders for postoperative laboratory tests, films, medications, diet, and patient activity are written. The postoperative echocardiogram is evaluated and reviewed. The patient's progress is discussed (oral and written) with the referring physician. Care is coordinated with other physicians. Evaluation, patient progress, and the care plan are documented in the medical record.

Discharge day work: A history and physical exam are performed. The final pathology/laboratory/film reports are checked and discussed with the patient's family or caregiver. Wounds and patient progress are checked. Dietary management, activities permitted, bathing, handling of wound, return appointment to office, and similar items are carefully explained to the patient's family. Expectations for recovery are outlined and adjusted to specific underlying cardiac state, associated chronic diseases, operative findings, and character of postoperative recovery. Potential complications, how to recognize them, and what to do if recovery is not as anticipated are described. Care is coordinated with other physicians. The patient's chart notes are reviewed with nursing and other staff. Post discharge wound care and activity limitations are reviewed with the family. Questions from the patient, family, and nursing and other staff are answered. Insurance staff questions are answered. Orders for post discharge laboratory tests, films, and medications are written. The patient's

discharge notes are charted, and prescriptions and discharge instructions are written. The nature, purpose, and expected duration of use of new medications are explained. The importance of secondary prevention of cardiac disease through risk factor reduction is explained to the family. Specific instructions on the need to notify other treating physicians and dentists of the presence of a Dacron, prosthetic graft and the need for prophylactic periprocedural antibiotics are given. The patient's home medications and homeopathic agents are explained to ensure that additional agents are compatible or will not be used. A discharge summary is dictated. Communication is made with patient's primary care physician(s). Special emphasis is made on communicating with primary care physician(s) the importance of continued evaluation the patient's neurologic function and adequacy of perfusion of the left and right upper extremities after the surgical re-implantation of the patient's innominate, left carotid and left subclavian arteries.

Postoperative office work: After discharge from the hospital, a detailed history and physical exam are performed. Medications are reviewed, and compliance is determined. Interval encounters are reviewed with other care providers. Wounds and patient progress are checked. Sutures/drains are removed. Post discharge laboratory tests/films are reviewed. Medications are reviewed and orders for medications are written. Questions from the patient and family are answered. Insurance staff questions are answered. The patient's progress is discussed (verbal and written) with the referring physician. The patient's care is coordinated with other physicians. Progress is discussed with the patient and family. A patient progress note is dictated for the medical chart, and letters are sent to referring physicians.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		10/2018				
Presenter(s):	Jim Levett, MD; Kirk Kanter, MD; Joseph Turek, MD; Jacob Schroder, MD					
Specialty Society(ies):	STS, AATS					
CPT Code:	33871					
Sample Size:	800	Resp N:	39	Response: 4.8 %		
Description of Sample:	Random sample of 650 self-identified cardiac surgeons and 150 self-identified congenital heart surgeons					
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	0.00	3.00	9.00	40.00
Survey RVW:		41.32	65.75	76.50	90.00	100.00
Pre-Service Evaluation Time:				77.50		
Pre-Service Positioning Time:				15.00		
Pre-Service Scrub, Dress, Wait Time:				15.00		
Intra-Service Time:		120.00	275.00	320.00	363.00	640.00
Immediate Post Service-Time:	<u>60.00</u>					
Post Operative Visits	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>				
Critical Care time/visit(s):	<u>140.00</u>	99291x 2.00	99292x 0.00			
Other Hospital time/visit(s):	<u>170.00</u>	99231x 1.00	99232x 1.00	99233x 2.00		
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.00	99239x 0.00	99217x 0.00		
Office time/visit(s):	<u>40.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 1.00	15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00		

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33871	Recommended Physician Work RVU: 65.75		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time
Pre-Service Evaluation Time:		60.00	40.00	20.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		15.00	20.00	-5.00
Intra-Service Time:		363.00		
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
9B General Anes or Complex Regional Blk/Cmplx Proc				
		Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:		60.00	33.00	27.00

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	<u>140.00</u>	99291x 2.00 99292x 0.00
Other Hospital time/visit(s):	<u>170.00</u>	99231x 1.00 99232x 1.00 99233x 2.00
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0 99239x 0.0 99217x 0.00
Office time/visit(s):	<u>40.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 1.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33877	090	69.03	RUC Time

CPT Descriptor Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33622	090	64.00	RUC Time

CPT Descriptor Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 11 % of respondents: 28.2 %

Number of respondents who choose 2nd Key Reference Code: 8 % of respondents: 20.5 %

TIME ESTIMATES (Median)

	CPT Code: <u>33871</u>	Top Key Reference CPT Code: <u>33877</u>	2nd Key Reference CPT Code: <u>33622</u>
Median Pre-Service Time	90.00	110.00	63.00
Median Intra-Service Time	363.00	324.00	300.00
Median Immediate Post-service Time	60.00	60.00	60.00
Median Critical Care Time	140.0	210.00	140.00
Median Other Hospital Visit Time	170.0	282.00	345.00
Median Discharge Day Management Time	38.0	38.00	38.00
Median Office Visit Time	40.0	86.00	40.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	901.00	1,110.0	986.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	9%	18%	27%	45%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
9%	27%	64%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	0%	36%	64%

Physical effort required	27%	27%	45%
--------------------------	-----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

9%	36%	55%
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2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	13%	25%	38%	25%
------------------------------	----	-----	-----	-----	-----

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

13%	50%	38%
-----	-----	-----

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	25%	50%	25%
--------------------------	-----	-----	-----

Physical effort required	0%	63%	38%
--------------------------	----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%	50%	50%
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Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

OVERALL RATIONALE

Tab 6 includes 6 codes that represent grafting procedures on the ascending aorta and the aortic arch. A new add-on code +33X01 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) that was developed to account for the additional work that is involved when the ascending aortic disease extends into the proximal portion of the transverse aortic arch was approved by the CPT Editorial Panel and surveyed for the January 2018 RUC meeting. The Expert Panel decided not to survey the ascending aortic replacement codes 33860, 33863 or 33864 for the January 2018 RUC meeting because they felt that the work involved in the aortic hemiarch replacement procedure represented an advancement in surgical technique representing new work that is not reflected in the work that is currently accounted for in the ascending aortic procedures. The specialties indicated that the aortic hemiarch replacement is more closely related to the work involved with the transverse aortic arch replacement code 33870 than to the work of the ascending aortic codes. At the January 2018 RUC meeting, the RUC determined that the specialties had to re-survey the family of aortic repair procedures including codes 33860, 33863, 33864, 33X01, 33870 for the April 2018 RUC meeting. As the specialty reviewed the codes with consideration of re-surveying them, they determined that they 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 felt that there is a sufficient difference in the work associated with these procedures and now there is enough 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 33X01. 3) Revise the guidelines to provide additional instructions on the appropriate use of these codes. The CCA was submitted to the CPT Editorial Panel for consideration at the May 2018 CPT meeting. The CPT Editorial Panel approved the deletion of two existing codes, 33860 and 33870. Code 33860 will be replaced with two new codes, 33858 and 33859 for ascending aortic aneurysm repair for dissection and for other aortic disease respectively. Due to the extensive changes of the descriptor for code 33870 to further differentiate that code from the aortic hemiarch code 33X01, the Panel decided to delete code 33870 and renumber it to the new code 33871. As a result, 4 ascending aortic grafting codes 33858, 33859, 33863 and 33864 and two aortic arch grafting codes 33X01 and 33871 were surveyed for the October 2018 meeting.

The recommended values for these procedures result in an overall budget savings for Medicare as represented in the table below:

CPT Source	Deleted	Source 2017 Utilization	New/ Revised Code	New/ Revised Code Utilization (reference 2017)	Percent	Source RVU	STS Rec RVU	New/ Revised Total RVUs	Total Source RVUs	Difference New/Rev - Source
33860	D	3800	33858	1140	0.3	59.46	65.00	74100	67784	6316
33860	D	3800	33859	2660	0.7	59.46	50.00	133000	158164	-25164
33863		1875	33863	1875	1	58.79	59.00	110625	110231	394
33864		282	33864	282	1	60.08	63.00	17766	16943	823
33870	D	999	33871	300	0.3	46.06	65.75	19725	13818	5907
33870	D	999	33X01	699	0.7	46.06	19.74	13798	32196	-18398
Totals								369014	399136	-30122

Code 33860 which is split into two new codes 33858 and 33859 results in a recommended increase in value for code 33858 (recommended RVW 65.00, current RVW 59.46) and a decrease in value for the more commonly performed code 33859 (recommended RVW 50.00, current RVW 59.46) resulting in an overall budget savings for that code. Code 33870 is also split into two new codes 33X01 and 33871, which results in a recommended increase in value for code 33871 (recommended RVW 65.75, current RVW 46.06) and a decrease in value for the more commonly performed code 33X01 (recommended RVW 19.74, current RVW 46.06) resulting in an overall budget savings for that code. The RVW recommendations for the other two codes, 33863 and 33864 result in slight increases for each code, but these increases are offset by the savings from the changes to the other codes. Additional information regarding the recommended revisions are included for each code.

Rationale 33871

Code 33871 is a renumbered code for aortic arch grafting with reimplantation of arch vessel(s). This procedure previously was reported with code 33870. The code descriptor was extensively revised to clearly differentiate between the work of a transverse arch graft repair and a hemiarch repair. The current Medicare volume for 33870 is 999. The RUC database shows an increase in volume of this code starting in 2014, which is around the time that hemiarch grafting started to become more prevalent. An increased understanding of isolated cerebral perfusion/cooling and its protective effects has made it safer to perform procedures with total circulatory arrest and deep hypothermia. Due to the increased familiarity, safety and knowledge surrounding circulatory arrest and cerebral perfusion procedures, the hemiarch procedure is now safer to perform and results in reduced risk to the patient by avoiding subsequent reoperation that that might be required without the aortic hemiarch replacement or the increased risk associated with a total transverse aortic arch replacement. It is estimated that 30% of the transverse aortic arch repairs will be performed using this code, resulting in an estimated Medicare volume of 300 procedures per year. Transverse aortic arch grafting with reimplantation of arch vessel(s) is a procedure that requires a median sternotomy, cardiopulmonary bypass, profound hypothermia, total circulatory arrest and isolated cerebral perfusion. The arch vessels are transected at the base, and the transverse aortic arch involved in the aneurysm is resected and replaced with a graft. The arch vessels (innominate artery, left carotid artery and left subclavian artery) are individually anastomosed to the arch tube graft or the three arch vessels are left attached to a remnant of the resected arch and anastomosed as an island to the newly constructed arch tube graft.

Pre-Time Package 4

Pre-Time Changes: The Expert Panel selected pre-service time package 4 representing a difficult patient and difficult procedure done in a facility under anesthesia. The Expert Panel is recommending increases in time for the evaluation of the patient and for the positioning of the patient. The survey only supported 15 minutes for scrub dress and wait time, so the Expert Panel is recommending a 5-minute reduction for a total of 15 minutes for the scrub dress and wait time for the procedure per the survey.

Evaluation (total = 60 minutes): For the evaluation, the Expert Panel is recommending a 20-minute increase in time over the package for a total evaluation time of 60 minutes. This is supported by the survey data with 60 minutes of pre-service evaluation. The total evaluation time accounts for the review of the patient, by the surgeon and the collaborative efforts that go into each case. The additional evaluation time of 20 minutes accounts 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 Scan, 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 Expert Panel felt that adding 20 minutes of evaluation time to package 4 was reasonable and would cover all aspects of the pre-service work involved with the procedure.

Positioning (total = 15 minutes): The Expert Panel is recommending a 12-minute increase in time over the package for a total positioning time of 15 minutes, which is common for cardiac procedures and there are numerous examples in the RUC database supporting this time. The survey supported 15-minutes for positioning of the patient. The additional 12-minutes above the package time can be attributed to the time spent for careful protection of pressure points on the patient with this prolonged operation.

Scrub, Dress and Wait (total = 15 minutes): There is a 5-minute decrease from the package time, which represents the scrub dress and wait time from the survey.

Post-time Package 9b

Total = 60 minutes: The expert panel selected post-time package 9B for a general anesthesia or complex regional block/complex procedure. The Expert Panel is recommending a 27-minute increase in time over the package for a total immediate post time of 60 minutes and there are numerous examples in the RUC database and the cardiothoracic surgery codes supporting this time. The survey supported 60 minutes of immediate post time. The additional 27-minutes above the package time can be attributed to additional time 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.

Critical Care Visits: 94% of the survey respondents replied that the procedure was performed in the hospital, and that 100% of the patients stayed overnight for more than 24 hours. 61% of the respondents indicated that they provided an E&M Visit on the same day of surgery.

The survey respondents indicated that they spent over 40 minutes providing critical care services to the patient once the patient arrives in the ICU on the day of the procedure and an additional 40 minutes of critical care the day after the procedure for a total of two critical care visits for the procedure. The critical care visit covers that time that the physician spends with the patient directly related to the procedure providing critical care services. The survey supported two critical care visits for the procedure and the Expert Panel agreed.

Intensity and complexity of the procedure: 39 surveys were completed by a random pool of 800 cardiac surgeons which consisted of 650 self-identified adult cardiac surgeons and 150 self-identified congenital cardiac surgeons. 11 respondents selected code 33877, thoracoabdominal aneurysm repair as a reference code making it the 1st key reference service (KRS). That code has a slightly higher value, a shorter intraservice time and a longer total time than the survey code. The respondents ranged in their intensity/complexity comparison saying that the survey code is more or much more intense/complex than 33877 for all of the intensity/complexity measures except for the physical effort where the respondents indicated that the survey code identical or more complex than 33877. 8 respondents selected code 33622, complex cardiac anomaly reconstruction with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavo-pulmonary anastomosis and removal of right and left pulmonary bands as a reference code making it the 2nd KRS. This code has a slightly lower value with a shorter intraservice and a longer total time. The respondents ranged in their intensity/complexity comparison saying that the survey code is identical to, somewhat or much more intense/complex than 33622 for all of the intensity/complexity measures.

Recommended RVW: The survey data for code 33871 (transverse arch graft and arch vessel reimplantation) shows that the median intra-operative time is 320 minutes. The current intra-service time for this procedure is 330 minutes. 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 Expert Panel felt that the survey respondents underestimated the intra-service time of the procedure and are recommending the 75th percentile of intra-service time from the survey, which is 363 minutes. The 75th percentile of 363 minutes is lower than the STS Database times. The 75th percentile intra-service time from the survey is more than the intra-time for the current code. The surveys also supported two critical care visits during the post-operative period which is the same number included in the current code. The hospital LOS from the survey represents one day less than the LOS in the current code and the total time from the survey is higher at 901 minutes than that for the current code at 770 minutes. The Recommended RVW and the total time for the survey code falls between the RVW and total time of both the KRS codes. The intraservice time of the survey code is longer than the intra-service time of both the KRS codes. The intensity (0.123) for the survey code is higher than the intensity for 1st (0.114) KRS code and is the same as the intensity for the 2nd (0.123) KRS code. The Expert panel felt that this is appropriate and is supported by the intensity and complexity measures.

The Expert Panel is recommending the 25th percentile work RVW of 65.75, with the 75th percentile intra-service time of 363 minutes, and total time of 901 minutes. Pre-time package 4 was selected with adjustments made to the evaluation and positioning time for a total pre-service time of 90 minutes. Immediate post-service time package 9b with additional time added for a total time of 60 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 33870

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiothoracic surgery How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 450

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2017 Medicare frequency for 33870 is 999. The STS database shows that 60% of patients that receive a transverse aortic arch graft are non-Medicare patients.

It is estimated that 30% of aortic arch procedures for 33870 are for transverse aortic arch graft. This results in the following:

For code 33871, it is estimated that 450 procedures per year will be provided nationally and 300 procedures per year will be provided to Medicare patients.

Specialty cardiothoracic surgery Frequency 450 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 300

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2017 Medicare frequency for 33870 is 999. The STS database shows that 60% of patients that receive a transverse aortic arch graft are non-Medicare patients.

It is estimated that 30% of aortic arch procedures for 33870 are for transverse aortic arch graft. This results in the following:

For code 33871, it is estimated that 450 procedures per year will be provided nationally and 300 procedures per year will be provided to Medicare patients.

Specialty cardiothoracic surgery Frequency 300 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:

Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33870

ISSUE: Aortic Graft Procedures (33858, 33859, 33863, 33864, 33871, 33866)

TAB: 6

Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	FAC-inpt/same day						Office				
					MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		91	92	33	32	31	38	39	15	14	13	12
1st REF	33412	Replacement, aortic valve; with tra	14	0.122			59.00			866	40	3	20			300			60	2		3	1	1	1.0		1			
2nd REF	33877	Repair of thoracoabdominal aortic	7	0.114			69.03			1110	50	45	15			324			60	3		3	2	1		1	1	2		
CURRENT	33860	Ascending aorta graft, with cardiop		0.114			59.46			931	45	15	20			305			40	2		3	2	1	1.0		1	1		
SVY	33858	Ascending aorta graft, with cardiop	41	0.127	41.32	60.00	65.00	80.00	100.00	946	60	14	15	120	240	300	360	540	60	3		2	1	1	1.0		2			
SVY mean DB	33858	Dissection		0.128	65.00					932	60	15	15			301			60	3		2	1	1	1.0		1	1		
SVY med DB	33858	Dissection		0.137	65.00					912	60	15	15			281			60	3		2	1	1	1.0		1	1		
SVY REC	33858	Dissection		0.130	65.00					911	40	15	15			300			60	3		2	1	1	1.0		1	1		

Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	FAC-inpt/same day						Office				
					MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		91	92	33	32	31	38	39	15	14	13	12
1st REF	33430	Replacement, mitral valve, with car	12	0.105			50.93			913	60	15	20			232			40	2		3	2	1		1	2			
2nd REF	33877	Repair of thoracoabdominal aortic	8	0.114			69.03			1110	50	45	15			324			60	3		3	2	1		1	2			
CURRENT	33860	Ascending aorta graft, with cardiopulmona		0.114			59.46			931	45	15	20			305			40	2		3	2	1	1.0		1	1		
SVY	33859	Ascending aorta graft, with cardiop	40	0.158	35.00	50.00	59.00	65.81	95.00	783	65	15	15	120	199	240	279	360	60	2		2	1	1	1.0		1			
SVY mean DB	33859	Aneurysm		0.096	50.00					839	60	15	15			301			60	2		2	1	1	1.0		1			
SVY med DB	33859	Aneurysm		0.103	50.00					819	60	15	15			281			60	2		2	1	1	1.0		1			
SVY REC	33859	Aneurysm		0.121	50.00					778	60	15	15			240			60	2		2	1	1	1.0		1			

Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	FAC-inpt/same day						Office				
					MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		91	92	33	32	31	38	39	15	14	13	12
1st REF	33412	Replacement, aortic valve; with tra	12	0.122			59.00			866	40	3	20			300			60	2		3	1	1	1.0		1			
2nd REF	33877	Repair of thoracoabdominal aortic	8	0.114			69.03			1110	50	45	15			324			60	3		3	2	1		1	1	2		
CURRENT	33863	Ascending aorta graft, with cardiopulmona		0.121			58.79			905	60	15	20			287			40	2		3	2	1	1.0		1			
SVY	33863	Ascending aorta graft, with cardiop	41	0.146	41.32	59.00	62.00	78.00	100.00	824	67.5	13.5	15	180	240	280	300	480	60	2		2	1	1	1.0		1			
SVY mean DB	33863	Root replacement with valved cond		0.127			59.00			836	60	15	15			298			60	2		2	1	1	1.0		1			
SVY med DB	33863	Root replacement with valved cond		0.118			59.00			860	60	15	15			322			60	2		2	1	1	1.0		1			
REC	33863	Root replacement with valved cond		0.126			59.00			838	60	15	15			300	75th time		60	2		2	1	1	1.0		1			

Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	FAC-inpt/same day						Office				
					MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		91	92	33	32	31	38	39	15	14	13	12
1st REF	33412	Replacement, aortic valve; with tra	9	0.122			59.00			866	40	3	20			300			60	2		3	1	1	1.0		1			
2nd REF	33877	Repair of thoracoabdominal aortic	7	0.114			69.03			1110	50	45	15			324			60	3		3	2	1		1	1	2		
CURRENT	33864	Ascending aorta graft, with cardiopulmona		0.130			60.08			853	85	15	20			300			60	2		1	2	1	1.0		1			
SVY	33864	Ascending aorta graft, with cardiop	40	0.159	41.32	63.00	69.03	80.00	100.00	848	70	15	15	120	240	300	353	480	60	2		2	1	1	1.0		1			
SVY mean DB	33864	Valve-sparing aortic root remodelin		0.136			63.00			846	60	15	15			308			60	2		2	1	1	1.0		1			
SVY med DB	33864	Valve-sparing aortic root remodelin		0.131			63.00			858	60	15	15			320			60	2		2	1	1	1.0		1			
REC	33864	Valve-sparing aortic root remodelin		0.140			63.00			838	60	15	15			300			60	2		2	1	1	1.0		1			

Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	FAC-inpt/same day						Office				
					MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		91	92	33	32	31	38	39	15	14	13	12
1st REF	33877	Repair of thoracoabdominal aortic	11	0.114			69.03			1110	50	45	15			324			60	3		3	2	1		1	2			
2nd REF	33622	Reconstruction of complex cardiac	8	0.123			64.00			986	40	3	20			300			60	2		3	1	7	1.0		1			
CURRENT	33870	Transverse arch graft, with cardiop		0.090			46.06			770	60					330			70	1			1	5	1.0		2	1		
SVY	33871	Transverse aortic arch graft, with c	39	0.172	41.32	65.75	76.50	90.00	100.00	876	77.5	15	15	120	275	320	363	640	60	2		2	1	1	1.0		1			
SVY mean DB	33871	Total Arch		0.115	65.75					928	60	15	15			390			60	2		2	1	1	1.0		1			
SVY med DB	33871	Total Arch		0.112	65.75					938	60	15	15			400			60	2		2	1	1	1.0		1			
REC	33871	Total Arch		0.123	65.75					901	60	15	15			363	75th time		60	2		2	1	1	1.0		1			

Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	FAC-inpt/same day						Office				
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[illegible]

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor:

33858	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic dissection
33859	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic disease other than dissection (eg, aneurysm)
33863	Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, Bentall)
33864	Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub procedure)
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)
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)

Global Period: 090 Meeting Date: 10/2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel was convened to develop the PE recommendations for codes 33858, 33859, 33863, 33864, 33871 and 33866.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Codes 33858 and 33871 are currently reported with code 33860. Codes 33871 and 33866 are currently reported with code 33870. 33863 and 33864 are existing codes that were re-surveyed as related codes. 33877 Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass has been included as a reference code. 33877 represents an aortic procedure with similar inputs. 33877 was also selected as one of the KRS codes in the survey.

3. Is this code(s) typically billed with an E/M service?

No, none of these codes are typically billed with an E/M service.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

Code 33858 is typically performed as an emergency for Type I aortic dissection. 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 90 day cardiothoracic procedure. The specialties are recommending the following changes to the standard times for an emergent procedure:

- *For activity code CA002 Coordinate pre-surgery services the emergent time is 7 minutes. The specialties are recommending 10 minutes for this clinical activity because there are still 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 emergent time is 4 minutes. The specialties are recommending the standard 90-day clinical staff time of 8 minutes for this clinical activity. The clinical staff will still 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.*

The specialties are recommending the standard 90 day global clinical staff times for codes 33859, 33863, 33864 and 33871, which is the same as the PE inputs for the current codes.

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence:

N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:

N/A

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

N/A

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.

N/A

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:

N/A

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:

N/A

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:

The only equipment included on the practice expense spreadsheet are the standard post-operative visit equipment, which includes an exam table for the total post-operative visit time.

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:

Code 33866 is an add-on code and does not have any associated PE inputs.

13. If there is any other item on your spreadsheet that needs further explanation please include here:

The majority of offices of our specialty utilize RN's or advance practice providers (PA's or NP's) because of the complexity of triaging outpatient care for cardiac surgery patients. Since CMS does not recognize PAs or NPs as clinical staff, the RN level has been traditionally accepted. This is a long-standing standard and is consistent in the family of cardiothoracic surgery codes that are not typically performed by multiple specialties. Codes 33858, 33859, 33863, 33864, 33871 and 33866 are all performed by cardiothoracic surgeons and would not be considered multi-specialty procedures.

14. Please include an explanation of each line item:

	A	B	D	E	F	G	H	I
1	RUC Practice Expense Spreadsheet					REFERENCE CODE	CURRENT	RECOMMENDED
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>				33877	33860	33858
3		<u>RUC Collaboration Website</u>						
4	Clinical Activity Code	Meeting Date: 10/2018 Tab: 6 Specialty: STS/ AATS	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute	Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic dissection
5		LOCATION				Facility	Facility	Facility
6		GLOBAL PERIOD				090	090	090
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				\$ 109.33	\$ 89.72	\$ 72.89
8		TOTAL CLINICAL STAFF TIME	L051A	RN	0.51	197.0	161.0	128.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L051A	RN	0.51	60.0	60.0	27.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L051A	RN	0.51	12.0	12.0	12.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L051A	RN	0.51	125.0	89.0	89.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE				\$ 100.47	\$ 82.11	\$ 65.28
13		PRE-SERVICE PERIOD						
14		Start: Following visit when decision for surgery or procedure made						
15	CA001	Complete pre-service diagnostic and referral forms	L051A	RN	0.51	5	5	5
16	CA002	Coordinate pre-surgery services (including test results)	L051A	RN	0.51	20	20	10
17	CA003	Schedule space and equipment in facility	L051A	RN	0.51	8	8	8
18	CA004	Provide pre-service education/obtain consent	L051A	RN	0.51	20	20	0
19	CA005	Complete pre-procedure phone calls and prescription	L051A	RN	0.51	7	7	4
20	CA006	Confirm availability of prior images/studies	L051A	RN	0.51			
21	CA007	Review patient clinical extant information and questionnaire	L051A	RN	0.51			
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L051A	RN	0.51			
29		End: When patient enters office/facility for surgery/procedure						
30		SERVICE PERIOD						
74	CA036	Discharge day management	L051A	RN	0.51	12	12	12
81		End: Patient leaves office						
82		POST-SERVICE PERIOD						
83		Start: Patient leaves office/facility						
84	CA037	Conduct patient communications	L051A	RN	0.51			
85	CA038	Coordinate post-procedure services	L051A	RN	0.51			
86		Office visits: List Number and Level of Office Visits	MINUTES			# visits	# visits	# visits
87		99211 16 minutes	16					
88		99212 27 minutes	27					
89		99213 36 minutes	36			2	1	1
90		99214 53 minutes	53			1	1	1
91		99215 63 minutes	63					
92	CA039	Post-operative visits (total time)	L051A	RN	0.51	125.0	89.0	89.0
99		End: with last office visit before end of global period						

	A	B	D	E	F	G	H	I
1	RUC Practice Expense Spreadsheet					REFERENCE CODE	CURRENT	RECOMMENDED
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>				33877	33860	33858
3		<u>RUC Collaboration Website</u>						
4	Clinical Activity Code	Meeting Date: 10/2018 Tab: 6 Specialty: STS/ AATS	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute	Repair of thoracoabdominal aortic aneurysm with graft, with or without cardiopulmonary bypass	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic dissection
5		LOCATION				Facility	Facility	Facility
6		GLOBAL PERIOD				090	090	090
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				\$ 109.33	\$ 89.72	\$ 72.89
8		TOTAL CLINICAL STAFF TIME	L051A	RN	0.51	197.0	161.0	128.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L051A	RN	0.51	60.0	60.0	27.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L051A	RN	0.51	12.0	12.0	12.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L051A	RN	0.51	125.0	89.0	89.0
100	Supply Code	MEDICAL SUPPLIES	PRICE	UNIT				
101		TOTAL COST OF SUPPLY QUANTITY x PRICE				\$ 8.49	\$ 7.34	\$ 7.34
102	SA048	pack, minimum multi-specialty visit	1.143	pack		3	2	2
103	SA052	pack, post-op incision care (staple)	5.056	pack		1	1	1
104	SA053	pack, post-op incision care (suture & staple)	6.11	pack				
105								
106								
107								
108		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A						
110	Equipment Code	EQUIPMENT	Purchase Price	Equipment Formula	Cost Per Minute			
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE				\$ 0.37	\$ 0.26	\$ 0.26
112	EF023	table, exam	1338.17		0.002976617	125	89	89
113	EF031	table, power	6153.63		0.016330051			
114	EQ168	light, exam	1630.12		0.004325893			
115								
116								
117								
118		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A						

	A	B	J	K	L	M
1	RUC Practice	Expense Spreadsheet	CURRENT	RECOMMENDED	CURRENT	RECOMMENDED
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>	33860	33859	33863	33863
3		<u>RUC Collaboration Website</u>				
4	Clinical Activity Code	Meeting Date: 10/2018 Tab: 6 Specialty: STS/ AATS	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic disease other than dissection (eg,	Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary	Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary
5		LOCATION	Facility	Facility	Facility	Facility
6		GLOBAL PERIOD	090	090	090	090
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 89.72	\$ 63.99	\$ 70.11	\$ 63.99
8		TOTAL CLINICAL STAFF TIME	161.0	113.0	125.0	113.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	60.0	60.0	60.0	60.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	12.0	0.0	12.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	89.0	53.0	53.0	53.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	\$ 82.11	\$ 57.63	\$ 63.75	\$ 57.63
13		PRE-SERVICE PERIOD				
14		Start: Following visit when decision for surgery or procedure made				
15	CA001	Complete pre-service diagnostic and referral forms	5	5	5	5
16	CA002	Coordinate pre-surgery services (including test results)	20	20	20	20
17	CA003	Schedule space and equipment in facility	8	8	8	8
18	CA004	Provide pre-service education/obtain consent	20	20	20	20
19	CA005	Complete pre-procedure phone calls and prescription	7	7	7	7
20	CA006	Confirm availability of prior images/studies				
21	CA007	Review patient clinical extant information and questionnaire				
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)				
29		End: When patient enters office/facility for surgery/procedure				
30		SERVICE PERIOD				
74	CA036	Discharge day management	12		12	
81		End: Patient leaves office				
82		POST-SERVICE PERIOD				
83		Start: Patient leaves office/facility				
84	CA037	Conduct patient communications				
85	CA038	Coordinate post-procedure services				
86		Office visits: List Number and Level of Office Visits	# visits	# visits	# visits	# visits
87		99211 16 minutes				
88		99212 27 minutes				
89		99213 36 minutes	1			
90		99214 53 minutes	1	1	1	1
91		99215 63 minutes				
92	CA039	Post-operative visits (total time)	89.0	53.0	53.0	53.0
99		End: with last office visit before end of global period				

	A	B	J	K	L	M
1	RUC Practice Expense Spreadsheet		CURRENT	RECOMMENDED	CURRENT	RECOMMENDED
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>	33860	33859	33863	33863
3		<u>RUC Collaboration Website</u>				
4	Clinical Activity Code	Meeting Date: 10/2018 Tab: 6 Specialty: STS/ AATS	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed	Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic disease other than dissection (eg,	Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary	Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary
5		LOCATION	Facility	Facility	Facility	Facility
6		GLOBAL PERIOD	090	090	090	090
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 89.72	\$ 63.99	\$ 70.11	\$ 63.99
8		TOTAL CLINICAL STAFF TIME	161.0	113.0	125.0	113.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	60.0	60.0	60.0	60.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	12.0	0.0	12.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	89.0	53.0	53.0	53.0
100	Supply Code	MEDICAL SUPPLIES				
101		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ 7.34	\$ 6.20	\$ 6.20	\$ 6.20
102	SA048	pack, minimum multi-specialty visit	2	1	1	1
103	SA052	pack, post-op incision care (staple)	1	1	1	1
104	SA053	pack, post-op incision care (suture & staple)				
105						
106						
107						
108		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A				
110	Equipment Code	EQUIPMENT				
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ 0.26	\$ 0.16	\$ 0.16	\$ 0.16
112	EF023	table, exam	89	53	53	53
113	EF031	table, power				
114	EQ168	light, exam				
115						
116						
117						
118		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A				

	A	B	N	O	P	Q
1	RUC Practice Expense Spreadsheet		CURRENT	RECOMMENDED	CURRENT	RECOMMENDED
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>	33864	33864	33870	33871
3		<u>RUC Collaboration Website</u>				
4	Clinical Activity Code	Meeting Date: 10/2018 Tab: 6 Specialty: STS/ AATS	Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub	Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub	Transverse arch graft, with cardiopulmonary bypass	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)
5		LOCATION	Facility	Facility	Facility	Facility
6		GLOBAL PERIOD	090	090	090	090
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 72.10	\$ 63.99	\$ 95.99	\$ 63.99
8		TOTAL CLINICAL STAFF TIME	125.0	113.0	171.0	113.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	60.0	60.0	60.0	60.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	12.0	0.0	12.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	53.0	53.0	99.0	53.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	\$ 63.75	\$ 57.63	\$ 87.21	\$ 57.63
13		PRE-SERVICE PERIOD				
14		Start: Following visit when decision for surgery or procedure made				
15	CA001	Complete pre-service diagnostic and referral forms	5	5	5	5
16	CA002	Coordinate pre-surgery services (including test results)	20	20	20	20
17	CA003	Schedule space and equipment in facility	8	8	8	8
18	CA004	Provide pre-service education/obtain consent	20	20	20	20
19	CA005	Complete pre-procedure phone calls and prescription	7	7	7	7
20	CA006	Confirm availability of prior images/studies				
21	CA007	Review patient clinical extant information and questionnaire				
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)				
29		End: When patient enters office/facility for surgery/procedure				
30		SERVICE PERIOD				
74	CA036	Discharge day management	12		12	
81		End: Patient leaves office				
82		POST-SERVICE PERIOD				
83		Start: Patient leaves office/facility				
84	CA037	Conduct patient communications				
85	CA038	Coordinate post-procedure services				
86		Office visits: List Number and Level of Office Visits	# visits	# visits	# visits	# visits
87		99211 16 minutes				
88		99212 27 minutes			1	
89		99213 36 minutes			2	
90		99214 53 minutes	1	1		1
91		99215 63 minutes				
92	CA039	Post-operative visits (total time)	53.0	53.0	99.0	53.0
99		End: with last office visit before end of global period				

	A	B	N	O	P	Q
1	RUC Practice Expense Spreadsheet		CURRENT	RECOMMENDED	CURRENT	RECOMMENDED
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>	33864	33864	33870	33871
3		<u>RUC Collaboration Website</u>				
4	Clinical Activity Code	Meeting Date: 10/2018 Tab: 6 Specialty: STS/ AATS	Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub	Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, David Procedure, Yacoub	Transverse arch graft, with cardiopulmonary bypass	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)
5		LOCATION	Facility	Facility	Facility	Facility
6		GLOBAL PERIOD	090	090	090	090
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 72.10	\$ 63.99	\$ 95.99	\$ 63.99
8		TOTAL CLINICAL STAFF TIME	125.0	113.0	171.0	113.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	60.0	60.0	60.0	60.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	12.0	0.0	12.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	53.0	53.0	99.0	53.0
100	Supply Code	MEDICAL SUPPLIES				
101		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ 7.25	\$ 6.20	\$ 8.49	\$ 6.20
102	SA048	pack, minimum multi-specialty visit	1	1	3	1
103	SA052	pack, post-op incision care (staple)		1	1	1
104	SA053	pack, post-op incision care (suture & staple)	1			
105						
106						
107						
108		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A				
110	Equipment Code	EQUIPMENT				
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ 1.09	\$ 0.16	\$ 0.29	\$ 0.16
112	EF023	table, exam		53	99	53
113	EF031	table, power	53			
114	EQ168	light, exam	53			
115						
116						
117						
118		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A				

	A	B	R	S
1	RUC Practice Expense Spreadsheet		CURRENT	RECOMMENDED
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>	33866 Jan 2018	33866
3		<u>RUC Collaboration Website</u>		
4	Clinical Activity Code	Meeting Date: 10/2018 Tab: 6 Specialty: STS/ AATS	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	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
5		LOCATION	Facility	Facility
6		GLOBAL PERIOD	ZZZ	ZZZ
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ -	\$ -
8		TOTAL CLINICAL STAFF TIME	0.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	\$ -	\$ -
13		PRE-SERVICE PERIOD		
14		Start: Following visit when decision for surgery or procedure made		
15	CA001	Complete pre-service diagnostic and referral forms		
16	CA002	Coordinate pre-surgery services (including test results)		
17	CA003	Schedule space and equipment in facility		
18	CA004	Provide pre-service education/obtain consent		
19	CA005	Complete pre-procedure phone calls and prescription		
20	CA006	Confirm availability of prior images/studies		
21	CA007	Review patient clinical extant information and questionnaire		
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)		
29		End: When patient enters office/facility for surgery/procedure		
30		SERVICE PERIOD		
74	CA036	Discharge day management		
81		End: Patient leaves office		
82		POST-SERVICE PERIOD		
83		Start: Patient leaves office/facility		
84	CA037	Conduct patient communications		
85	CA038	Coordinate post-procedure services		
86		Office visits: List Number and Level of Office Visits	# visits	# visits
87		99211 16 minutes		
88		99212 27 minutes		
89		99213 36 minutes		
90		99214 53 minutes		
91		99215 63 minutes		
92	CA039	Post-operative visits (total time)	0.0	0.0
99		End: with last office visit before end of global period		

	A	B	R	S
1	RUC Practice Expense Spreadsheet		CURRENT	RECOMMENDED
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>		
3		<u>RUC Collaboration Website</u>		
4	Clinical Activity Code	Meeting Date: 10/2018 Tab: 6 Specialty: STS/ AATS	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	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
5		LOCATION	Facility	Facility
6		GLOBAL PERIOD	ZZZ	ZZZ
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ -	\$ -
8		TOTAL CLINICAL STAFF TIME	0.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0
100	Supply Code	MEDICAL SUPPLIES		
101		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ -	\$ -
102	SA048	pack, minimum multi-specialty visit		
103	SA052	pack, post-op incision care (staple)		
104	SA053	pack, post-op incision care (suture & staple)		
105				
106				
107				
108		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A		
110	Equipment Code	EQUIPMENT		
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ -	\$ -
112	EF023	table, exam		
113	EF031	table, power		
114	EQ168	light, exam		
115				
116				
117				
118		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A		

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2018

Transanal Hemorrhoidal Dearterialization

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 IWPUR for CPT code 46945 and a very low IWPUR 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 IWPUR (-0.04) for 46945 and a low IWPUR (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 appropriate 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 appropriate 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.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery Digestive System Anus <p>For incision of thrombosed external hemorrhoid, use 46083. For ligation of internal hemorrhoid(s), see 46221, 46945, 46946. For excision of internal and/or external hemorrhoid(s), see 46250-46262, 46320. For injection of hemorrhoid(s), use 46500. For destruction of internal hemorrhoid(s) by thermal energy, use 46930. For destruction of hemorrhoid(s) by cryosurgery, use 46999. <u>For transanal hemorrhoidal dearterialization, including ultrasound guidance, with mucopexy when performed, use 46948.</u> For hemorrhoidopexy, use 46947. Do not report 46600 in conjunction with 46020-46947-46942, 0184T, 0249T, 0377T during the same operative session.</p> Incision <p>46020 <i>Placement of seton</i> (Do not report 46020 in addition to 46060, 46280, 46600, 0249T)</p> Excision <p>46221 <i>Hemorrhoidectomy, internal, by rubber band ligation(s)</i> (Do not report 46221 in conjunction with 45350, 45398) (For ligation, hemorrhoidal vascular bundle(s), including ultrasound guidance, use 0249T)</p>				
▲46945	E1	Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group, <u>without imaging guidance</u>	090	3.69

▲46946	E2	2 or more hemorrhoid columns/groups, <u>without imaging guidance</u> (Do not report 46221, 46945, and 46946 in conjunction with 0249T 46948) (Do not report 46945, 46946 in conjunction with 76872, 76942, 76998)	090	4.50
●46948	E3	Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy when performed (Do not report 46948 in conjunction with 76872, 76942, 76998) (For transanal hemorrhoidal dearterialization, single hemorrhoid column/group, use 46999)	090	5.57
<p>#46220 <i>Excision of single external papilla or tag, anus</i></p> <p>46260 <i>Hemorrhoidectomy, internal and external, 2 or more columns/groups;</i></p> <p>46261 <i>with fissurectomy</i></p> <p>46262 <i>with fistulectomy, including fissurectomy, when performed</i></p> <p>(Do not report 46250-46262 in conjunction with 0249T46948)</p> <p>Endoscopy</p> <p>46600 <i>Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)</i></p> <p>(Do not report 46600 in conjunction with 46020-46947, 0184T, 0249T, 0377T during the same operative session)</p>				

Radiology**Diagnostic Ultrasound****Genitalia**

76872 *Ultrasound, transrectal;*

(Do not report 76872 in conjunction with 45341, 45342, 45391, 45392, ~~0249T~~ 46948, 0421T)

Ultrasonic Guidance Procedures

76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*

(Do not report 76942 in conjunction with, 10021, 10030, 19083, 19285, 20604, 20606, 20611, 27096, 32554, 32555, 32556, 32557, 37760, 37761, 43232, 43237, 43242, 45341, 45342, 46948, 55874, 64479, 64480, 64483, 64484, 64490, 64491, 64493, 64494, 64495, 76975, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T, 0228T, 0229T, 0230T, 0231T, 0232T, ~~0249T~~, 0481T)

(For harvesting, preparation, and injection[s] of platelet rich plasma, use 0232T)

Other Procedures

76998 *Ultrasonic guidance, intraoperative*

(Do not report 76998 in conjunction with 36475, 36479, 37760, 37761, 46948, 47370, 47371, 47380, 47381, 47382, ~~0249T~~, 0576T, 0577T, 0578T)

(For ultrasound guidance for open and laparoscopic radiofrequency tissue ablation, use 76940)

Category III

D0249T	-	Ligation, hemorrhoidal vascular bundle(s), including ultrasound guidance (Do not report 0249T in conjunction with 46020, 46221, 46250-46262, 46600, 46945, 46946, 76872, 76942, 76998) (<u>0249T</u> has been deleted. To report, use <u>46948</u>)	YYY	N/A
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AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 46945	Tracking Number E1	Original Specialty Recommended RVU: 3.69
		Presented Recommended RVU: 3.69
Global Period: 090	Current Work RVU: 2.21	RUC Recommended RVU: 3.69

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male with a single symptomatic column of internal hemorrhoids undergoes suture ligation of the hemorrhoidal tissue.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 36% , In the ASC 63%, In the office 1%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 96% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 4%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 100%

Description of Pre-Service Work: The surgeon will select and order the appropriate antibiotic(s) and confirm timing and administration and confirm any necessary pre-operative adjustments to other medications. The patient will be examined, with an interval update to the prior H&P. Pre-admission testing will be reviewed. The indications for the procedure, as well as the operative risks and benefits, are explained to the patient and/or family/caregiver, and informed consent is obtained. The length and type of anesthesia is reviewed with the anesthesiologist. The availability of all necessary instruments and equipment is confirmed. The patient is placed in the prone jackknife position making sure that the all pressure points are well padded and the chest rolls are properly position and a safety strap is placed over the legs. The buttocks are effaced with silk tape to allow better exposure of the anus, then prepped and draped in standard fashion. The surgeon scrubs and gowns. A surgical "time out" with the operating surgical team out is performed. The surgeon injects local anesthesia around the anus and bilaterally into ischioanal fossa to block the pudendal nerves.

Description of Intra-Service Work: After induction of anesthesia, a digital rectal exam is performed. Next, a lubricated operative anoscope is placed in the anal canal. The anoscope is rotated 180° and the obturator is removed. Visual inspection is performed through the anoscope which identifies a single hemorrhoid column. Fecal matter is removed with suction. A Hill Ferguson anal retractor is placed to dilate the anus and the large friable internal hemorrhoid column is isolated. The hemorrhoid column is sutured at the apex, middle and distal portions of the column in order destroy the blood supply to the hemorrhoid (total of three interrupted sutures). Irrigation and suction are performed to remove any remaining blood. At completion of the procedure, the retractor is removed.

Description of Post-Service Work: A small gel foam pack that will be passed by the patient at a later time is placed internally to prevent bleeding. The surgeon assists with repositioning the patient supine. A brief operative note is written. After emergence from anesthesia, the surgeon will answer any patient/family questions and discuss activity restrictions and re-emphasize the use of sitz baths and a diet rich in fluids and fiber to prevent diarrhea and increased frequency of bowel movements that could cause an early disruption of the rectal sutures. The surgeon will write prescriptions for medications (eg, pain, stool softener), reconcile medications, and provide discharge instructions. The procedure, including relevant anatomic findings and follow-up treatment plan are documented in the medical chart with copy to the referring provider. At the first follow-up visit, the surgeon will perform an anoscopic exam (not separately reportable) to determine effectiveness

of treatment and to assess the treated area for infection or sepsis. At a second follow-up visit, the surgeon will perform a digital rectal exam. Scrupulous adherence to a dietary protocol is repeated at every office visit to prevent urinary retention and tenesmus that can be accompanied by a transient sensation of urge to defecate which can disrupt the sutures and cause bleeding. Postoperative care is also strongly directed toward the control of pain. The surgeon will answer any patient/family questions at each visit. The anoscopy findings, digital rectal exam and any changes to the treatment plan are discussed with the patient and documented in the medical chart with copy to the referring provider.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS; Charles Mabry, MD, FACS; Nader Massarweh, MD, FACS				
Specialty(s):	American Society of Colon and Rectal Surgeons; American College of Surgeons				
CPT Code:	46945				
Sample Size:	1800	Resp N:	76	Response: 4.2 %	
Description of Sample:	random - society membership database				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	5.00	13.00	100.00
Survey RVW:	1.80	3.69	4.91	5.42	6.73
Pre-Service Evaluation Time:			25.00		
Pre-Service Positioning Time:			10.00		
Pre-Service Scrub, Dress, Wait Time:			10.00		
Intra-Service Time:	5.00	10.00	15.00	20.00	60.00
Immediate Post Service-Time:	15.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	38.00	99238x 1.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	39.00	99211x 0.00 12x 1.00 13x 1.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the **pre-service time package** that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	46945	Recommended Physician Work RVU: 3.69		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	25.00	33.00	-8.00	
Pre-Service Positioning Time:	10.00	3.00	7.00	
Pre-Service Scrub, Dress, Wait Time:	10.00	15.00	-5.00	
Intra-Service Time:	15.00			
Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) 9B General Anes or Complex Regional Blk/Cmplx Proc				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	15.00	33.00	-18.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>19.00</u>	99238x 0.5	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>39.00</u>	99211x 0.00	12x 1.00	13x 1.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
46270	090	4.92	RUC Time

CPT Descriptor Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
46275	090	5.42	RUC Time

CPT Descriptor Surgical treatment of anal fistula (fistulectomy/fistulotomy); intersphincteric**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
46930	090	1.61	RUC Time	8,894
<u>CPT Descriptor 1</u> Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
33240	090	5.80	RUC Time	462

CPT Descriptor 2 Insertion of implantable defibrillator pulse generator only; with existing single lead

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 19 % of respondents: 25.0 %

Number of respondents who choose 2nd Key Reference Code: 12 % of respondents: 15.7 %

TIME ESTIMATES (Median)

	CPT Code: <u>46945</u>	Top Key Reference CPT Code: <u>46270</u>	2nd Key Reference CPT Code: <u>46275</u>
Median Pre-Service Time	45.00	60.00	60.00
Median Intra-Service Time	15.00	15.00	30.00
Median Immediate Post-service Time	15.00	20.00	20.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	19.0	19.00	19.00
Median Office Visit Time	39.0	55.00	55.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	133.00	169.00	184.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	5%	11%	58%	26%	0%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
26%	53%	21%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	11%	58%	32%
Physical effort required	16%	63%	21%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

5%

58%

37%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

8%

17%

50%

25%

0%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

42%

42%

17%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

17%

58%

25%

Physical effort required

8%

75%

17%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

25%

58%

17%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

Category III code 0249T will be deleted and a new Category I code 46948 will be added to the CPT 2020 code set to describe a hemorrhoidectomy by transanal hemorrhoidal dearterialization of 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy when performed. Current Cat I codes to report a hemorrhoidectomy of one column/group (46945) and 3 or more columns/groups (46946) were revised to indicate "without imaging guidance" to clearly distinguish these codes from 46948.

Compelling Evidence – Codes 46945 and 46946

Flawed Methodology of Previous Valuation in 1995

For the first 5 year review, codes 46945 and 46946 were nominated by the Contractor Medical Directors (CMD) as overvalued:

46945 Ligation of internal hemorrhoids; single procedure
1995 RVW: 3.06 CMD Recommended RVW: 1.90

46946 Ligation of internal hemorrhoids; multiple procedures
1995 RVW: 4.04 CMD Recommended RVW: 2.76

CMD Rationale for Change: This procedure appears overvalued in comparison to hemorrhoidectomy by simple ligature (code 46221, 1.38 RVWs). The Harvard study gives the intraservice and other work for 46221 as being of equal size.

However, as shown in the excerpt below from the Harvard Study, the Harvard pre/post work value for 46945 and 46946 were more than twice the work value for 46221. Similarly, the Harvard intra-work was not of "equal size."

CPT	DESCRIPTOR	Hvd glob	Hvd total work	Hvd Intra work	Hvd P/P work
46221	Ligation of hemorrhoid	010	161	80	81
46945	Ligation of hemorrhoid	090	307	120	187
46946	Ligation of hemorrhoid	090	353	163	190

Source: March 1992 (Harvard Study Phase 3D data) William C. Hsiao, Peter Braun, Daniel Dunn, Edmund Becker, Nancy L. Kelly, Douwe B. Yntema

At the time of review, the specialty society did not have the Harvard Study data above to refute the CMD rationale about the Harvard work values and agreed to the recommended reduction in work RVUs without conducting a survey. The RVW for 46945 was reduced by 38% and the RVW for 46946 by 32% for 1997. **We believe this was a flawed methodology: 1) Misrepresenting Harvard study data; and 2) Comparing total and pre/post work for 90-day global facility codes to the total and pre/post work for a 10-day office code.**

Flawed Methodology of Previous Valuation in 2000

In March 2000, the American College of Surgeons (ACS) submitted a list of 322 general surgery codes as potentially misvalued for review during the second 5 year review in 2000. An alternative approach was provided to review this large number of codes; including expert panel review, NSQIP data, building block methodology and benchmarking. The recommendations included recommendations for both increasing and

decreasing RVWs and also highlighted rank order anomalies. The comment letter and detailed process and recommendation files were forwarded to the RUC for consideration. After a presentation to the Workgroup charged with reviewing this set of codes, the ACS was directed to group the codes into families, choose two or more codes in each family, and conduct a full RUC survey for those codes to validate the RVW recommendations predicted by the proposed alternative methodology.

In August 2000, we submitted SoRs for 32 high volume codes that were surveyed using the traditional RUC survey and a table with data for 282 additional codes for which a mini-survey was performed. The codes that were grouped together were loosely based on similar anatomy and similar work RVWs.

Although we believed that the direction of the Workgroup to conduct full surveys and mini-surveys for groups of codes was meant to validate the recommendations for all codes, the Workgroup instead decided to review the codes that had a traditional full survey and then apply a percent change to all codes in the group based on the change determined for the code with the traditional full survey. Although we could clearly show that the groups were loosely put together and there were rank order anomalies within the groups, the Workgroup maintained that the traditional RUC survey was all they could accept and the application of a percentage change across other codes in the group would maintain relativity.

Codes 46945 and 46946 were included in a group of "Anus/Rectum – Hemorrhoids/Fistula" codes. The RVWs for both codes were decreased by 14% based on the Workgroup recommendation to decrease code 46262 from 8.73 to 7.50. This reduction resulted in a negative IWPOT (-0.04) for 46945 and a low IWPOT (0.03) for 46946. In addition, the Workgroup required that the data from the mini-surveys be used for the time/visit details, resulting in 46945 including two postop office visits and 46946 including only one postop office visit.

We believe applying percentage changes across groups of codes without considering the relativity of the final value both internally and against references was a flawed methodology.

Survey Process

A survey request was sent to a random selection of members from the membership databases of the American College of Surgeons (self-identified as general surgeons) and the American Society of Colon and Rectal Surgeons.

Recommendation - 46945

Work RVU: The survey 25th percentile work RVU of 3.69 is recommended for 46945.

Pre-time Package 3: Straightforward Patient/Difficult Procedure

The procedure is not typically reported with an E/M service.

Evaluation: Subtract 8 minutes to be consistent with the survey median.

Positioning: Add 7 minutes for prone positioning with padding and effacement of buttocks

Scrub, dress, and wait: Subtract 5 minutes to be consistent with the survey median.

Post-time Package 9b: General Anesthesia or Complex Regional Block/Complex Procedure

Subtract 18 minutes to be consistent with the survey median.

Postop Office Visits: 99213: In addition to an evaluation and management service, including (but not limited to) a discussion of pain, diet, and activity restrictions, an anoscopy (not separately reportable) will be performed to assess for postoperative complications which may include delayed bleeding, sepsis, urinary retention, urinary tract infection, and/or fecal impaction. Urinary retention is often due to pain that results in pelvic floor spasms. Sepsis or wound infection may require the removal of all or some of the ligature. All patients undergoing ligation are at potential risk, but it may be greater in those who are immunocompromised, diabetic, and neutropenic. Although this technique has the most postoperative discomfort and pain requiring

management, it has the best long term results with the lowest recurrence rates. 99212: In addition to an evaluation and management service, including (but not limited to) a discussion of pain, diet, and activity restrictions, a digital rectal exam will be performed to assess the wound.

Key Reference Codes

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST	99238	99213	99212
46945	Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group, without ultrasound guidance	3.69	0.027	133	45	15	15	0.5	1	1
46270	Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous	4.92	0.052	169	60	15	10	0.5	1	2
46275	Surgical treatment of anal fistula (fistulectomy/fistulotomy); intersphincteric	5.42	0.042	184	60	30	20	0.5	1	2

MPC Comparison

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST	99238	99213	99212
46930	Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)	1.61	0.047	46	13	5	5		1	
46945	Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group, without ultrasound guidance	3.69	0.027	133	45	15	15	0.5	1	1
33240	Insertion of implantable defibrillator pulse generator only; with existing single lead	5.80	0.074	135	28	45	20	0.5	1	

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 46945

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty colorectal surgery How often? Rarely

Specialty general surgery How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national utilization not available

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 820

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2018v2 RUC database

Specialty colorectal surgery	Frequency 410	Percentage 50.00 %
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Specialty general surgery	Frequency 390	Percentage 47.56 %
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 46945

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 46946	Tracking Number E2	Original Specialty Recommended RVU: 4.50
		Presented Recommended RVU: 4.50
Global Period: 090	Current Work RVU: 2.63	RUC Recommended RVU: 4.50

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male with multiple symptomatic columns of internal hemorrhoids undergoes suture ligation the hemorrhoidal tissue.

Percentage of Survey Respondents who found Vignette to be Typical: 76%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 43% , In the ASC 57%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 91% , Overnight stay-less than 24 hours 6% , Overnight stay-more than 24 hours 3%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 67%

Description of Pre-Service Work: The surgeon will select and order the appropriate antibiotic(s) and confirm timing and administration and confirm any necessary pre-operative adjustments to other medications. The patient will be examined, with an interval update to the prior H&P. Pre-admission testing will be reviewed. The indications for the procedure, as well as the operative risks and benefits, are explained to the patient and/or family/caregiver, and informed consent is obtained. The length and type of anesthesia is reviewed with the anesthesiologist. The availability of all necessary instruments and equipment is confirmed. The patient is placed in the prone jackknife position making sure that the all pressure points are well padded and the chest rolls are properly position and a safety strap is placed over the legs. The buttocks are effaced with silk tape to allow better exposure of the anus, then prepped and draped in standard fashion. The surgeon scrubs and gowns. A surgical "time out" with the operating surgical team out is performed. The surgeon injects local anesthesia around the anus and bilaterally into ischioanal fossa to block the pudendal nerves.

Description of Intra-Service Work: After induction of anesthesia, a digital rectal exam is performed. Next, a lubricated operative anoscope is placed in the anal canal. The anoscope is rotated 180° and the obturator is removed. Visual inspection is performed through the anoscope which identifies three hemorrhoid columns; right anterior, left lateral and right posterior. Fecal matter is removed with suction. A Hill Ferguson anal retractor is placed to dilate the anus and the first large friable internal hemorrhoid column is isolated and sutured at the apex, middle and distal portions of the column in order destroy the blood supply to the hemorrhoid (total of three interrupted sutures). Irrigation and suction are performed to remove blood. The retractor is moved and this process is repeated on the other two columns. At completion of the procedure, the retractor is removed.

Description of Post-Service Work: A small gel foam pack that will be passed by the patient at a later time is placed internally to prevent bleeding. The surgeon assists with repositioning the patient supine. A brief operative note is written. After emergence from anesthesia, the surgeon will answer any patient/family questions and discuss activity restrictions and re-emphasize the use of sitz baths and a diet rich in fluids and fiber to prevent diarrhea and increased frequency of bowel movements that could cause an early disruption of the rectal sutures. The surgeon will write prescriptions for medications (eg, pain, stool softener), reconcile medications, and provide discharge instructions. The procedure, including relevant anatomic findings and follow-up treatment plan are documented in the medical chart with copy to the referring provider. At

the first follow-up visit, the surgeon will perform an anoscopic exam (not separately reportable) to determine effectiveness of treatment and to assess the treated area for infection or sepsis. At a second follow-up visit, the surgeon will perform a digital rectal exam. Scrupulous adherence to a dietary protocol is repeated at every office visit to prevent urinary retention and tenesmus that can be accompanied by a transient sensation of urge to defecate which can disrupt the sutures and cause bleeding. Postoperative care is also strongly directed toward the control of pain. The surgeon will answer any patient/family questions at each visit. The anoscopy findings, digital rectal exam and any changes to the treatment plan are discussed with the patient and documented in the medical chart with copy to the referring provider.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS; Charles Mabry, MD, FACS; Nader Massarweh, MD, FACS				
Specialty(s):	American Society of Colon and Rectal Surgeons; American College of Surgeons				
CPT Code:	46946				
Sample Size:	1800	Resp N:	79	Response: 4.3 %	
Description of Sample:	random - society membership database				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	6.00	20.00	66.00
Survey RVW:	2.50	4.50	5.50	6.00	8.00
Pre-Service Evaluation Time:			30.00		
Pre-Service Positioning Time:			10.00		
Pre-Service Scrub, Dress, Wait Time:			10.00		
Intra-Service Time:	9.00	16.00	25.00	30.00	60.00
Immediate Post Service-Time:	15.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	38.00	99238x 1.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	39.00	99211x 0.00 12x 1.00 13x 1.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	46946	Recommended Physician Work RVU: 4.50		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	30.00	33.00	-3.00	
Pre-Service Positioning Time:	10.00	3.00	7.00	
Pre-Service Scrub, Dress, Wait Time:	10.00	15.00	-5.00	
Intra-Service Time:	25.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) 9B General Anes or Complex Regional Blk/Cmplx Proc				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	15.00	33.00	-18.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>19.00</u>	99238x 0.5	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>39.00</u>	99211x 0.00	12x 1.00	13x 1.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
46947	090	5.57	RUC Time

CPT Descriptor Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids) by stapling**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
46270	090	4.92	RUC Time

CPT Descriptor Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
46930	090	1.61	RUC Time	8,894

CPT Descriptor 1 Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
33240	090	5.80	RUC Time	462

CPT Descriptor 2 Insertion of implantable defibrillator pulse generator only; with existing single lead

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 16 % of respondents: 20.2 %

Number of respondents who choose 2nd Key Reference Code: 10 % of respondents: 12.6 %

TIME ESTIMATES (Median)

	CPT Code: <u>46946</u>	Top Key Reference CPT Code: <u>46947</u>	2nd Key Reference CPT Code: <u>46270</u>
Median Pre-Service Time	50.00	60.00	60.00
Median Intra-Service Time	25.00	30.00	15.00
Median Immediate Post-service Time	15.00	22.00	20.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	19.0	19.00	19.00
Median Office Visit Time	39.0	39.00	55.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	148.00	170.00	169.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	19%	50%	25%	6%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
19%	56%	25%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	25%	44%	31%
Physical effort required	19%	56%	25%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

13%

63%

25%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

10%

40%

50%

0%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

20%

30%

50%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

10%

40%

50%

Physical effort required

0%

60%

40%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

30%

40%

30%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

Category III code 0249T will be deleted and a new Category I code 46948 will be added to the CPT 2020 code set to describe a hemorrhoidectomy by transanal hemorrhoidal dearterialization of 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy when performed. Current Cat I codes to report a hemorrhoidectomy of one column/group (46945) and 3 or more columns/groups (46946) were revised to indicate "without imaging guidance" to clearly distinguish these codes from 46948.

Compelling Evidence – Codes 46945 and 46946

Flawed Methodology of Previous Valuation in 1995

For the first 5 year review, codes 46945 and 46946 were nominated by the Contractor Medical Directors (CMD) as overvalued:

46945 Ligation of internal hemorrhoids; single procedure
1995 RVW: 3.06 CMD Recommended RVW: 1.90

46946 Ligation of internal hemorrhoids; multiple procedures
1995 RVW: 4.04 CMD Recommended RVW: 2.76

CMD Rationale for Change: This procedure appears overvalued in comparison to hemorrhoidectomy by simple ligation (code 46221, 1.38 RVWs). The Harvard study gives the intraservice and other work for 46221 as being of equal size.

However, as shown in the excerpt below from the Harvard Study, the Harvard pre/post work value for 46945 and 46946 were more than twice the work value for 46221. Similarly, the Harvard intra-work was not of "equal size."

CPT	DESCRIPTOR	Hvd glob	Hvd total work	Hvd Intra work	Hvd P/P work
46221	Ligation of hemorrhoid	010	161	80	81
46945	Ligation of hemorrhoid	090	307	120	187
46946	Ligation of hemorrhoid	090	353	163	190

Source: March 1992 (Harvard Study Phase 3D data) William C. Hsiao, Peter Braun, Daniel Dunn, Edmund Becker, Nancy L. Kelly, Douwe B. Yntema

At the time of review, the specialty society did not have the Harvard Study data above to refute the CMD rationale about the Harvard work values and agreed to the recommended reduction in work RVUs without conducting a survey. The RVW for 46945 was reduced by 38% and the RVW for 46946 by 32% for 1997. **We believe this was a flawed methodology: 1) Misrepresenting Harvard study data; and 2) Comparing total and pre/post work for 90-day global facility codes to the total and pre/post work for a 10-day office code.**

Flawed Methodology of Previous Valuation in 2000

In March 2000, the American College of Surgeons (ACS) submitted a list of 322 general surgery codes as potentially misvalued for review during the second 5 year review in 2000. An alternative approach was provided to review this large number of codes; including expert panel review, NSQIP data, building block methodology and benchmarking. The recommendations included recommendations for both increasing and

decreasing RVWs and also highlighted rank order anomalies. The comment letter and detailed process and recommendation files were forwarded to the RUC for consideration. After a presentation to the Workgroup charged with reviewing this set of codes, the ACS was directed to group the codes into families, choose two or more codes in each family, and conduct a full RUC survey for those codes to validate the RVW recommendations predicted by the proposed alternative methodology.

In August 2000, we submitted SoRs for 32 high volume codes that were surveyed using the traditional RUC survey and a table with data for 282 additional codes for which a mini-survey was performed. The codes that were grouped together were loosely based on similar anatomy and similar work RVWs.

Although we believed that the direction of the Workgroup to conduct full surveys and mini-surveys for groups of codes was meant to validate the recommendations for all codes, the Workgroup instead decided to review the codes that had a traditional full survey and then apply a percent change to all codes in the group based on the change determined for the code with the traditional full survey. Although we could clearly show that the groups were loosely put together and there were rank order anomalies within the groups, the Workgroup maintained that the traditional RUC survey was all they could accept and the application of a percentage change across other codes in the group would maintain relativity.

Codes 46945 and 46946 were included in a group of "Anus/Rectum – Hemorrhoids/Fistula" codes. The RVWs for both codes were decreased by 14% based on the Workgroup recommendation to decrease code 46262 from 8.73 to 7.50. This reduction resulted in a negative IWPOT (-0.04) for 46945 and a low IWPOT (0.03) for 46946. In addition, the Workgroup required that the data from the mini-surveys be used for the time/visit details, resulting in 46945 including two postop office visits and 46946 including only one postop office visit.

We believe applying percentage changes across groups of codes without considering the relativity of the final value both internally and against references was a flawed methodology.

Survey Process

A survey request was sent to a random selection of members from the membership databases of the American College of Surgeons (self-identified as general surgeons) and the American Society of Colon and Rectal Surgeons.

Recommendation - 46946

Work RVU: The survey 25th percentile work RVU of 4.50 is recommended for 46946.

Pre-time Package 3: Straightforward Patient/Difficult Procedure

The procedure is not typically reported with an E/M service.

Evaluation: Subtract 3 minutes to be consistent with the survey median.

Positioning: Add 7 minutes for prone positioning with padding and effacement of buttocks

Scrub, dress, and wait: Subtract 5 minutes to be consistent with the survey median.

Post-time Package 9b: General Anesthesia or Complex Regional Block/Complex Procedure

Subtract 18 minutes to be consistent with the survey median.

Postop Office Visits: 99213: In addition to an evaluation and management service, including (but not limited to) a discussion of pain, diet, and activity restrictions, an anoscopy (not separately reportable) will be performed to assess for postoperative complications which may include delayed bleeding, sepsis, urinary retention, urinary tract infection, and/or fecal impaction. Urinary retention is often due to pain that results in pelvic floor spasms. Sepsis or wound infection may require the removal of all or some of the ligature. All patients undergoing ligation are at potential risk, but it may be greater in those who are immunocompromised, diabetic, and neutropenic. Although this technique has the most postoperative discomfort and pain requiring

management, it has the best long term results with the lowest recurrence rates. 99212: In addition to an evaluation and management service, including (but not limited to) a discussion of pain, diet, and activity restrictions, a digital rectal exam will be performed to assess the wound.

Key Reference Codes

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST	99238	99213	99212
46946	Hemorrhoidectomy, internal, by ligation other than rubber band; 2 or more hemorrhoid columns/groups, without ultrasound guidance	4.50	0.044	148	50	25	15	0.5	1	1
46270	Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous	4.92	0.052	169	60	15	10	0.5	1	2
46947	Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids) by stapling	5.57	0.060	170	60	30	22	0.5	1	1

MPC Comparison

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST	99238	99213	99212
46930	Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)	1.61	0.047	46	13	5	5		1	
46946	Hemorrhoidectomy, internal, by ligation other than rubber band; 2 or more hemorrhoid columns/groups, without ultrasound guidance	4.50	0.044	148	50	25	15	0.5	1	1
33240	Insertion of implantable defibrillator pulse generator only; with existing single lead	5.80	0.074	135	28	45	20	0.5	1	

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 46946

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty colorectal surgery How often? Sometimes

Specialty general surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national utilization not available

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,398

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2018v2 RUC database

Specialty colorectal surgery	Frequency 1100	Percentage 45.87 %
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Specialty general surgery	Frequency 725	Percentage 30.23 %
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 46946

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 46948	Tracking Number E3	Original Specialty Recommended RVU: 5.57
		Presented Recommended RVU: 5.57
Global Period: 090	Current Work RVU:	RUC Recommended RVU: 5.57

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male with a long history of bright red rectal bleeding due to grade III internal hemorrhoids undergoes ultrasound-guided hemorrhoidal artery ligation with mucopexy as required.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 46% , In the ASC 54%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 97% , Overnight stay-less than 24 hours 3% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The surgeon will select and order the appropriate antibiotic(s) and confirm timing and administration and confirm any necessary pre-operative adjustments to other medications. The patient will be examined, with an interval update to the prior H&P. Pre-admission testing will be reviewed. The indications for the procedure, as well as the operative risks and benefits, are explained to the patient and/or family/caregiver, and informed consent is obtained. The length and type of anesthesia is reviewed with the anesthesiologist. The availability of all necessary instruments and equipment is confirmed. The patient is placed in the prone jackknife position making sure that the all pressure points are well padded and the chest rolls are properly position and a safety strap is placed over the legs. The buttocks are effaced with silk tape to allow better exposure of the anus, then prepped and draped in standard fashion. The surgeon scrubs and gowns. A surgical "time out" with the operating surgical team out is performed. The surgeon injects local anesthesia around the anus and bilaterally into ischioanal fossa to block the pudendal nerves.

Description of Intra-Service Work: After induction of anesthesia, a digital rectal exam is performed. Next, a lubricated n anoscope with an ultrasound probe attachment and equipped to deliver sutures is inserted into the anus. Visual inspection is performed. 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. At completion of the procedure, the anoscope with ultrasound probe attachment is removed.

Description of Post-Service Work: A small gel foam pack that will be passed by the patient at a later time is placed internally to prevent bleeding. The surgeon assists with repositioning the patient supine. A brief operative note is written. After emergence from anesthesia, the surgeon will answer any patient/family questions and discuss activity restrictions and re-emphasize the use of sitz baths and a diet rich in fluids and fiber to prevent diarrhea and increased frequency of bowel

movements that could cause an early disruption of the rectal sutures. The surgeon will write prescriptions for medications (eg, pain, stool softener), reconcile medications, and provide discharge instructions. The procedure, including relevant anatomic findings and follow-up treatment plan are documented in the medical chart with copy to the referring provider. At the first follow-up visit, the surgeon will perform an anoscopic exam (not separately reportable) to determine effectiveness of treatment and to assess the treated area for infection or sepsis. At a second follow-up visit, the surgeon will perform a digital rectal exam. Scrupulous adherence to a dietary protocol is repeated at every office visit to prevent urinary retention and tenesmus that can be accompanied by a transient sensation of urge to defecate which can disrupt the sutures and cause bleeding. Postoperative care is also strongly directed toward the control of pain. The surgeon will answer any patient/family questions at each visit. The anoscopy findings, digital rectal exam and any changes to the treatment plan are discussed with the patient and documented in the medical chart with copy to the referring provider.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Steve Sentovich, MD, FACS; Guy Orangio, MD, FACS; Charles Mabry, MD, FACS; Nader Massarweh, MD, FACS				
Specialty(s):	American Society of Colon and Rectal Surgeons; American College of Surgeons				
CPT Code:	46948				
Sample Size:	1800	Resp N:	74	Response: 4.1 %	
Description of Sample:	random - society membership database				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	5.00	12.00	50.00
Survey RVW:	3.25	5.57	6.00	6.80	8.00
Pre-Service Evaluation Time:			30.00		
Pre-Service Positioning Time:			10.00		
Pre-Service Scrub, Dress, Wait Time:			10.00		
Intra-Service Time:	15.00	28.00	40.00	45.00	90.00
Immediate Post Service-Time:	15.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	38.00	99238x 1.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	39.00	99211x 0.00 12x 1.00 13x 1.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the **pre-service time package** that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

3-FAC Straightforward Patient/Difficult Procedure

CPT Code:	46948	Recommended Physician Work RVU: 5.57		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	30.00	33.00	-3.00	
Pre-Service Positioning Time:	10.00	3.00	7.00	
Pre-Service Scrub, Dress, Wait Time:	10.00	15.00	-5.00	
Intra-Service Time:	40.00			
Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) 9B General Anes or Complex Regional Blk/Cmplx Proc				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	15.00	33.00	-18.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>19.00</u>	99238x 0.5	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>39.00</u>	99211x 0.00	12x 1.00	13x 1.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
46947	090	5.57	RUC Time

CPT Descriptor Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids) by stapling**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
46280	090	6.39	RUC Time

CPT Descriptor Surgical treatment of anal fistula (fistulectomy/fistulotomy); transsphincteric, suprasphincteric, extrasphincteric or multiple, including placement of seton, when performed**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
46930	090	1.61	RUC Time	8,894

CPT Descriptor 1 Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
33240	090	5.80	RUC Time	462

CPT Descriptor 2 Insertion of implantable defibrillator pulse generator only; with existing single lead

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 25 % of respondents: 33.7 %

Number of respondents who choose 2nd Key Reference Code: 15 % of respondents: 20.2 %

TIME ESTIMATES (Median)

	CPT Code: <u>46948</u>	Top Key Reference CPT Code: <u>46947</u>	2nd Key Reference CPT Code: <u>46280</u>
Median Pre-Service Time	50.00	60.00	60.00
Median Intra-Service Time	40.00	30.00	45.00
Median Immediate Post-service Time	15.00	22.00	20.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	19.0	19.00	19.00
Median Office Visit Time	39.0	39.00	55.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	163.00	170.00	199.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	12%	36%	44%	8%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
16%	48%	36%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	4%	44%	52%
Physical effort required	8%	52%	40%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

24%

40%

36%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More****Overall intensity/complexity**

7%

7%

27%

33%

27%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

13%

27%

60%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

7%

33%

60%

Physical effort required

7%

40%

53%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

20%

13%

67%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

Category III code 0249T will be deleted and a new Category I code 46948 will be added to the CPT 2020 code set to describe a hemorrhoidectomy by transanal hemorrhoidal dearterialization of 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy when performed. Current Cat I codes to report a hemorrhoidectomy of one column/group (46945) and 3 or more columns/groups (46946) were revised to indicate "without imaging guidance" to clearly distinguish these codes from 46948.

Survey Process

A survey request was sent to a random selection of members from the membership databases of the American College of Surgeons (self-identified as general surgeons) and the American Society of Colon and Rectal Surgeons.

Recommendation – 46948

Work RVU: The survey 25th percentile work RVU of 5.57 is recommended for 46948.

Pre-time Package 3: Straightforward Patient/Difficult Procedure

The procedure is not typically reported with an E/M service.

Evaluation: Subtract 3 minutes to be consistent with the survey median.

Positioning: Add 7 minutes for prone positioning with padding and effacement of buttocks

Scrub, dress, and wait: Subtract 5 minutes to be consistent with the survey median.

Post-time Package 9b: General Anesthesia or Complex Regional Block/Complex Procedure

Subtract 18 minutes to be consistent with the survey median.

Postop Office Visits: 99213: In addition to an evaluation and management service, including (but not limited to) a discussion of pain, diet, and activity restrictions, an anoscopy (not separately reportable) will be performed to assess for postoperative complications which may include delayed bleeding, sepsis, urinary retention, urinary tract infection, and/or fecal impaction. Urinary retention is often due to pain that results in pelvic floor spasms. Sepsis or wound infection may require the removal of all or some of the ligature. All patients undergoing ligation are at potential risk, but it may be greater in those who are immunocompromised, diabetic, and neutropenic. Although this technique has the most postoperative discomfort and pain requiring management, it has the best long term results with the lowest recurrence rates. 99212: In addition to an evaluation and management service, including (but not limited to) a discussion of pain, diet, and activity restrictions, a digital rectal exam will be performed to assess the wound.

Key Reference Codes

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST	99238	99213	99212
46948	Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy when performed	5.57	0.054	163	50	40	15	0.5	1	1
46947	Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids) by stapling	5.57	0.060	170	60	30	22	0.5	1	1
46280	Surgical treatment of anal fistula (fistulectomy/fistulotomy); transsphincteric, suprasphincteric, extrasphincteric or multiple, including placement of seton, when performed	6.39	0.050	199	60	45	20	0.5	1	2

MPC Comparison

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST	99238	99213	99212
46930	Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)	1.61	0.047	46	13	5	5		1	
46948	Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy when performed	5.57	0.054	163	50	40	15	0.5	1	1
33240	Insertion of implantable defibrillator pulse generator only; with existing single lead	5.80	0.074	135	28	45	20	0.5	1	

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 0249T

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty colorectal surgery How often? Sometimes

Specialty general surgery How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national utilization not available

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,100
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2018v2 RUC database utilization for 0249T multiplied by four. Rationale: Payers often deny claims for Category III codes. In 2016, over 400 claims were submitted to Medicare, but only 271 were paid. When the new Category I code is available for reporting, the paid claims will likely increase.

Specialty colorectal surgery	Frequency 440	Percentage 40.00 %
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Specialty general surgery	Frequency 660	Percentage 60.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 46270

ISSUE: Transanal Hemorrhoidal Dearterialization

TAB: 7

SOURCE	CPT	DESC	Resp	IWPUT	RVW				Total Time	PRE			INTRA				POST SD	POST-FAC		POST-OFFICE					
					MIN	25th	MED	75th		MAX	EVAL	POSIT	SDW	MIN	25th	MED		75th	MAX	38	39	15	14	13	12
REF1	46270	Surgical treatment of anal fistula (fistulectomy)	19	0.052			4.92			169	30	15	15			15			20	0.5				1	2
REF2	46275	Surgical treatment of anal fistula (fistulectomy)	12	0.042			5.42			184	30	15	15			30			20	0.5				1	2
current	46945	Hemorrhoidectomy, internal, by ligation other than rubber band		-0.039			2.21			114	30					15			30					1	1
SVY	46945	Hemorrhoidectomy, internal, by ligation other than rubber band	76	0.065	1.80	3.69	4.91	5.42	6.73	152	25	10	10	5	10	15	20	60	15	1.0				1	1
REC	46945	25th percentile		0.027			3.69			133	25	10	10			15			15	0.5				1	1

REF1	46947	Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids)	16	0.060			5.57			170	40	10	10			30			22	0.5				1	1
REF2	46270	Surgical treatment of anal fistula (fistulectomy)	10	0.052			4.92			169	30	15	15			15			20	0.5				1	2
current	46946	Hemorrhoidectomy, internal, by ligation other than rubber band		0.032			2.63			101	30					25			30						1
SVY	46946	Hemorrhoidectomy, internal, by ligation other than rubber band	79	0.058	2.50	4.50	5.50	6.00	8.00	167	30	10	10	9	16	25	30	60	15	1.0				1	1
REC	46946	25th percentile		0.044			4.50			148	30	10	10			25			15	0.5				1	1

REF1	46947	Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids)	25	0.060			5.57			170	40	10	10			30			22	0.5				1	1
REF2	46280	Surgical treatment of anal fistula (fistulectomy)	15	0.050			6.39			199	30	15	15			45			20	0.5				1	2
NEW	0249T	Ligation, hemorrhoidal vascular bundle(s), internal		n/a																					
SVY	46948	Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization	74	0.049	3.25	5.57	6.00	6.80	8.00	182	30	10	10	15	28	40	45	90	15	1.0				1	1
REC	46948	25th percentile		0.054			5.57			163	30	10	10			40			15	0.5				1	1

REVISED 9-24-18
AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT CODE / DESCRIPTOR		GLOBAL
46945	Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group, without imaging guidance	090
46946	Hemorrhoidectomy, internal, by ligation other than rubber band; 2 or more hemorrhoid columns/groups, without imaging guidance	090
46948	Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy when performed	090

Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel: [The ASCRS and ACS Advisors reviewed the clinical aspects of these codes and facility practice expense inputs for 46945 and 46946.](#)
2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here: [Facility inputs for 46945 and 46946 are referenced along with 10-day global code 46500, specifically for the inputs related to one postop visit. The PE SC and CMS approved the details for 46500 in 2014 and again in the recent CY 2019 proposed rule.](#)
3. Is this code(s) typically billed with an E/M service? [No](#)
4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: [N/A](#)
5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: [When 46945 and 46946 were reviewed in 2003, the PE Subcommittee and the specialties did not report the time \(setting up and cleaning scope\), supplies related to anoscopy and equipment related to an anoscopy performed at a followup postop office visit. These details have since been established, in 2014 and more recently by CMS in the proposed rule for 2019 \(code 46500\).](#)
6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: [N/A](#)
7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: [N/A](#)
8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: [N/A](#)
10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: [N/A](#)
11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

The first POV will be performed in a procedure room because an anoscopy will be performed.

The second POV will be performed in an exam room.

Therefore, the surgical light, anoscopy equipment and suction machine will be used during the first POV. At the second POV, the exam room will have an exam light, not a surgical light. For both visits, general and colorectal surgeons have power tables in all rooms - both procedure and exam.

Time for set-up and cleaning the scope equipment has been added where appropriate for the first POV.

			46945	46946	46948
EF014	light, surgical	Other Formula	=L87+L88-27	=P87+P88-27	=R87+R88-27
EQ168	light, exam	Other Formula	=27	=27	=27
EF031	table, power	Other Formula	=L87+L88	=P87+P88	=R87+R88
ES002	anoscope with light source	Other Formula	=L87+L88+L89-27	=P87+P88+P89-27	=R87+R88+R89-27
EQ235	suction machine (Gomco)	Other Formula	=L87+L88-27	=P87+P88-27	=R87+R88-27

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: [N/A](#)
13. If there is any other item on your spreadsheet that needs further explanation please include here: [A surgeon's office will typically have and use a non-disposable anoscope with light source equipment item for anoscopy procedures \(both diagnostic and therapeutic\) performed in the office. Therefore, we have recommended deleting the disposable anoscope and separate xenon light source with ES002 \(anoscope with light source\).](#)
14. Please include an explanation of each line item:

		2003	REC	2003	REC	REC	
		49945	46945	46946	46946	46948	
	Global	090	090	090	090	090	
	LOCATION	Fac	Fac	Fac	Fac	Fac	
code	PRE-SERVICE PERIOD						
CA001	Complete pre-service diagnostic and referral forms	5	5	5	5	5	standard 90-day global
CA002	Coordinate pre-surgery services (including test results)	20	20	20	20	20	standard 90-day global
CA003	Schedule space and equipment in facility	8	8	8	8	8	standard 90-day global
CA004	Provide pre-service education/obtain consent	20	20	20	20	20	standard 90-day global
CA005	Complete pre-procedure phone calls and prescription	7	7	7	7	7	standard 90-day global
code	SERVICE PERIOD						
CA036	Discharge day management	6	6	6	6	6	standard 90-day global for same day discharge
code	POST-SERVICE PERIOD						

CPT Code 46945, 46946, 46948
Specialty Society ASCRS, ACS

		2003	REC	2003	REC	REC	
		49945	46945	46946	46946	46948	
	Global LOCATION	090	090	090	090	090	
		Fac	Fac	Fac	Fac	Fac	
	99212 27 minutes	1	1	1	1	1	office visits per survey
	99213 36 minutes	1	1		1	1	office visits per survey
CA045	Setup scope at global postoperative office visit		5		5	5	postop visit anoscopy not separately reportable
CA046	Clean scope at global postoperative office visit		5		5	5	postop visit anoscopy not separately reportable
code	MEDICAL SUPPLIES						
SA048	pack, minimum multi-specialty visit	2	2	1	2	2	one pack at each postop office visit
SB027	gown, staff, impervious		1		1	1	necessary for anoscopy exam at first postop office visit
SB034	mask, surgical, with face shield		1		1	1	necessary for anoscopy exam at first postop office visit
SD009	canister, suction		1		1	1	necessary for anoscopy exam at first postop office visit
SD132	tubing, suction, non-latex (6ft uou)		1		1	1	necessary for anoscopy exam at first postop office visit
SD134	tubing, suction, non-latex (6ft) with Yankauer tip (1)		1		1	1	necessary for anoscopy exam at first postop office visit
SH069	sodium chloride 0.9% irrigation (500-1000ml uou)		1		1	1	necessary for anoscopy exam at first postop office visit
SC056	syringe 50-60ml		1		1	1	necessary for anoscopy exam at first postop office visit
SJ009	basin, irrigation		1		1	1	necessary for anoscopy exam at first postop office visit
SJ032	lubricating jelly (K-Y) (5gm uou)	4	5	4	5	5	4 packs with anoscopy at first postop office visit and 1 pack for digital rectal exam at second postop office visit
SA042	pack, cleaning and disinfecting, endoscope	1	1	1	1	1	necessary for anoscopy exam at first postop office visit
SJ052	swab, procto 16in	3	3	3	3	3	necessary for anoscopy exam at first postop office visit
SD003	anoscope	1		1			delete and replace with ES002
code	EQUIPMENT						
EF014	light, surgical	66	41	30	41	41	first visit plus time to set up scope
EQ168	light, exam		27		27	27	second postop visit
EF031	table, power	66	68	30	68	68	both postop office visits
ES002	anoscope with light source		46		46	46	first visit plus time to set up scope and to clean scope
EQ235	suction machine (Gomco)		41		41	41	first visit plus time to set up scope
EQ167	light source, xenon	39		30			delete and replace with ES002

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT CODE / DESCRIPTOR	GLOBAL
46945 Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group, without imaging guidance	090
46946 Hemorrhoidectomy, internal, by ligation other than rubber band; 2 or more hemorrhoid columns/groups, without imaging guidance	090
46948 Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy when performed	090

Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel: The ASCRS and ACS Advisors reviewed the clinical aspects of these codes and claims data.

When the practice expense for codes 46945 and 46946 were last reviewed in March 2003, the code descriptors were not clear and many considered these codes similar if not synonymous with rubber band ligation, just for larger or multiple hemorrhoids. As such, codes 46945 and 46946 were reviewed in tandem with many procedures performed in an office setting and priced in the office setting.

For CPT 2010, the code descriptors for 46221 and 46945/46946 were revised to clarify that 46221 was to be reported for single or multiple banding using rubber bands (10-day global office-based procedure) and that code 46945/46946 were for ligation of column(s)/group(s) not using banding (90-day global facility-based procedures). Codes 46945/46946 were also moved to the excision subsection of Anus in CPT.

Despite the CPT coding changes in 2010 and several CPT Assistant "frequently asked question" articles, we believe there is miscoding of 46945 and 46946 in the office for procedures that should correctly be reported with codes for other techniques. This is based on a review of Medicare claims data that indicate almost 60% of the office based claims for both codes comes from only a few providers in New York and Florida. In fact a single provider submitted 193 office claims for 118 patients in one year. These are not procedures that would be "repeated."

Based on this research and expert panel discussion, along with the fact that these procedures will require sedation, most commonly general anesthesia but never just local anesthesia, ***we are not recommending pricing for the non-facility (office) setting.***

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here: N/A
3. Is this code(s) typically billed with an E/M service? N/A
Is this code(s) typically billed with the E/M service in the nonfacility? N/A
(Please see provided data in PE Subcommittee folder)
4. What specialty is the dominant provider in the nonfacility? N/A
What percent of the time does the dominant provider provide the service(s) in the nonfacility? N/A

Is the dominant provider in the nonfacility different then for the global? N/A
(Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: N/A
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time. N/A
7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: N/A
8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code)
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:
N/A
9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*: N/A
10. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. N/A
11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: N/A
12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.
13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: N/A
14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: N/A
15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here: N/A
16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: N/A
17. If there is any other item on your spreadsheet that needs further explanation please include here: N/A
18. Please include an explanation of each line item: N/A

	A	B	E	H	I	J	K	L	M	N	O							
1	RUC Practice Expense Spreadsheet			REFERENCE CODE	CURRENT		RECOMMENDED		CURRENT		RECOMMENDED							
2		REVISED 9-24-2018		46500 PE approved 01/18	46945		46945		46946		46946							
3		RUC Collaboration Website		Injection of sclerosing solution, hemorrhoids	Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid		Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid		Hemorrhoidectomy, internal, by ligation other than rubber band; 2 or more hemorrhoid		Hemorrhoidectomy, internal, by ligation other than rubber band; 2 or more hemorrhoid							
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 7 Specialty: ASCRS, ACS	Clinical Staff Type															
5		LOCATION										Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD										010	090	090	090	090	090	090
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME		\$ 55.33	\$ 127.96	\$ 72.54	\$ -	\$ 85.20	\$ 116.95	\$ 57.01	\$ -							
8		TOTAL CLINICAL STAFF TIME	RN/LPN/MTA	64	145	132	0	139	119	96	0							
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	RN/LPN/MTA	12	35	60	0	60	35	60	0							
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	RN/LPN/MTA	6	44	6	0	6	54	6	0							
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	RN/LPN/MTA	46	66	66	0	73	30	30	0							
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE		\$ 19.98	\$ 53.65	\$ 48.84	\$ -	\$ 47.73	\$ 44.03	\$ 35.52	\$ -							
13	PRE-SERVICE PERIOD																	
14		Start: Following visit when decision for surgery or procedure made																
15	CA001	Complete pre-service diagnostic and referral forms	RN/LPN/MTA	3	5	5		5	5	5								
16	CA002	Coordinate pre-surgery services (including test results)	RN/LPN/MTA	3	10	20		20	10	20								
17	CA003	Schedule space and equipment in facility	RN/LPN/MTA	3		8		8		8								
18	CA004	Provide pre-service education/obtain consent	RN/LPN/MTA		10	20		20	10	20								
19	CA005	Complete pre-procedure phone calls and prescription	RN/LPN/MTA	3	10	7		7	10	7								
29	End: When patient enters office/facility for surgery/procedure																	
30	SERVICE PERIOD																	
31		Start: When patient enters office/facility for surgery/procedure:																
32	Pre-Service (of service period)																	
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	RN/LPN/MTA		6				6									
34	CA010	Obtain vital signs	RN/LPN/MTA		3				3									
35	CA011	Provide education/obtain consent	RN/LPN/MTA															
36	CA013	Prepare room, equipment and supplies	RN/LPN/MTA		2				2									
37	CA015	Setup scope (nonfacility setting only)	RN/LPN/MTA															
38	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	RN/LPN/MTA		2				2									
39	CA017	Sedate/apply anesthesia	RN/LPN/MTA		2				2									
46	Intra-service (of service period)																	
47	CA018	Assist physician or other qualified healthcare professional---directly	RN/LPN/MTA		15				25									
54	Post-Service (of service period)																	
55	CA022	Monitor patient following procedure/service, multitasking 1:4	RN/LPN/MTA															
56	CA023	Monitor patient following procedure/service, no multitasking	RN/LPN/MTA		3				3									
57	CA024	Clean room/equipment by clinical staff	RN/LPN/MTA		3				3									
58	CA025	Clean scope	RN/LPN/MTA		5				5									
59	CA026	Clean surgical instrument package	RN/LPN/MTA															
62	CA029	Check dressings, catheters, wounds	RN/LPN/MTA		1				3									
68	CA035	Review home care instructions, coordinate visits/prescriptions	RN/LPN/MTA		2													
69	CA036	Discharge day management	RN/LPN/MTA	6	n/a	6	n/a	6	n/a	6	n/a							
76	End: Patient leaves office																	
77	POST-SERVICE PERIOD																	
78	Start: Patient leaves office/facility																	
79	CA037	Conduct patient communications	RN/LPN/MTA		3	3			3	3								
80	CA038	Coordinate post-procedure services	RN/LPN/MTA															
81	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits							
82		99211 16 minutes																
83		99212 27 minutes			1	1		1	1	1								
84		99213 36 minutes		1	1	1		1										
85		99214 53 minutes																
86		99215 63 minutes																
87	CA039	Post-operative visits (total time)	RN/LPN/MTA	36.0	63.0	63.0	0.0	63.0	27.0	27.0	0.0							
88	CA045	Setup scope at global postoperative office visit		5				5										
89	CA046	Clean scope at global postoperative office visit		5				5										
93	Other activity: please include short clinical description here and type																	
94	End: with last office visit before end of global period																	

	A	B	E	H	I	J	K	L	M	N	O								
1	RUC Practice Expense Spreadsheet			REFERENCE CODE	CURRENT		RECOMMENDED		CURRENT		RECOMMENDED								
2		REVISED 9-24-2018		46500 PE approved 01/18	46945		46945		46946		46946								
3		RUC Collaboration Website		Injection of sclerosing solution, hemorrhoids	Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid		Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid		Hemorrhoidectomy, internal, by ligation other than rubber band; 2 or more hemorrhoid		Hemorrhoidectomy, internal, by ligation other than rubber band; 2 or more hemorrhoid								
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 7 Specialty: ASCRS, ACS	Clinical Staff Type																
5		LOCATION										Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac
6		GLOBAL PERIOD										010	090	090	090	090	090	090	090
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME		\$ 55.33	\$127.96	\$ 72.54	\$ -	\$ 85.20	\$116.95	\$ 57.01	\$ -								
8		TOTAL CLINICAL STAFF TIME	RN/LPN/MTA	64	145	132	0	139	119	96	0								
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	RN/LPN/MTA	12	35	60	0	60	35	60	0								
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	RN/LPN/MTA	6	44	6	0	6	54	6	0								
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	RN/LPN/MTA	46	66	66	0	73	30	30	0								
95	Supply	MEDICAL SUPPLIES	UNIT																
96		TOTAL COST OF SUPPLY QUANTITY x PRICE		\$ 34.02	\$ 68.91	\$ 20.89	\$ -	\$ 35.58	\$ 67.77	\$ 19.74	\$ -								
97	SA048	pack, minimum multi-specialty visit	pack	1	3	2		2	2	1									
98	SB027	gown, staff, impervious	item	1	2			1	2										
99	SB034	mask, surgical, with face shield	item	1	2			1	2										
100	SD009	canister, suction	item	1	1			1	1										
101	SD132	tubing, suction, non-latex (6ft uou)	item	1	1			1	1										
102	SD134	tubing, suction, non-latex (6ft) with Yankauer tip (1)	item	1	1			1	1										
103	SH069	sodium chloride 0.9% irrigation (500-1000ml uou)	item	1				1											
104	SC056	syringe 50-60ml	item	1				1											
105	SJ009	basin, irrigation	item	1				1											
106	SJ032	lubricating jelly (K-Y) (5gm uou)	item	4	8	4		5	8	4									
107	SA042	pack, cleaning and disinfecting, endoscope	pack	1	2	1		1	2	1									
108	SJ052	swab, procto 16in	item		6	3		3	6	3									
109	SB001	cap, surgical	item		2				2										
110	SB039	shoe covers, surgical	pair		2				2										
111	SC029	needle, 18-27g	item		2				2										
112	SC051	syringe 10-12ml	item		2				2										
113	SD003	anoscope	item		2	1			2	1									
114	SF015	cautery, monopolar, blade, extended shaft	item		1				1										
115	SF020	cautery, monopolar, pencil-handpiece	item		1				1										
116	SF021	cautery, patient ground pad w-cord	item		1				1										
117	SG050	gauze, non-sterile 2in x 2in	item		8				8										
118	SH046	lidocaine 1% w-epi inj (Xylocaine w-epi)	ml		30				30										
119	SJ010	basin, emesis	item		1				1										
120	SJ053	swab-pad, alcohol	item		2				2										
121	SL036	cup, biopsy-specimen sterile 4oz	item		1				1										
122		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A																	
124	Equipment Code	EQUIPMENT	Equipment Formula																
125		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE		\$ 1.34	\$ 5.40	\$ 2.82	\$ -	\$ 1.89	\$ 5.15	\$ 1.75	\$ -								
126	EF014	light, surgical	Other Formula	41	110	66		41	84	30									
127	EQ168	light, exam	Other Formula					27	84	30									
128	EF031	table, power	Other Formula	41	110	66		68	84	30									
129	ES002	anoscope with light source	Other Formula	46				46											
130	EQ235	suction machine (Gomco)	Other Formula	41	44			41	54										
131	EQ110	electrocautery-hyfreicator, up to 45 watts			44				54										
132	EQ167	light source, xenon			83	39			84	30									
133		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A																	

	A	B	P	Q	R
1	RUC Practice Expense Spreadsheet		RECOMMENDED	RECOMMENDED	
2		REVISED 9-24-2018	946	46948	
3		RUC Collaboration Website	idectomy,	Hemorrhoidectomy,	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 7 Specialty: ASCRS, ACS	by ligation in rubber or more rrhoid	internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid	
5		LOCATION	Facility	Non Fac	Facility
6		GLOBAL PERIOD	090	090	090
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 85.20	\$ -	\$ 85.20
8		TOTAL CLINICAL STAFF TIME	139	0	139
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	60	0	60
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	6	0	6
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	73	0	73
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	\$ 47.73	\$ -	\$ 47.73
13		PRE-SERVICE PERIOD			
14		Start: Following visit when decision for surgery or procedure made			
15	CA001	Complete pre-service diagnostic and referral forms	5		5
16	CA002	Coordinate pre-surgery services (including test results)	20		20
17	CA003	Schedule space and equipment in facility	8		8
18	CA004	Provide pre-service education/obtain consent	20		20
19	CA005	Complete pre-procedure phone calls and prescription	7		7
29		End: When patient enters office/facility for surgery/procedure			
30		SERVICE PERIOD			
31		Start: When patient enters office/facility for surgery/procedure:			
32		Pre-Service (of service period)			
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are			
34	CA010	Obtain vital signs			
35	CA011	Provide education/obtain consent			
36	CA013	Prepare room, equipment and supplies			
37	CA015	Setup scope (nonfacility setting only)			
38	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient			
39	CA017	Sedate/apply anesthesia			
46		Intra-service (of service period)			
47	CA018	Assist physician or other qualified healthcare professional---directly			
54		Post-Service (of service period)			
55	CA022	Monitor patient following procedure/service, multitasking 1:4			
56	CA023	Monitor patient following procedure/service, no multitasking			
57	CA024	Clean room/equipment by clinical staff			
58	CA025	Clean scope			
59	CA026	Clean surgical instrument package			
62	CA029	Check dressings, catheters, wounds			
68	CA035	Review home care instructions, coordinate visits/prescriptions			
69	CA036	Discharge day management	6	n/a	6
76		End: Patient leaves office			
77		POST-SERVICE PERIOD			
78		Start: Patient leaves office/facility			
79	CA037	Conduct patient communications			
80	CA038	Coordinate post-procedure services			
81		Office visits: List Number and Level of Office Visits	# visits	# visits	# visits
82		99211 16 minutes			
83		99212 27 minutes	1		1
84		99213 36 minutes	1		1
85		99214 53 minutes			
86		99215 63 minutes			
87	CA039	Post-operative visits (total time)	63.0	0.0	63.0
88	CA045	Setup scope at global postoperative office visit	5		5
89	CA046	Clean scope at global postoperative office visit	5		5
93		Other activity: please include short clinical description here and type			
94		End: with last office visit before end of global period			

	A	B	P	Q	R
1	RUC Practice Expense Spreadsheet		RECOMMENDED	RECOMMENDED	
2		REVISED 9-24-2018	946	46948	
3		RUC Collaboration Website	idectomy,	Hemorrhoidectomy,	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 7 Specialty: ASCRS, ACS	by ligation in rubber or more rrhoid	internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid	
5		LOCATION	Facility	Non Fac	Facility
6		GLOBAL PERIOD	090	090	090
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 85.20	\$ -	\$ 85.20
8		TOTAL CLINICAL STAFF TIME	139	0	139
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	60	0	60
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	6	0	6
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	73	0	73
95	Supply	MEDICAL SUPPLIES			
96		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ 35.58	\$ -	\$ 35.58
97	SA048	pack, minimum multi-specialty visit	2		2
98	SB027	gown, staff, impervious	1		1
99	SB034	mask, surgical, with face shield	1		1
100	SD009	canister, suction	1		1
101	SD132	tubing, suction, non-latex (6ft uou)	1		1
102	SD134	tubing, suction, non-latex (6ft) with Yankauer tip (1)	1		1
103	SH069	sodium chloride 0.9% irrigation (500-1000ml uou)	1		1
104	SC056	syringe 50-60ml	1		1
105	SJ009	basin, irrigation	1		1
106	SJ032	lubricating jelly (K-Y) (5gm uou)	5		5
107	SA042	pack, cleaning and disinfecting, endoscope	1		1
108	SJ052	swab, procto 16in	3		3
109	SB001	cap, surgical			
110	SB039	shoe covers, surgical			
111	SC029	needle, 18-27g			
112	SC051	syringe 10-12ml			
113	SD003	anoscope			
114	SF015	cautery, monopolar, blade, extended shaft			
115	SF020	cautery, monopolar, pencil-handpiece			
116	SF021	cautery, patient ground pad w-cord			
117	SG050	gauze, non-sterile 2in x 2in			
118	SH046	lidocaine 1% w-epi inj (Xylocaine w-epi)			
119	SJ010	basin, emesis			
120	SJ053	swab-pad, alcohol			
121	SL036	cup, biopsy-specimen sterile 4oz			
122		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A			
124	Equipment Code	EQUIPMENT			
125		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ 1.89	\$ -	\$ 1.89
126	EF014	light, surgical	41		41
127	EQ168	light, exam	27		27
128	EF031	table, power	68		68
129	ES002	anoscope with light source	46		46
130	EQ235	suction machine (Gomco)	41		41
131	EQ110	electrocautery-hyfreacator, up to 45 watts			
132	EQ167	light source, xenon			
133		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A			

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2018

Preperitoneal Pelvic Packing

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*;

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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.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery Digestive System Abdomen, Peritoneum, and Omentum Incision				
49000		<i>Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)</i> <i>(To report wound exploration due to penetrating trauma without laparotomy, use 20102)</i>		
49002		<i>Reopening of recent laparotomy</i> <i>(To report re-exploration of hepatic wound for removal of packing, use 47362)</i> <u><i>(To report re-exploration of pelvic wound for removal including repacking when performed, use 49014)</i></u>		
49010		<i>Exploration, retroperitoneal area with or without biopsy(s) (separate procedure)</i> <i>(To report wound exploration due to penetrating trauma without laparotomy, use 20102)</i>		
●49013	F1	Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration	000	8.35
●49014	F2	Re-exploration of pelvic wound with removal of preperitoneal pelvic packing including repacking, when performed	000	6.73

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 49013	Tracking Number F1	Original Specialty Recommended RVU: 8.35
		Presented Recommended RVU: 8.35
Global Period: 000	Current Work RVU:	RUC Recommended RVU: 8.35

CPT Descriptor: Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male presents following pelvic trauma with evidence of continued active hemorrhage in the pelvis. Angiographic evaluation is not readily available and hypotension persists despite active resuscitation. Preperitoneal pelvic packing and local exploration is performed

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The surgeon will review any relevant labs and imaging available. The surgeon will then coordinate taking the patient to the operating room with anesthesia and other surgical specialties that may also be involved with this trauma patient, including orthopedic surgery, thoracic surgery and/or neurosurgery. This coordination will include a discussion of the sequence, timing, and scope of the procedures along with supportive measures that may be needed, such as massive transfusion protocols. The surgeon will order and confirm pre-operative antibiotics. The length and type of anesthesia are reviewed with the anesthesiologist, including the possibility for an emergent laparotomy or thoracotomy. The availability of all required instruments and supplies is verified, including instruments and supplies that may be needed for a potential thoracotomy or laparotomy. Assistance is provided in the transfer of the patient from the gurney to the operating table. The patient is positioned supine and the abdomen is marked and prepped from the groin to the clavicles in order to reach the thorax and abdomen if an emergent laparotomy or thoracotomy is needed. The surgeon scrubs and gowns. The surgical area is draped. A surgical time-out is performed with the operating surgical team and anesthesia team.

Description of Intra-Service Work: A Pfannenstiel low horizontal incision is made just above the pubic rim. The upper edge of the pubic bone is palpated, a low transverse incision with detachment of the rectus muscles from their insertion on the rami pubic is made, and dissection is then carried out until the urinary bladder is identified. Without opening the peritoneum, the urinary bladder is retracted to one side while blunt dissection is manually carried out onto the iliacus muscle. Identification of the extra-peritoneal bladder is critical as is a retraction of the urinary bladder to the contralateral side in order to directly approach the presacral vessels. Packing is directed downward and posteriorly while sliding down the urinary bladder directing the surgeon's fingers posteriorly and deep into the true pelvis, reaching posteriorly until the sacroiliac joint is palpated. Surgical abdominal pads are then firmly packed via this route down into the sacroiliac joint. The abdominal pads are directed toward the pelvic venous plexus and branches of the internal iliac artery, which are in close proximity to the sacrum and pelvic bones. Considerable pressure is mandatory in this packing maneuver, so that the abdominal pads are firmly packed on the pelvic ring from the sacrum to the pelvic rim, thus creating pressure directly onto the presacral vessels. The same maneuver is then repeated on the contralateral side of the bladder. Care is taken to avoid compression of the femoral vessels. After controlling the pelvic bleeding and once the patient's vital signs improve, drains are placed and the incision is closed with temporary sutures.

Description of Post-Service Work: Sterile dressings are applied. The patient is monitored during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough. Assistance is

provided in transfer of the patient from the operating table to a gurney. The patient is monitored for hemodynamic stability until and during transfer to the intensive care unit (ICU). Postoperative recovery care is discussed with ICU staff. Extensive postoperative orders for medications, imaging, and laboratory tests are written in the patient's chart. Procedure and outcome are discussed with family, if available. A brief operative note is written. A complete operative report is dictated. Monitoring for hemodynamic stability continues.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Charles Mabry, MD FACS; Nader Massarweh, MD FACS				
Specialty(s):	American College of Surgeons; Excelsior Surgical Society; American Association for the Surgery of Trauma				
CPT Code:	49013				
Sample Size:	1780	Resp N:	38	Response: 2.1 %	
Description of Sample:	Random selection from: -American College of Surgeons (members self-designated as trauma/critical care and members in the Excelsior Surgical Society) -American Association for the Surgery of Trauma				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	2.00	4.00	10.00
Survey RVW:	6.50	8.00	8.35	13.75	15.00
Pre-Service Evaluation Time:			30.00		
Pre-Service Positioning Time:			10.00		
Pre-Service Scrub, Dress, Wait Time:			10.00		
Intra-Service Time:	20.00	35.00	45.00	60.00	90.00
Immediate Post Service-Time:	60.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	49013	Recommended Physician Work RVU: 8.35		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	30.00	40.00	-10.00	
Pre-Service Positioning Time:	10.00	3.00	7.00	
Pre-Service Scrub, Dress, Wait Time:	10.00	20.00	-10.00	
Intra-Service Time:	45.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended post time should not exceed your survey median time)				
9B General Anes or Complex Regional Blk/Cmplx Proc				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	60.00	33.00	27.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37244	000	13.75	RUC Time

CPT Descriptor 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

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31603	000	6.00	RUC Time

CPT Descriptor Tracheostomy, emergency procedure; transtracheal

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
52354	000	8.00	RUC Time	8,777

CPT Descriptor 1 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
37244	000	13.75	RUC Time	10,941

CPT Descriptor 2 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

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 11 % of respondents: 28.9 %

Number of respondents who choose 2nd Key Reference Code: 7 % of respondents: 18.4 %

TIME ESTIMATES (Median)

	CPT Code: 49013	Top Key Reference CPT Code: 37244	2nd Key Reference CPT Code: 31603
Median Pre-Service Time	50.00	31.00	45.00
Median Intra-Service Time	45.00	90.00	30.00
Median Immediate Post-service Time	60.00	45.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	155.00	166.00	105.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	9%	0%	27%	64%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
0%	9%	91%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	18%	18%	64%
Physical effort required	0%	9%	94%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%

0%

100%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More****Overall intensity/complexity**

0%

0%

14%

57%

29%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

0%

0%

100%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

0%

57%

43%

Physical effort required

0%

29%

71%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%

57%

43%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In 2014, the American College of Surgeons (ACS) and the U.S. Department of Defense Military Health System (MHS) formed the Military Health System Strategic Partnership American College of Surgeons (MHSSPACS) to improve educational opportunities, systems-based practices, and research capabilities in surgery. Although some trauma-related procedures are not common in the United States, members of the MHSSPACS have indicated that CPT codes are used

by the U.S. military medical personnel to indicate work performed at military bases and on the battle field around the world. For CPT 2020, the CPT Editorial Panel approved a new CPT Category I code to report preperitoneal pelvic packing without the need for a laparotomy. This procedure may be performed when angioembolization services are not available or not available in a timely manner. A second code was approved for removal that will occur on a subsequent day, if the patient survives.

Survey Process

A survey request was sent to: 1) A random selection of ACS members who self-designated as trauma or critical care surgeons; 2) A random selection of U.S. member of the American Association for the Surgery of Trauma; and 3) A random selection of members of the Excelsior Surgical Society (These surgeons are ACS members who are currently serving on active duty in a branch of the US Uniformed Medical Service; currently active or inactive Armed Forces Reserve or National Guard; or are retired or discharged under honorable conditions from a US Uniformed Medical Service after at least one year of service.) A majority of respondents had experience with these procedures in the past 12 months. Because preperitoneal pelvic packing has been widely disseminated as part of the educational curriculum of trauma courses such as the American College of Surgeons' Committee on Trauma ASSET course, those who did not have recent experience are likely familiar with the procedure.

Recommendation – 49013

Work RVU: The survey median work RVU of 8.35 is recommended for 49013.

Pre-time Package 4: Difficult Patient/Difficult Procedure

Evaluation: Subtract 10 minutes to be consistent with the survey median and to acknowledge the urgent nature of this service. This is the same evaluation time recently approved for a similarly urgent procedure (31603).

Positioning: Seven minutes has been added to the time for patient positioning. 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 operation will likely have a pelvic c-clamp for stabilization and other injuries that need to be considered while positioning the patient.

Scrub, dress, and wait: Subtract 10 minutes to be consistent with the survey median and to acknowledge the urgent nature of this service. This is the same evaluation time recently approved for a similarly urgent procedure (31603).

Post-time Package 9b: General Anesthesia or Complex Regional Block/Complex Procedure

Add 27 minutes for a total of 60 minutes. Postoperatively, the patient's hemodynamic status will be monitored very closely for more than the 10 minutes included in the package for monitoring patient recover. Significant coordination with other treating physicians (eg, orthopaedic) and ICU staff will be necessary. Time for this activity is not included in the postop package. Order entry will take more than 5 minutes. Our expert panel agrees that 60 minutes of postoperative work on the day of this procedure is a minimum.

Key Reference Codes

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
31603	Tracheostomy, emergency procedure; transtracheal	6.00	0.149	105	45	30	30
49013	Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration	8.35	0.134	155	50	45	60
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	13.75	0.135	166	31	90	45

MPC Comparison

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
52354	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion	8.00	0.110	133	53	60	20
49013	Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration	8.35	0.134	155	50	45	60
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	13.75	0.135	166	31	90	45

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☒ Other reason (please explain) Critical care services may be separately reported, when performed. Also, depending on the patient presentation, other procedures and services may also be performed

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 48500

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. This will be a low volume code. We request assignment of "general surgery" as the single anticipated specialty.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 49014	Tracking Number F2	Original Specialty Recommended RVU: 6.73
		Presented Recommended RVU: 6.73
Global Period: 000	Current Work RVU:	RUC Recommended RVU: 6.73

CPT Descriptor: Re-exploration of pelvic wound with removal of preperitoneal pelvic packing including repacking, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male is returned to the operating room one or more days following initial preperitoneal packing for active hemorrhage to have the packing removed.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is;
Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The appropriate antibiotic(s) are selected and ordered, and timing and administration are confirmed. Recent lab tests and imaging are reviewed. The planned procedure and postoperative management are reviewed with the patient and family. Informed consent is obtained. The length and type of anesthesia are reviewed with the anesthesiologist. The availability of all required instruments and supplies is verified, including instruments and supplies that may be needed for a potential laparotomy. Assistance is provided in the transfer of the patient from the gurney to the operating table. The surgical area is prepped and draped. The surgeon scrubs and gowns. A surgical time-out is performed with operating surgical team and anesthesia team.

Description of Intra-Service Work: The previous incision is opened and the wound is debrided as needed. The packing is carefully removed, one pad at a time to confirm bleeding has been controlled. Local exploration and irrigation is performed with each pad removal. The wound is closed in layers with drains inserted as required.

Description of Post-Service Work: Sterile dressings are applied. The patient is monitored during reversal of anesthesia, protecting the wound with a hand so that wound disruption does not occur with an unrestrained cough. Assistance is provided in transfer of the patient from the operating table to a gurney. Postoperative recovery care is discussed with surgical floor staff. Postoperative orders for medications, imaging, and laboratory tests are written. Procedure and outcome are discussed with the family. A brief operative note is written. An operative report is dictated.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Charles Mabry, MD FACS; Nader Massarweh, MD FACS				
Specialty(s):	American College of Surgeons; Excelsior Surgical Society; American Association for the Surgery of Trauma				
CPT Code:	49014				
Sample Size:	1780	Resp N:	38	Response: 2.1 %	
Description of Sample:	Random selection from: -American College of Surgeons (members self-designated as trauma/critical care and members in the Excelsior Surgical Society) -American Association for the Surgery of Trauma				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	2.00	4.00	10.00
Survey RVW:	4.50	5.70	6.73	8.73	14.00
Pre-Service Evaluation Time:			45.00		
Pre-Service Positioning Time:			10.00		
Pre-Service Scrub, Dress, Wait Time:			15.00		
Intra-Service Time:	20.00	30.00	45.00	60.00	100.00
Immediate Post Service-Time:	30.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	49014	Recommended Physician Work RVU: 6.73		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	40.00	40.00	0.00	
Pre-Service Positioning Time:	3.00	3.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	15.00	20.00	-5.00	
Intra-Service Time:	45.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
9B General Anes or Complex Regional Blk/Cmplx Proc				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	30.00	33.00	-3.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37193	000	7.10	RUC Time

CPT Descriptor 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

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31600	000	5.50	RUC Time

CPT Descriptor Tracheostomy, planned (separate procedure);

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
52351	000	5.75	RUC Time	22,573

CPT Descriptor 1 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
52352	000	6.75	RUC Time	24,504

CPT Descriptor 2 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 11 **% of respondents:** 28.9 %

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 23.6 %

TIME ESTIMATES (Median)

	CPT Code: 49014	Top Key Reference CPT Code: 37193	2nd Key Reference CPT Code: 31600
Median Pre-Service Time	58.00	31.00	60.00
Median Intra-Service Time	45.00	45.00	30.00
Median Immediate Post-service Time	30.00	15.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	133.00	91.00	120.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	36%	64%	0%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
9%	27%	64%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	36%	55%	9%

Physical effort required	9%	36%	55%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

9%	27%	64%
----	-----	-----

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	22%	33%	44%	0%
------------------------------	----	-----	-----	-----	----

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

22%	44%	33%
-----	-----	-----

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	67%	22%	11%
--------------------------	-----	-----	-----

Physical effort required	22%	33%	44%
--------------------------	-----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

33%	44%	22%
-----	-----	-----

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In 2014, the American College of Surgeons (ACS) and the U.S. Department of Defense Military Health System (MHS) formed the Military Health System Strategic Partnership American College of Surgeons (MHSSPACS) to improve

educational opportunities, systems-based practices, and research capabilities in surgery. Although some trauma-related procedures are not common in the United States, members of the MHSSPACS have indicated that CPT codes are used by the U.S. military medical personnel to indicate work performed at military bases and on the battle field around the world. For CPT 2020, the CPT Editorial Panel approved a new CPT Category I code to report preperitoneal pelvic packing without the need for a laparotomy. This procedure may be performed when angioembolization services are not available or not available in a timely manner. A second code was approved for removal that will occur on a subsequent day, if the patient survives.

Survey Process

A survey request was sent to: 1) A random selection of ACS members who self-designated as trauma or critical care surgeons; 2) A random selection of U.S. member of the American Association for the Surgery of Trauma; and 3) A random selection of members of the Excelsior Surgical Society (These surgeons are ACS members who are currently serving on active duty in a branch of the US Uniformed Medical Service; currently active or inactive Armed Forces Reserve or National Guard; or are retired or discharged under honorable conditions from a US Uniformed Medical Service after at least one year of service.) A majority of respondents had experience with these procedures in the past 12 months. Because preperitoneal pelvic packing has been widely disseminated as part of the educational curriculum of trauma courses such as the American College of Surgeons' Committee on Trauma ASSET course, those who did not have recent experience are likely familiar with the procedure.

Recommendation – 49014

Work RVU: A survey median work RVU of 6.73 is recommended for 49014.

Pre-time Package 4: Difficult Patient/Difficult Procedure

Evaluation: Standard package time of 40 minutes.

Positioning: Standard package time of 3 minutes for supine positioning.

Scrub, dress, and wait: Subtract 10 minutes to be consistent with the survey median..

Post-time Package 9b: General Anesthesia or Complex Regional Block/Complex Procedure

Subtract 3 minutes to be consistent with the survey median.

Key Reference Codes

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
31600	Tracheostomy, planned (separate procedure);	5.56	0.123	120	60	30	30
49014	Re-exploration of pelvic wound with removal of preperitoneal pelvic packing including repacking, when performed	6.73	0.111	133	58	45	30
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	7.10	0.136	91	31	45	15

MPC Comparison

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
52351	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic	5.75	0.096	118	53	45	20
49014	Re-exploration of pelvic wound with removal of preperitoneal pelvic packing including repacking, when performed	6.73	0.111	133	58	45	30
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)	6.75	0.118	118	53	45	20

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49999 Unlisted procedure, abdomen, peritoneum and omentum

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty general surgery How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national utilization not available

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 25 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Less than 0.25% of the Medicare utilization for 49999 may be reported with new codes 490X1 and 490X2. High energy pelvic trauma is not typical for the Medicare-age population. The typical clinical scenario requiring this service includes motor vehicle accidents, acts of terrorism, and battlefield injuries. The technique for performing preperitoneal pelvic packing has been widely disseminated as part of the educational curriculum of trauma courses such as the American College of Surgeons' Committee on Trauma ASSET course.

Specialty general surgery	Frequency 25	Percentage 100.00 %
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Specialty	Frequency	Percentage	%
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 48500

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. This will be a low volume code. We request assignment of "general surgery" as the single anticipated specialty.

ISSUE: Preperitoneal Pelvic Packing

TAB: 8

SOURCE	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE			INTRA					POST P-SD
					MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	
REF1	37244	Vascular embolization or occlusion, inclusive of all	11	0.135			13.75			166	23	3	5			90			45
REF2	31603	Tracheostomy, emergency procedure; transtracheal	7	0.149			6.00			105	30	5	10			30			30
current	NEW			N/A						n/a									
SVY	49013	Preperitoneal pelvic packing for hemorrhage assoc	38	0.134	6.50	8.00	8.35	13.75	15.00	155	30	10	10	20	35	45	60	90	60
REC	49013	MEDIAN		0.134			8.35			155	30	10	10			45			60

REF1	37193	Retrieval (removal) of intravascular vena cava filter	11	0.136			7.10			91	23	3	5			45			15
REF2	31600	Tracheostomy, planned (separate procedure);	9	0.123			5.56			120	40	10	10			30			30
current	NEW			N/A						n/a									
SVY	49014	Re-exploration of pelvic wound with removal of pre	38	0.104	4.50	5.70	6.73	8.73	14.00	145	45	10	15	20	30	45	60	100	30
REC	49014	MEDIAN		0.111			6.73			133	40	3	15			45			30

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor:

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

Global Period: 000 Meeting Date: October 2018

****No direct practice expense inputs recommended****

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:
2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:
3. Is this code(s) typically billed with an E/M service?
4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence:
6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:
7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:
8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.
9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:
10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:
11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:
13. If there is any other item on your spreadsheet that needs further explanation please include here:
14. Please include an explanation of each line item:

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor:

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

Global Period: 000 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

The ACS convened an expert panel familiar with 49014 and similar services to determine appropriate practice expense inputs.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Code 31600 has been used as a reference—this is also the 2nd key reference service from the RUC survey. Similar to 49014, code 31600 is a planned major operation that will be performed on a patient who is already hospitalized and has a 0-day global assignment.

3. Is this code(s) typically billed with an E/M service? No
4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

Code 49014 is a planned major operation performed in an OR under general anesthesia. We recommend the 0-day standard package for extensive use of clinical staff minus the time for providing pre-service education and follow-up phone calls to the patient since the typical patient is already in the hospital. This is the same time (20 minutes) that was approved by the PEAC recently for reference code 31600.

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: N/A
6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: N/A
7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: N/A
8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: N/A
10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: N/A
11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here: N/A
12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: N/A
13. If there is any other item on your spreadsheet that needs further explanation please include here: N/A
14. Please include an explanation of each line item: N/A

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor:

- | | |
|-------|---|
| 49013 | Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration |
| 49014 | Re-exploration of pelvic wound with removal of preperitoneal pelvic packing including repacking, when performed |

Global Period: 000 Meeting Date: October 2018

****No direct practice expense inputs recommended****

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:
2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:
3. Is this code(s) typically billed with an E/M service?
Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)
4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different then for the global?
(Please see provided data in PE Subcommittee folder)
5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.
7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:
8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code)
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:
9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly*

related to physician work time or Perform procedure/service---NOT directly related to physician work time:

10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:
12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.
13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:
14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:
15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:
16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:
17. If there is any other item on your spreadsheet that needs further explanation please include here:
18. Please include an explanation of each line item:

	A	B	G	H	I	J	K	L
1	RUC Practice Expense Spreadsheet		REFERENCE CODE		RECOMMENDED		RECOMMENDED	
2		C. For more complete information about summaries and guidelines	31600		49013		49014	
3		RUC Collaboration Website	Tracheostomy, planned (separate procedure);		Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma,		Re-exploration of pelvic wound with removal of preperitoneal pelvic packing including	
4	Clinical Activity Code	Meeting Date: 10/2018 Tab: 8 Specialty: ACS						
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	N/A	000	N/A	000	N/A	000
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ -	\$ 7.40	\$ -	\$ -	\$ -	\$ 7.40
8		TOTAL CLINICAL STAFF TIME	0	20	0	0	0	20
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0	20	0	0	0	20
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0	0	0	0	0	0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0	0	0	0	0	0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	\$ -	\$ 7.40	\$ -	\$ -	\$ -	\$ 7.40
13		PRE-SERVICE PERIOD						
14		Start: Following visit when decision for surgery or procedure made						
15	CA001	Complete pre-service diagnostic and referral forms		5				5
16	CA002	Coordinate pre-surgery services (including test results)		10				10
17	CA003	Schedule space and equipment in facility		5				5
18	CA004	Provide pre-service education/obtain consent						
19	CA005	Complete pre-procedure phone calls and prescription						
29		End: When patient enters office/facility for surgery/procedure						
30		SERVICE PERIOD						
82		POST-SERVICE PERIOD						

	A	B	G	H	I	J	K	L
1	RUC Practice Expense Spreadsheet		REFERENCE CODE		RECOMMENDED		RECOMMENDED	
2		C. For more complete information about summaries and guidelines	31600		49013		49014	
3		<u>RUC Collaboration Website</u>	Tracheostomy, planned (separate procedure);		Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma,		Re-exploration of pelvic wound with removal of preperitoneal pelvic packing including	
4	Clinical Activity Code	Meeting Date: 10/2018 Tab: 8 Specialty: ACS						
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	N/A	000	N/A	000	N/A	000
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ -	\$ 7.40	\$ -	\$ -	\$ -	\$ 7.40
8		TOTAL CLINICAL STAFF TIME	0	20	0	0	0	20
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0	20	0	0	0	20
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0	0	0	0	0	0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0	0	0	0	0	0
100	Supply	MEDICAL SUPPLIES						
	Equipme	EQUIPMENT						
110	nt Code							

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2018

Somatic Nerve Injection

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 IWPUTs. **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.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>Nervous System Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic</p> <p><i>(For destruction by neurolytic agent or chemodenervation, see 62280-62282, 64600-64681)</i></p> <p><i>(For epidural or subarachnoid injection, see 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327)</i></p> <p><i>(64400-64455, 64461, 64462, 64463, 64479, 64480, 64483, 64484, 64490-64495 are unilateral procedures. For bilateral procedures, use modifier 50)</i></p> <p>Somatic Nerves</p> <p><u>Codes 64400-64489 describe the introduction/injection of an anesthetic agent and/or steroid into the somatic nervous system for diagnostic or therapeutic purposes. For injection or destruction of genicular nerve branches, see 644X0, 644X1.</u></p> <p><u>Codes 64400-64450, 644X0 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.</u></p>				

Image guidance (ultrasound, fluoroscopy, CT) and any injection of contrast are inclusive components of 644X0.

Codes 64455, 64479, 64480, 64483, 64484 are reported for a single or multiple injections at the same site. For 64479, 64480, 64483, 64484, image guidance (fluoroscopy or CT) and any injection of contrast are inclusive components and are not reported separately. For 64455, image guidance (ultrasound, fluoroscopy, CT) and localization may be reported separately.

Codes 64461, 64462, 64463 describe injection of a paravertebral block (PVB). Codes 64486, 64487, 64488, 64489 describe injection of a transversus abdominis plane (TAP) block. Image guidance and any injection of contrast are inclusive components of 64461, 64462, 64463 and 64486, 64487, 64488, 64489 and are not reported separately.

▲ 64400	H1	Injection(s), anesthetic agent(s) <u>and/or steroid</u> ; trigeminal nerve, <u>each any division or branch (ie, ophthalmic, maxillary, mandibular)</u>	000	1.00
D64402	-	facial nerve (64402 has been deleted. To report injection of anesthetic agent and/or steroid to the facial nerve, use 64999)	000	N/A (2018 work RVU = 1.25)
▲ 64405	H2	greater occipital nerve	000	0.94 (Affirmed April 2017 RUC Recommendation)
▲ 64408	H3	vagus nerve	000	0.90
D64410	-	phrenic nerve (64412 has been deleted. To report, use 64999)	000	N/A (2018 work RVU = 1.43)
D64413	-	cervical plexus (64410, 64413 have been deleted. To report injection of anesthetic agent and/or steroid to the phrenic nerve, cervical plexus, use 64999)	000	N/A (2018 work RVU = 1.40)

▲ 64415	H4	brachial plexus, single	000	1.42
▲ 64416	H5	brachial plexus, continuous infusion by catheter (including catheter placement) <i>(Do not report 64416 in conjunction with 01996)</i>	000	1.81
▲ 64417	H6	axillary nerve	000	1.27
▲ 64418	H7	suprascapular nerve	000	1.10 (Affirmed April 2016 RUC Recommendation)
▲ 64420	H8	intercostal nerve, single <u>level</u>	000	1.18
✚▲ 64421	H9	intercostal nerves, multiple, regional block , <u>each additional level (List separately in addition to code for primary procedure)</u> <i>(Use 64421 in conjunction with 64420)</i>	000 ZZZ	0.60
▲ 64425	H10	ilioinguinal, iliohypogastric nerves	000	1.19
▲ 64430	H11	pudendal nerve	000	1.15
▲ 64435	H12	paracervical (uterine) nerve	000	0.75

▲ 64445	H13	sciatic nerve, single	000	1.18
▲ 64446	H14	sciatic nerve, continuous infusion by catheter (including catheter placement) <i>(Do not report 64446 in conjunction with 01996)</i>	000	1.54
▲ 64447	H15	femoral nerve, single <i>(Do not report 64447 in conjunction with 01996)</i>	000	1.10
▲ 64448	H16	femoral nerve, continuous infusion by catheter (including catheter placement) <i>(Do not report 64448 in conjunction with 01996)</i>	000	1.55
▲ 64449	H17	lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) <i>(Do not report 64449 in conjunction with 01996)</i>	000	1.55
▲ 64450	H18	other peripheral nerve or branch	000	0.75

<u>Codes</u>	<u>Unit Per Code</u>	<u>Image Guidance</u>
64400-64450	1 unit per plexus, nerve, or branch injected regardless of the number of injections	Reported separately, when performed
64XX1	1 unit for any number of genicular nerve branches, with a required minimum of three nerve branches	Included, when performed
64455	1 or more injections per code	Reported separately, when performed
64479, ✚64480, 64483, ✚64484	1 or more injections per level	Included, when performed
64461, ✚64462, 64463	By injection site	Included, when performed
64486-64489	By block	Included, when performed

Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System			
Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic atic Nerve			
Code(s)	Unit	Image Guidance Included	Image Guidance Separately reported, when performed
Somatic Nerve			
64400-64450	1 unit per plexus, nerve, or branch injected regardless of the number of injections		X
64455	1 or more injections per code		X
64479	1 or more injections per code	X	
+64480	1 or more injections per code (add-on)	X	
64483	1 or more injections per code	X	
+64484	1 or more injections per code (add-on)	X	
64461	1 or more injections per level	X	
+64462	1 or more injections per code (add-on)	X	
64463	1 or more injections per code	X	
64486-64489	By injection site	X	
64XX0	1 unit for any number of genicular nerve branches, with a required minimum of three nerve branches		X

June 1, 2018

Peter K. Smith, MD, Chair
AMA/RVS Update Committee (RUC)
American Medical Association
330 N. Wabash Ave.
Chicago, IL 60611

Re: Somatic Nerve Procedures

Dear Dr. Smith:

At its recent May 2018 meeting, the CPT Editorial panel approved new guidelines for the Somatic Nerve code family as well as minor edits to the code language for 64400-64450. Included within the code family are two codes that were recently reviewed by the RUC:

- 64405 Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve – RUC reviewed April 2017, values will go into effect January 2019.
- 64418 Injection(s), anesthetic agent(s) and or steroid; suprascapular nerve – RUC reviewed April 2016.

While these codes underwent minor editorial changes, there has been no change in the physician work for these two codes since they were last surveyed. We do not believe a re-survey of these codes is necessary. The joint societies therefore recommend that the current RUC values and inputs for codes 64405 (0.94 work RVU) and 64418 (1.10 work RVU) be re-affirmed at the October 2018 RUC meeting.

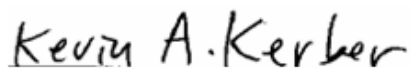
We look forward to presenting our recommendations for the Somatic Nerve code family at the upcoming RUC meeting. Please contact AAPM&R staff Carolyn Winter-Rosenberg at (847) 737-6024 or via email at cwinterrosenberg@aapmr.org if you have any questions.

Thank you for your consideration of this request.

Sincerely,

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Kevin A. Kerber, MD
AAN RUC Advisor



Matthew Grierson, MD
AAPM&R RUC Advisor



Richard W. Rosenquist, MD
ASA RUC Advisor

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 64400	Tracking Number	Original Specialty Recommended RVU: 1.14
		Presented Recommended RVU: 1.10
Global Period: 000	Current Work RVU: 1.11	RUC Recommended RVU: 1.00

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with a normal neurologic exam reports headaches that include pain in one or more branches of the trigeminal nerve (ophthalmic, maxillary, or mandibular). An injection of local anesthetic with or without a steroid is performed for nerve blockade.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The site of the proposed procedure is marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injectate is prepared. The provider prepares the skin with an antiseptic solution, applies sterile drapes and then performs the universal protocol ("time out") with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks bordering the procedure area are identified. A local anesthetic wheal is created and placed at the site of the injection. The provider penetrates the skin with the needle and injects the contents of the syringe along the course of the supraorbital nerve near the medial border of the eyebrow around the supraorbital notch. The needle is removed and the site is observed for bleeding and then covered with a sterile occlusive dressing.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and evidence of a successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Neal Cohen, MD (ASA); Kevin Kerber, MD (AAN); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA); Raissa Villanueva, MD (AAN)				
Specialty Society(ies):	American Academy of Neurology; American Society of Anesthesiologists				
CPT Code:	64400				
Sample Size:	7147	Resp N:	56	Response: 0.7 %	
Description of Sample:	random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	10.00	50.00	500.00
Survey RVW:	0.50	1.14	1.50	2.20	15.00
Pre-Service Evaluation Time:			18.00		
Pre-Service Positioning Time:			5.00		
Pre-Service Scrub, Dress, Wait Time:			5.00		
Intra-Service Time:	1.00	5.00	15.00	20.00	60.00
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

5-NF Proc w minimal anes care (if no deduct 1 min)

CPT Code:	64400	Recommended Physician Work RVU: 1.00		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	7.00	7.00	0.00	
Pre-Service Positioning Time:	1.00	0.00	1.00	
Pre-Service Scrub, Dress, Wait Time:	1.00	1.00	0.00	
Intra-Service Time:	6.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) N/A Survey Code is Non-Facility				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	5.00	0.00	5.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62325	000	2.20	RUC Time

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64644	000	1.82	RUC Time

CPT Descriptor Chemodenervation of one extremity; 5 or more muscles

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36620	000	1.00	RUC Time	577,293

CPT Descriptor 1 Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36556	000	1.75	RUC Time	450,710

CPT Descriptor 2 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
12002	000	1.14	RUC Time

CPT Descriptor Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 11 **% of respondents:** 19.6 %

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 14.2 %

TIME ESTIMATES (Median)

	CPT Code: 64400	Top Key Reference CPT Code: 62325	2nd Key Reference CPT Code: 64644
Median Pre-Service Time	9.00	20.00	15.00
Median Intra-Service Time	6.00	15.00	25.00
Median Immediate Post-service Time	5.00	10.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	20.00	45.00	45.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	0%	64%	36%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
0%	18%	82%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	0%	9%	91%

Physical effort required	0%	70%	30%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

18%

36%

45%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	13%	0%	50%	38%
------------------------------	----	-----	----	-----	-----

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

0%

38%

63%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	0%	25%	75%
--------------------------	----	-----	-----

Physical effort required	0%	57%	43%
--------------------------	----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

13%

13%

75%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64400 (Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular) is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several

specialties to request a code change application to provide further definition and descriptor transparency around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64400, is currently a Harvard-valued code that has not been previously surveyed. It is a 0-day global code. It was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA) and the American Academy of Neurology (AAN).

October 2018 RUC Meeting Recommendation Rationale

A total of 56 responses were received from a random sample of 7,147 clinicians (0.7 percent response rate). ASA and AAN convened an Expert Panel to review the survey data. ***The societies are recommending 1.10 wRVUs and time of pre (7/1/1), intra (15 min) and post (10 min).*** This results in an IWPUT of 0.046.

Vignette

The typical patient for code 64400 presents with a normal neurologic exam but reports headaches that include pain in one or more branches of the trigeminal nerve (ophthalmic, maxillary, or mandibular). An injection of local anesthetic with or without a steroid is performed for nerve blockade. 95% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64400			
Highlights from Survey Data			
	25th Percentile	Median	75th Percentile
Work	1.14	1.50	2.20
Pre		18/5/5	
Intra	5	15	20
Post		10	

After review of the reviewer comments of the societies original recommended wRVU of 1.14 and time inputs, the Expert Panel agreed to recommend the following revised work RVU and time recommendation:

- **wRVU**
 - 1.10 wRVUs; this value is less than the 25th percentile
- **Time**
 - Pre-time: Non-facility pre-service package #5 with an additional minute for positioning (7/1/1)
 - Intra-time: 15 minutes (survey median)
 - Post-time 10 minutes (survey median)

Crosswalk

The Expert Panel agreed to recommend as a value: 1.10 wRVU. The Expert Panel is basing its recommendation on a crosswalk to code **56605** (*Biopsy of vulva or perineum (separate procedure); 1 lesion*); with wRVU 1.10, with times 10/15/10 with resultant IWPUT 0.0435.

The Expert Panel also noted that the recommended value aligned with other reference code **12002** (*Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm*); with wRVU 1.14, with times 7/15/5 with resultant IWPUT 0.0590.

Current Value

- The current value of code 64400 is 1.11 wRVU
- The recommended wRVU of 1.10 is virtually and effectively identical

Comparison to Other Codes

The Expert Panel compared the recommendation for 64400 to other codes and identified other 0-day global codes with similar intra-time. These comparisons indicated the code was well aligned with other codes of similar time and value.

CPT Code	Long Desc	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
46614	Anoscopy; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	000	1.00	15	0.0338	887
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	000	1.01	15	0.0369	1,816,207
45335	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance	000	1.04	15	0.0263	3,140
50431	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access	000	1.10	15	0.0193	9,546
56605	Biopsy of vulva or perineum (separate procedure); 1 lesion	000	1.10	15	0.0435	30,749
64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)	0	1.10	15	0.046	33,977
12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm	000	1.14	15	0.059	146,808
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple	000	1.14	15	0.0345	36,331
36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access	000	1.2	15	0.04	5,630
44385	Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	000	1.2	15	0.037	1,359
57100	Biopsy of vaginal mucosa; simple (separate procedure)	000	1.2	15	0.0427	5,797
57500	Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	000	1.2	15	0.06	7,650
12013	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	000	1.22	15	0.0644	50,886
40490	Biopsy of lip	000	1.22	15	0.0577	34,141

In summary, for CPT code 64400 (*Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)*) **ASA and AAN recommend 1.10 wRVUs and 9/15/10 for time.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64400

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty Anesthesiology How often? Commonly

Specialty Nurse Practitioners How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 101931

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Neurology	Frequency 47541	Percentage 46.64 %
Specialty Anesthesiology	Frequency 9928	Percentage 9.73 %
Specialty Nurse Practitioners	Frequency 6891	Percentage 6.76 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 33,977 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization data

Specialty Neurology	Frequency 15847	Percentage 46.64 %
Specialty Anesthesiology	Frequency 3309	Percentage 9.73 %
Specialty Nurse Practitioners	Frequency 2297	Percentage 6.76 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Minor procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64400

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 64408	Tracking Number	Original Specialty Recommended RVU: 0.94
		Presented Recommended RVU: 0.90
Global Period: 000	Current Work RVU: 1.41	RUC Recommended RVU: 0.90
CPT Descriptor: Injection, anesthetic agent; vagus nerve		

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old female presents with a neurogenic cough. Injection of an anesthetic agent to the vagus nerve is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review history and physical findings, including prior tests. Discuss procedure with patient, and obtain informed consent. Ensure that necessary equipment is available and set up. After confirming correct injectant, remove disposable top from vial and clean medication top; then draw injectant. After patient is again examined and appropriate central and lateral neck landmarks are palpated, perform a time out; position patient in a partially recumbent position with head turned and neck extended; and place a shoulder roll if needed. Prep the neck using alcohol swabs.

Description of Intra-Service Work: Palpate the lateral neck landmarks. Guide spinal needle into paralaryngeal area. After aspiration for blood and air is performed to insure extraluminal and extravascular position, deliver the injectant solution. Remove injection needle then apply pressure to the injection site if needed to stop bleeding. Inspect the neck for signs of hematoma or other complications.

Description of Post-Service Work: Apply bandage. Return patient to sitting position. Observe the patient post-procedure for, any hemodynamic changes, new, unexpected neurologic deficits, vascular injury, or airway compromise. The physician communicates observation instructions with the nursing staff, patient, family, and other professionals (including written and telephone reports and orders). Document the procedure in the medical record, providing a detailed description of the placement of the injection and the patient's responses. After an appropriate period of monitoring for hemodynamic stability, mental orientation, and the neurovascular status of neck, reexamine the patient to confirm successful injection and adequate response. If the patient is stable, discharge her or him home after meeting all appropriate discharge criteria. Prior to discharge, remind the patient and family of signs and symptoms of potential complications, provide contact information to be used if such signs or symptoms develop, and discuss and arrange appropriate follow up.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2018				
Presenter(s):	Peter Manes, MD, Jay Shah, MD, Lance Manning, MD				
Specialty Society(ies):	AAO-HNS				
CPT Code:	64408				
Sample Size:	582	Resp N:	37	Response:	6.3 %
Description of Sample:	Targeted Random - Surveyed all Laryngologists in our membership				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	5.00	15.00	100.00
Survey RVW:	0.75	0.90	1.25	1.90	11.00
Pre-Service Evaluation Time:			21.00		
Pre-Service Positioning Time:			3.00		
Pre-Service Scrub, Dress, Wait Time:			2.00		
Intra-Service Time:	2.00	3.00	5.00	10.00	45.00
Immediate Post Service-Time:	6.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

5-NF Proc w minimal anes care (if no deduct 1 min)

CPT Code:	64408	Recommended Physician Work RVU: 0.90		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	7.00	7.00	0.00	
Pre-Service Positioning Time:	3.00	0.00	3.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	1.00	-1.00	
Intra-Service Time:	5.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) N/A Survey Code is Non-Facility				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	5.00	0.00	5.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
20552	000	0.66	RUC Time

CPT Descriptor Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64486	000	1.27	RUC Time

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
20552	000	0.66	RUC Time	371,780

CPT Descriptor 1 Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64644	000	1.82	RUC Time	31,712

CPT Descriptor 2 Chemodenervation of one extremity; 5 or more muscles

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64405	000	0.94	RUC Time

CPT Descriptor Injection, anesthetic agent; greater occipital nerve**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 7 % of respondents: 18.9 %

Number of respondents who choose 2nd Key Reference Code: 5 % of respondents: 13.5 %

TIME ESTIMATES (Median)

	CPT Code: <u>64408</u>	Top Key Reference CPT Code: <u>20552</u>	2nd Key Reference CPT Code: <u>64486</u>
Median Pre-Service Time	10.00	11.00	15.00
Median Intra-Service Time	5.00	5.00	10.00
Median Immediate Post-service Time	5.00	5.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	20.00	21.00	35.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	14%	57%	29%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	0%	14%	86%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	0%	0%	99%
Physical effort required	0%	71%	29%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%

43%

57%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

0%

60%

40%

0%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

0%

40%

60%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

0%

40%

60%

Physical effort required

40%

40%

20%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%

40%

60%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Why is this code being reviewed?

A code change proposal was brought before the CPT Editorial Panel in May 2018 requesting modifications to the Somatic Nerve Injection family of codes. This included 64408. The entire family was then referred for survey at the September 2018 RUC meeting. No other specialties indicated an interest in this code, and Otolaryngology as the dominant user of the service elected to survey it. No changes were made at CPT to this CPT code.

Description of Random Survey Sample

Our physician work RVU recommendation was derived by conducting a targeted random survey of AAO-HNS members with a designation of laryngology in our database. The standard 000 global survey instrument was utilized. Surveys were sent to 568 Otolaryngologists. We received 37 responses.

Physician Time**Pre-Time**

Regarding physician time, we recommend using pre-service package 5 Procedure with minimal anesthesia care which includes 7 minutes of evaluation, 0 minutes of positioning, and 1 minutes of scrub, dress, and wait time. Our expert panel felt this package was most appropriate given that this procedure does not utilize local anesthesia.

Evaluation time: Our experts felt that the 21 minutes of evaluation time provided by respondents was excessive given the short overall time for the procedure, therefore, we reduced this down to the package's recommended 7 minutes of evaluation time.

Positioning time: Regarding time for positioning, our expert panel reviewed the 0 minutes of time assigned by package 5 and felt this was insufficient for this particular procedure. Time must be taken to position the patient, using the headrest in order to ensure a successful injection. This includes time to palpate and figure out the trajectory of the injection site. We believe the three minutes assigned for this work by survey respondents is appropriate and are requesting 3 minutes for positioning.

Scrub, Dress, and Wait time: Last, we recommend the package time of 1 minute for scrub, dress, and wait.

Total Pre-Time: These modifications result in an overall pre-service time recommendation of 7/3/1, totaling 11 minutes for 64408.

Intra Time

Our expert panel agreed with our surveyees regarding the time for intra service work and are recommending the survey median time of 5 minutes for intra service work.

Immediate Post Time

Likewise, our experts felt that the survey's post time was an accurate reflection of the post time required for this procedure and are recommending the median post time of 6 minutes.

Physician Work

We are recommending our survey's 25th percentile of .90 for the physician work RVU. We believe the above recommendation is supported by the key reference codes, as well as crosswalk codes 64405 Injection, anesthetic agent; greater occipital nerve and 31575 Laryngoscopy, flexible; diagnostic. As the Panel is aware, 64405 is a part of this family of codes and serves as a strong comparator in work and time for 64408, we are asking that that value be reaffirmed at this meeting. In addition, 31575 is a service which has just been reviewed by the RUC and CMS and is provided by otolaryngology as the dominate specialty. We feel between these two codes survey respondents have a very clear understanding of these services and they serve as strong crosswalks for 64408. Survey respondents indicated this procedure was similar, and in many cases more, intense and complex than the selected KRS codes. We are also providing the following reference tables which include recently reviewed services which support our requested values for physician time and work for CPT 64408.

The table below compares the survey code to other RUC reviewed codes of similar time and work, providing further support that the recommended value for 64408 is appropriate.

CPT Code	Long Desc	Work RVU	Eval	Posit	SDW	Intra Time	Post Time	Total Time	RUC Review	IWPUT	MPC	2017 Utilization
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	0.66	5	1	5	5	5	21	2016-01	0.0746	Yes	371780

20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	0.75	5	1	5	5	5	21	2016-01	0.0926		844203
64450	Injection, anesthetic agent; other peripheral nerve or branch	0.75	10	0	0	5	5	20	2011-09	0.0828		413282
51720	Bladder instillation of antineoplastic agent (including retention time)	0.87	5	1	3	5	5	19	2016-01	0.1199		192279
31575	Laryngoscopy, flexible; diagnostic	0.94	8	1	5	5	5	24	2015-10	0.1172		644666
64405	Injection, anesthetic agent; greater occipital nerve	0.94	7	0	0	5	10	22	2010-10	0.1118		123405
20527	Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)	1	7	1	0	5	5	18	2011-04	0.1418		8973
65778	Placement of amniotic membrane on the ocular surface; without sutures	1	17	1	5	5	5	33	2015-04	0.0889		38047
67028	Intravitreal injection of a pharmacologic agent (separate procedure)	1.44	6	1	5	5	5	22	2009-10	0.2261		3456916
27197	Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation	1.53	12	0	0	5	10	27	2016-01	0.2074		13357
65800	Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous	1.53	12	1	5	5	5	28	2012-04	0.2173		22624

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these

data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 88 times in 2017 per the Medicare database.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 264

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is the 2017 Medicare volume multiplied by three in order to account for the national volume that may occur.

Specialty Otolaryngology Frequency 264 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 88 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on the 2017 volume in the Medicare database.

Specialty Otolaryngology Frequency 88 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Minor procedure

BETOS Sub-classification Level II:

Musculoskeletal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64408

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 64415	Tracking Number	Original Specialty Recommended RVU: 1.42
		Presented Recommended RVU: 1.42
Global Period: 000	Current Work RVU: 1.48	RUC Recommended RVU: 1.42

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year old female has a 1-year history of tumor that is infiltrating her arm causing significant pain and interfering with her ability to complete activities of daily living. She has had poor control of her pain despite multiple medication trials and physical therapy. Due to her persistent, debilitating pain, a brachial plexus block is scheduled to relieve her pain and improve her function.

Percentage of Survey Respondents who found Vignette to be Typical: 44%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The site of the proposed procedure is marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injectate is prepared. The provider prepares the skin with an antiseptic solution, applies sterile drapes and then performs the universal protocol ("time out") with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks bordering the brachial plexus are identified. A local anesthetic skin wheal is created and placed at the site of injection. A needle is advanced towards the brachial plexus and correct position is confirmed. A local anesthetic and steroid is infiltrated into the fascial plane containing the brachial plexus using intermittent aspiration and injection. The needle is removed, and the site is observed for bleeding and then covered with a sterile occlusive dressing.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and evidence of a successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Neal Cohen, MD (ASA); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA)				
Specialty Society(ies):	American Society of Anesthesiologists				
CPT Code:	64415				
Sample Size:	3891	Resp N:	57	Response: 1.4 %	
Description of Sample:	random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	25.00	76.00	600.00
Survey RVW:	0.70	1.42	1.70	2.00	10.00
Pre-Service Evaluation Time:			20.00		
Pre-Service Positioning Time:			4.00		
Pre-Service Scrub, Dress, Wait Time:			4.00		
Intra-Service Time:	1.00	8.00	12.00	15.00	60.00
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64415	Recommended Physician Work RVU: 1.42		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	13.00	13.00	0.00	
Pre-Service Positioning Time:	1.00	1.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	4.00	6.00	-2.00	
Intra-Service Time:	12.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) 7A Local/Simple Procedure				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	10.00	18.00	-8.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62323	000	1.80	RUC Time

CPT Descriptor 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); with imaging guidance (ie, fluoroscopy or CT)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64486	000	1.27	RUC Time

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block), unilateral; by injection(s) (includes imaging guidance, when performed)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36620	000	1.00	RUC Time	577,293

CPT Descriptor 1 Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36556	000	1.75	RUC Time	450,710

CPT Descriptor 2 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
51703	000	1.47	RUC Time

CPT Descriptor Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 13 % of respondents: 22.8 %

Number of respondents who choose 2nd Key Reference Code: 11 % of respondents: 19.2 %

TIME ESTIMATES (Median)

	CPT Code: 64415	Top Key Reference CPT Code: 62323	2nd Key Reference CPT Code: 64486
Median Pre-Service Time	18.00	20.00	15.00
Median Intra-Service Time	12.00	15.00	10.00
Median Immediate Post-service Time	10.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	40.00	45.00	35.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	16%	58%	25%	0%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
25%	50%	25%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	8%	62%	31%

Physical effort required	8%	69%	23%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

8%	62%	31%
----	-----	-----

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	0%	36%	55%	9%
------------------------------	----	----	-----	-----	----

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

0%	73%	27%
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Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	9%	27%	64%
--------------------------	----	-----	-----

Physical effort required	0%	73%	27%
--------------------------	----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%	45%	55%
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Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64415 (Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single) is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide

further definition and descriptor transparency around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64415 is a 0-day global. It was previously surveyed by the RUC in 2009. It was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA).

October 2018 RUC Meeting Recommendation Rationale

A total of 57 responses were received from a random sample of 3,891 clinicians (1.4 percent response rate). ASA convened an Expert Panel to review the survey data. ***The society is recommending 1.42 wRVUs (survey 25th) and time of pre (13/1/5), intra (12 min) and post (10 min).*** This results in an IWPOT of 0.070.

Vignette

The typical patient for code 64415 presents with persistent, debilitating pain interfering with the ability to complete daily activities. A brachial plexus block is performed to relieve her pain and improve her function.

The specialty did note that only 44% of the survey respondents found the vignette to be typical. The Expert Panel concluded that this was because while the vignette was for a female patient with pain in her arm, the code can be used for treatment for when the pain is throughout the brachial plexus which is a set of nerves that goes from the spinal cord in the neck down throughout the arm. The top diagnosis code reported in the 2018v2 RUC database is G89, Pain, not elsewhere classified. Survey respondents also indicated that the code is used for pre-operative pain as well as post-operative pain management for various types of orthopedic surgeries. Based on these factors the low typical vignette rate seemed reasonable.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64415 Highlights from Survey Data			
	25th Percentile	Median	75th Percentile
Work	1.42	1.70	2.0
Pre		20/4/4	
Intra	8	12	15
Post		10	

After a robust discussion the Expert Panel agreed to recommend:

- wRVU
 - 1.42 wRVUs (25th percentile)
- Time
 - Pre-time: Facility pre-service package #1 -adjusted (13/1/5)
 - Intra-time: 12 minutes (survey median)
 - Post-time 10 minutes (survey median)

The Expert Panel discussed how in general the treatment for pain conditions has become more complex as the opioid crisis has escalated, and treatment and coverage for other non-pharmacologic and non-interventional strategies has been limited. With worsening pain, this impacts mobility, and in general has led to a more sedentary population with increase in co-morbidities of diabetes, hypertension and obesity. These findings, particularly the increase in BMI, have led to increases in the technical skill and judgment necessary to perform the procedure as well as the associated psychological stress to reduce risk of complications, such as pneumothorax or intravascular complication.

The Expert Panel concluded that recommended wRVU value and times appropriately reflected how the service is currently performed and it aligns well within and outside of the code family.

In drafting their recommendations, the Expert Panel considered a number of factors.

Current Value

- The Expert Panel agreed that the 25th percentile of 1.42 was appropriate. It is slightly less than the current value of 1.48. The Expert Panel noted that this recommendation slightly raised the IWPUT to 0.070 from the current IWPUT of 0.0601. This was likely due to a slight decrease in the intra-service time (from 15 minutes to 12 minutes) but that this decrease of 3 minutes was accounted for in the decrease in the recommended wRVU from the current value.

Reference Code

- The Expert Panel also concluded that the recommendation aligned well with the top reference code, 62323 (*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); with imaging guidance (ie, fluoroscopy or CT)*) which was surveyed in 2015, has a wRVU of 1.80, IWPUT of .0800 and intra time of 15 minutes. The reference code includes catheter placement, infusion and image guidance. Since none of these services are included in the surveyed code (64415), the Expert Panel agreed that the higher wRVU and IWPUT for the reference code was appropriate.

Other Code with Same wRVU Value and Similar Time

- The Panel identified one RUC-surveyed 0-day global code with wRVU of 1.42 and similar time. The Expert Panel noted the slightly higher IWPUT of 64415 compared to 43200, they believed this appropriately reflected the difference of intensity and complexity between the two procedures. The Expert Panel believed code 43200 aligned well with the surveyed code and that it supported the recommendation.

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
43200	Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	000	1.42	15	0.0506	6,488
64415	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single	000	1.42	15	0.0700	175,767

Other Codes in the Somatic Nerve Injection Family

- The Expert Panel also concluded the recommendation maintained rank order in the Somatic Nerve Injection family.

Code#	Description	Proposed wRVU
+64421	N block inj intercost sng, addl level	0.60
64435	N block inj paracervical	0.75
64450	N block other peripheral	0.84
64405	N block inj occipital	0.94
64408	N block inj vagus	0.94
64418	N block inj suprascapular	1.10
64400	N block inj trigeminal	1.14
64430	N block inj pudendal	1.15
64425	N block inj ilio-ing/hypogi	1.19
64420	N block inj intercost sng	1.24
64417	N block inj axillary	1.27
64447	N block inj fem single	1.40
64415	N block inj brachial plexus	1.42

Code#	Description	Proposed wRVU
64445	N block inj sciatic sng	1.47
64448	N block inj fem cont inf	1.78
64446	N blk inj sciatic cont inf	1.80
64449	N block inj lumbar plexus	1.80
64416	N block cont infuse b plex	1.81

Rank Order

- The Expert Panel also considered other 0-day, RUC reviewed codes outside of the Somatic Nerve Injection family with similar intra-time and concluded that the recommendation aligned well with these codes and provided further evidence of the appropriateness of the recommendation.

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
67515	Injection of medication or other substance into Tenon's capsule	000	1.40	5	0.2083	26,441
43453	Dilation of esophagus, over guide wire	000	1.41	20	0.0326	1,861
43200	Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	000	1.42	15	0.0516	6,488
64415	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single	000	1.42	15	0.070	175,767
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	000	1.44	17	0.0697	22,716
65430	Scraping of cornea, diagnostic, for smear and/or culture	000	1.47	10	0.1067	4,674
51703	Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)	000	1.47	15	0.0580	57,100
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed	000	1.48	11	0.0861	470,242
64487	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by continuous infusion(s) (includes imaging guidance, when performed)	000	1.48	15	0.0661	314
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	000	1.50	15	0.0609	103,189
46612	Anoscopy; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique	000	1.50	16	0.0492	66

In summary, for CPT code CPT Code 64415 (*Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single*) **ASA recommends 1.42 wRVUs and 19/12/10 for time.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
☒ Multiple codes are used to maintain consistency with similar codes.
☒ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CPT code 76942-26 (Global: XXX; wRVUs: 0.67; Time: 7/15/5)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64415

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty CRNA How often? Commonly

Specialty Interventional Pain Management How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 527301

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology Frequency 460650 Percentage 87.35 %

Specialty CRNA Frequency 50937 Percentage 9.65 %

Specialty Interventional Pain Management Frequency 4060 Percentage 0.76 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 175,767 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization data

Specialty Anesthesiology Frequency 153550 Percentage 87.35 %

Specialty CRNA Frequency 16979 Percentage 9.65 %

Specialty Interventional Pain Management Frequency 1353 Percentage 0.76 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Major procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64415

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 64416	Tracking Number	Original Specialty Recommended RVU: 1.81
		Presented Recommended RVU: 1.81
Global Period: 000	Current Work RVU: 1.81	RUC Recommended RVU: 1.81

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 54-year-old female has a 6-month history of tumor that is infiltrating her arm, causing constant trials and she has been unable to tolerate physical therapy or perform normal activities of daily living with her arm. Due to her persistent, debilitating pain, a brachial plexus block with a catheter and a continuous infusion of local anesthetic is scheduled to relieve her pain and allow her to participate in physical therapy to improve her function.

Percentage of Survey Respondents who found Vignette to be Typical: 55%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The site of the proposed procedure is marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injection is prepared. The provider prepares the skin with an antiseptic solution, applies sterile drapes and then performs the universal protocol ("time out") with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks bordering the brachial plexus are identified and placed at the site of injection. A local anesthetic skin wheal is created. A needle is advanced towards the brachial plexus and correct position is confirmed. A catheter is advanced to lie next to the brachial plexus and subsequently, a local anesthetic and steroid is infiltrated into the fascial plane containing the brachial plexus using intermittent aspiration and injection. The needle is removed, and the site is observed for bleeding and then covered with a sterile occlusive dressing.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and evidence of a successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Neal Cohen, MD (ASA); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA)				
Specialty Society(ies):	American Society of Anesthesiologists				
CPT Code:	64416				
Sample Size:	3891	Resp N:	42	Response: 1.0 %	
Description of Sample:	Random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	18.00	43.00	400.00
Survey RVW:	1.00	1.81	2.10	2.20	12.00
Pre-Service Evaluation Time:			23.00		
Pre-Service Positioning Time:			5.00		
Pre-Service Scrub, Dress, Wait Time:			5.00		
Intra-Service Time:	1.00	15.00	20.00	24.00	60.00
Immediate Post Service-Time:	15.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

2-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	64416	Recommended Physician Work RVU: 1.81		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	13.00	18.00	-5.00	
Pre-Service Positioning Time:	1.00	1.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	5.00	6.00	-1.00	
Intra-Service Time:	20.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) 7A Local/Simple Procedure				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	10.00	18.00	-8.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62325	000	2.20	RUC Time

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62323	000	1.80	RUC Time

CPT Descriptor 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); with imaging guidance (ie, fluoroscopy or CT)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64644	000	1.82	RUC Time	31,712

CPT Descriptor 1 Chemodenervation of one extremity; 5 or more muscles

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64483	000	1.90	RUC Time	1,043,217

CPT Descriptor 2 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62324	000	1.89	RUC Time

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 26 % of respondents: 61.9 %

Number of respondents who choose 2nd Key Reference Code: 9 % of respondents: 21.4 %

TIME ESTIMATES (Median)

	CPT Code: 64416	Top Key Reference CPT Code: 62325	2nd Key Reference CPT Code: 62323
Median Pre-Service Time	19.00	20.00	20.00
Median Intra-Service Time	20.00	15.00	15.00
Median Immediate Post-service Time	10.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	49.00	45.00	45.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	4%	12%	36%	36%	12%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	36%	36%	28%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	12%	44%	44%
Physical effort required	12%	60%	28%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	15%	42%	42%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	44%	56%	0%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	22%	44%	33%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	0%	67%	33%
Physical effort required	0%	78%	22%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	11%	33%	56%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUP analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64416 (*Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement)*) is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64416 is a 0-day global. It was previously surveyed by the RUC in 2008. It was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA).

October 2018 RUC Meeting Recommendation Rationale

A total of 42 responses were received from a random sample of 3,891 clinicians (1.0 percent response rate). ASA convened an Expert Panel to review the survey data. ***The society is recommending 1.81 wRVUs (survey 25th) and time of pre (19/1/5), intra (20 min) and post (15 min).*** This results in an IWPOT of 0.049.

Vignette

The vignette in the survey described a typical patient for code 64416 as someone with persistent, debilitating pain interfering with the ability to complete daily activities. A brachial plexus block with continuous infusion of an anesthetic is performed to relieve her pain and improve her function.

The specialty did note that only 55% of the survey respondents found the vignette to be typical. The Expert Panel concluded that this was because while the vignette was for a female patient with pain in her arm, the code can be used for treatment for when the pain is throughout the brachial plexus which is a set of nerves that goes from the spinal cord in the neck down throughout the arm. The top diagnosis code reported in the 2018v2 RUC database is G89, Pain, not elsewhere classified. Survey respondents also indicated that the code is used for pre-operative pain as well as post-operative pain management for various types of orthopedic surgeries. Based on these factors the low typical vignette rate seemed reasonable.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64416			
Highlights from Survey Data			
	25th Percentile	Median	75th Percentile
Work	1.81	2.10	2.20
Pre		23/5/5	
Intra	15	20	24
Post		15	

After a robust discussion the Expert Panel agreed to recommend:

- wRVU
 - 1.81 wRVUs (25th percentile)
- Time
 - Pre-time: Facility pre-service package #2 -adjusted (19/1/5)
 - Intra-time: 20 minutes (survey median)
 - Post-time 15 minutes (survey median)

The Expert Panel discussed how in general the treatment for pain conditions has become more complex as the opioid crisis has escalated, and treatment and coverage for other non-pharmacologic and non-interventional strategies has been limited. With worsening pain, this impacts mobility, and in general has led to a more sedentary population with increase in co-morbidities of diabetes, hypertension and obesity. These findings, particularly the increase in BMI, have led to

increases in the technical skill and judgment necessary to perform the procedure as well as the associated psychological stress to reduce risk of complications, such as pneumothorax or intravascular complication.

The Expert Panel concluded that recommended wRVU value and times appropriately reflected how the service is currently performed and it aligns well within and outside of the code family.

In drafting their recommendations, the Expert Panel considered a number of factors.

Current Value

- The Expert Panel agreed that the 25th percentile of 1.81, which is also the current value of the code was appropriate. The Expert Panel also noted that the intra time of 20 minutes was the same for both the current survey as well as the previous survey conducted in 2008. This provides further evidence of the appropriateness of the recommendation.

Reference Code

- The Expert Panel also concluded that the recommendation aligned well with the top reference code, 62325 (*Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)*) which has a wRVU of 2.20, IWPUT of 0.1066 and intra time of 15 minutes. The reference code includes catheter placement, infusion and image guidance. While code 64416 includes catheter placement and infusion it does not include image guidance. Additionally, code 62325 is reported for more complex neuraxial nerve blocks while 64416 is used for peripheral nerve blocks. The Expert Panel agreed that the higher wRVU and IWPUT for the reference code was appropriate.

Other Code with Same wRVU Value and Similar Time

- The Panel identified a recently RUC-surveyed (2017) 0-day global code with wRVU of 1.81 and similar time. The Expert Panel noted the similar IWPUTs of the two codes, they believe this appropriately reflected the similar intensity and complexity between the two procedures. The Expert Panel believed code 36514 (which is included on the MPC list) aligns well with the surveyed code and that it supports the recommendation.

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
36514	Therapeutic apheresis; for plasma pheresis	000	1.81	20	0.0412	28,945
64416	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement)	000	1.81	20	0.049	20,870

Other Codes in the Somatic Nerve Injection Family

- The Expert Panel also concluded the recommendation maintained rank order in the Somatic Nerve Injection family.

Code#	Description	Proposed wRVU
+64421	N block inj intercost sng, addl level	0.60
64435	N block inj paracervical	0.75
64450	N block other peripheral	0.84
64405	N block inj occipital	0.94
64408	N block inj vagus	0.94
64418	N block inj suprascapular	1.10
64400	N block inj trigeminal	1.14

64430	N block inj pudendal	1.15
64425	N block inj ilio-ing/hypogi	1.19
64420	N block inj intercost sng	1.24
64417	N block inj axillary	1.27
64447	N block inj fem single	1.40
64415	N block inj brachial plexus	1.42
64445	N block inj sciatic sng	1.47
64448	N block inj fem cont inf	1.78
64446	N blk inj sciatic cont inf	1.80
64449	N block inj lumbar plexus	1.80
64416	N block cont infuse b plex	1.81

Rank Order

- The Expert Panel also considered other 0-day, RUC reviewed codes outside of the Somatic Nerve Injection family with similar intra-time and concluded that the recommendation aligned well with these codes and provided further evidence of the appropriateness of the recommendation.

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance	000	1.78	15	0.0816	7,763
62320	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, cervical or thoracic; without imaging guidance	000	1.80	15	0.0830	10,537
62323	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); with imaging guidance (ie, fluoroscopy or CT)	000	1.80	15	0.0800	738,694
64489	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by continuous infusions (includes imaging guidance, when performed)	000	1.80	20	0.0656	1,443
64646	Chemodenervation of trunk muscle(s); 1-5 muscle(s)	000	1.80	20	0.0676	7,062
64416	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement	000	1.81	20	0.049	20,870
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level	000	1.82	15	0.0858	247,465

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
32554	Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance	000	1.82	20	0.0543	16,651
62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance	000	1.89	15	0.0890	25,856
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block	000	1.90	15	0.0866	246
62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	000	1.90	15	0.0866	2,316
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level	000	1.90	15	0.0816	1,043,217
64463	Paravertebral block (PVB) (paraspinal block), thoracic; continuous infusion by catheter (includes imaging guidance, when performed)	000	1.90	20	0.0605	1,066
36555	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age	000	1.93	15	0.0842	38
62321	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, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	000	1.95	15	0.0900	215,908

In summary, for CPT code CPT Code 64416 (*Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement)*) **ASA recommends 1.81 wRVUs and 25/20/15 for time.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☒ Multiple codes are used to maintain consistency with similar codes.
- ☒ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CPT code 76942-26 (Global: XXX; wRVUs: 0.67; Time: 7/15/5)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64416

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty CRNA How often? Commonly

Specialty Pain Management How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 62610

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology	Frequency 57733	Percentage 92.21 %
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Specialty CRNA	Frequency 4189	Percentage 6.69 %
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Specialty Pain Management	Frequency 351	Percentage 0.56 %
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 20,870 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization data

Specialty Anesthesiology	Frequency 19244	Percentage 92.20 %
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Specialty CRNA	Frequency 1396	Percentage 6.68 %
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Specialty Pain Management	Frequency 117	Percentage 0.56 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64416

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 64417	Tracking Number	Original Specialty Recommended RVU: 1.27
		Presented Recommended RVU: 1.27
Global Period: 000	Current Work RVU: 1.44	RUC Recommended RVU: 1.27

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; axillary nerve

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old male has a 3-year history of a painful mass in his deltoid that is interfering with his ability to complete activities of daily living. He has had poor control of his pain despite multiple medication trials and physical therapy. Due to his persistent, debilitating pain, an axillary nerve block is scheduled to relieve his pain and improve his function.

Percentage of Survey Respondents who found Vignette to be Typical: 53%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The site of the proposed procedure is marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injectate is prepared. The skin is cleansed with an antiseptic solution, sterile drapes are applied and then the universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks are identified and placed at the site of the injection. A local anesthetic skin wheal is created. A needle is advanced towards the axillary nerve and correct position is confirmed. A local anesthetic and steroid is infiltrated around the nerve using intermittent aspiration and injection. The needle is removed, and the site is observed for bleeding and then covered with a sterile occlusive dressing.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and evidence of a successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Neal Cohen, MD (ASA); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA)				
Specialty Society(ies):	American Society of Anesthesiologists				
CPT Code:	64417				
Sample Size:	3891	Resp N:	45	Response: 1.1 %	
Description of Sample: random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	6.00	12.00	500.00
Survey RVW:	0.68	1.27	1.50	2.00	12.00
Pre-Service Evaluation Time:			21.00		
Pre-Service Positioning Time:			4.00		
Pre-Service Scrub, Dress, Wait Time:			4.00		
Intra-Service Time:	1.00	5.00	10.00	18.00	35.00
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64417	Recommended Physician Work RVU: 1.27		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	13.00	13.00	0.00	
Pre-Service Positioning Time:	1.00	1.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	4.00	6.00	-2.00	
Intra-Service Time:	10.00			
Please, pick the <u>post</u>-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
7A Local/Simple Procedure				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	10.00	18.00	-8.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64486	000	1.27	RUC Time

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62323	000	1.80	RUC Time

CPT Descriptor 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); with imaging guidance (ie, fluoroscopy or CT)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36620	000	1.00	RUC Time	577,293

CPT Descriptor 1 Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36556	000	1.75	RUC Time	450,710

CPT Descriptor 2 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

Other Reference CPT Code	Global	Work RVU	Time Source
62322	000	1.55	RUC Time

CPT Descriptor 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

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 15 % of respondents: 33.3 %

Number of respondents who choose 2nd Key Reference Code: 8 % of respondents: 17.7 %

TIME ESTIMATES (Median)

	CPT Code: 64417	Top Key Reference CPT Code: 64486	2nd Key Reference CPT Code: 62323
Median Pre-Service Time	18.00	15.00	20.00
Median Intra-Service Time	10.00	10.00	15.00
Median Immediate Post-service Time	10.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	38.00	35.00	45.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	7%	53%	33%	7%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
0%	64%	36%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	13%	47%	40%
Physical effort required	13%	80%	7%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

7%

53%

40%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More****Overall intensity/complexity**

0%

13%

13%

75%

0%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

13%

38%

50%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

13%

38%

50%

Physical effort required

13%

50%

38%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

13%

50%

38%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64417 (*Injection(s), anesthetic agent(s) and/or steroid; axillary nerve*) is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64417 is a 0-day global. It is currently a Harvard-valued code that has not been previously surveyed and was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA).

October 2018 RUC Meeting Recommendation Rationale

A total of 45 responses were received from a random sample of 3,891 clinicians (1.1 percent response rate). ASA convened an Expert Panel to review the survey data. ***The society is recommending 1.27 wRVUs (survey 25th) and time of pre (13/1/5), intra (10 min) and post (10 min).*** This results in an IWPUT of 0.069.

Vignette

The vignette in the survey described a typical patient for code 64417 as someone with a painful mass in his deltoid that is interfering with his ability to complete activities of daily living. He has had poor control of his pain despite multiple medication trials and physical therapy. Due to his persistent, debilitating pain, an axillary nerve block is scheduled to relieve his pain and improve his function. The specialty did note that only 53% of the survey respondents found the vignette to be typical. Survey respondents indicated that the code is also used for pre-operative pain as well as post-operative pain management for various types of orthopedic surgeries. Based on these factors the low typical vignette rate seemed reasonable.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64417 Highlights from Survey Data			
	25th Percentile	Median	75th Percentile
Work	1.27	1.50	2.00
Pre		21/4/4	
Intra	5	10	18
Post		10	

After a robust discussion the Expert Panel agreed to recommend:

- wRVU
 - 1.27 wRVUs (25th percentile)
- Time
 - Pre-time: Facility pre-service package #1 -adjusted (13/1/5)
 - Intra-time: 10 minutes (survey median)
 - Post-time 10 minutes (survey median)

The Expert Panel discussed how in general the treatment for pain conditions has become more complex as the opioid crisis has escalated, and treatment and coverage for other non-pharmacologic and non-interventional strategies has been limited. With worsening pain, this impacts mobility, and in general has led to a more sedentary population with increase in co-morbidities of diabetes, hypertension and obesity. These findings, particularly the increase in BMI, have led to increases in the technical skill and judgment necessary to perform the procedure as well as the associated psychological stress to reduce risk of complications, such as pneumothorax or intravascular complication.

The Expert Panel concluded that recommended wRVU value and times appropriately reflect how the service is currently performed and it aligns well within and outside of the code family.

In drafting their recommendations, the Expert Panel considered a number of factors.

Current Value

- The Expert Panel agreed that the 25th percentile of 1.27 which is less than the current wRVU of 1.44 is appropriate. The Expert Panel noted that this recommendation did increase the IWPUT to 0.069 from the current IWPUT of 0.0451. This was largely due to a decrease in the intra-service time (from 19 minutes to 10 minutes). This decrease in intra-time is accounted for in the recommended wRVU decrease from the current value. Since the code was previously Harvard-valued, they felt the surveyed time more appropriately reflects current practice and the resulting IWPUT was appropriate. This position is consistent with the RUC comments on the CY 2019 NPRM for code 95970 where they state that Harvard time “holds zero validity for comparison.”

Reference Code

- The Expert Panel also concluded that the recommendation aligned well with the top reference code, 64486 (*Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)*) which was recently surveyed (2014), has a wRVU of 1.27, IWP/UT of 0.0781 and intra-time of 10 minutes. The Expert Panel noted that the codes had the same intra time but the reference code had a slightly higher IWP/UT. The reference code includes catheter placement, infusion and image guidance. They concluded it was appropriate for the two codes to be valued the same, at 1.27 wRVUs.

Other Code with Same wRVU Value and Similar Time

- The Panel identified three RUC-surveyed 0-day global codes with wRVU of 1.27 and similar time. The Expert Panel noted the similar IWP/UTs of the two codes, they believed this appropriately reflected the similar intensity and complexity between the two procedures.

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWP/UT	2017 Utilization
58301	Removal of intrauterine device (IUD)	000	1.27	15	0.0473	1,496
64417	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve	000	1.27	10	0.0690	13,923
64486*	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	000	1.27	10	0.0781	7,349
67505	Retrobulbar injection; alcohol	000	1.27	10	0.0781	181

* 64486 is also the top reference code

Other Codes in the Somatic Nerve Injection Family

- The Expert Panel also concluded the recommendation maintained rank order in the Somatic Nerve Injection family.

Code#	Description	Proposed wRVU
+64421	N block inj intercost sng, addl level	0.60
64435	N block inj paracervical	0.75
64450	N block other peripheral	0.84
64405	N block inj occipital	0.94
64408	N block inj vagus	0.94
64418	N block inj suprascapular	1.10
64400	N block inj trigeminal	1.14
64430	N block inj pudendal	1.15
64425	N block inj ilio-ing/hypogi	1.19
64420	N block inj intercost sng	1.24
64417	N block inj axillary	1.27
64447	N block inj fem single	1.40
64415	N block inj brachial plexus	1.42
64445	N block inj sciatic sng	1.47
64448	N block inj fem cont inf	1.78
64446	N blk inj sciatic cont inf	1.80

64449	N block inj lumbar plexus	1.80
64416	N block cont infuse b plex	1.81

Rank Order

- The Expert Panel also considered other 0-day, RUC reviewed codes outside of the Somatic Nerve Injection family with similar intra-time and concluded that the recommendation aligned well with these codes and provided further evidence of the appropriateness of the recommendation.

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
12013	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	000	1.22	15	0.0644	50,886
40490	Biopsy of lip	000	1.22	15	0.0577	34,141
32562	Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day	000	1.24	10	0.0654	1,532
49082	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance	000	1.24	10	0.0654	12,016
64417	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve	000	1.27	10	0.0690	13,923
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	000	1.27	10	0.0781	7,349
67505	Retrobulbar injection; alcohol	000	1.27	10	0.0781	181
58301	Removal of intrauterine device (IUD)	000	1.27	15	0.0473	1,496
43450	Dilation of esophagus, by unguided sound or bougie, single or multiple passes	000	1.28	15	0.0363	72,504
46610	Anoscopy; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery	000	1.28	15	0.0378	166

In summary, for CPT code CPT Code 64417 (Injection(s), anesthetic agent(s) and/or steroid; axillary nerve) **ASA recommends 1.27 wRVUs and 19/10/10 for time.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
☒ Multiple codes are used to maintain consistency with similar codes.
☒ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CPT code 76942-26 (Global: XXX; wRVUs: 0.67; Time: 7/15/5)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64417

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty CRNA How often? Commonly

Specialty Neurology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 41769

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology Frequency 33035 Percentage 79.08 %

Specialty CRNA Frequency 5309 Percentage 12.71 %

Specialty Neurology Frequency 1846 Percentage 4.41 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 13,923 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization data

Specialty Anesthesiology Frequency 11012 Percentage 79.09 %

Specialty CRNA Frequency 1770 Percentage 12.71 %

Specialty Neurology Frequency 615 Percentage 4.41 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Minor procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64417

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 64420	Tracking Number	Original Specialty Recommended RVU: 1.24
		Presented Recommended RVU: 1.18
Global Period: 000	Current Work RVU: 1.18	RUC Recommended RVU: 1.18

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old female has a 2-year history of rib pain that is interfering with her ability to complete activities of daily living. She has had poor control of her pain despite multiple medication trials and physical therapy. Due to her persistent, debilitating pain, a trial of intercostal nerve block is scheduled to relieve her pain and improve her function.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The site of the proposed procedure is marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injectate is prepared. The provider cleans the skin with an antiseptic solution, applies a sterile drape, and then performs the universal protocol ("time out") with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks are identified and placed at the site of the injection. A local anesthetic skin wheal is created. A needle is advanced at an angle of approximately 20° cephalad to the skin until the rib is contacted. With the same angle of insertion, the needle is walked off the inferior border of the rib and advanced 3 mm to place the tip in the space containing the neurovascular bundle between the internal and innermost intercostal muscles. After negative aspiration, a local anesthetic is injected. The needle is removed, and the site is observed for bleeding and covered with a sterile occlusive dressing.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and evidence of a successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Neal Cohen, MD (ASA); Eduardo Fraifeld, MD (AAPM); Matthew Grierson, MD (AAPM&R); Marc Leib, MD (ASA); Gregory Polston, MD (AAPM); Richard Rosenquist, MD (ASA)				
Specialty Society(ies):	American Academy of Pain Medicine; American Academy of Physical Medicine and Rehabilitation, American Society of Anesthesiologists				
CPT Code:	64420				
Sample Size:	2452	Resp N:	60	Response: 2.4 %	
Description of Sample:	random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	10.00	25.00	500.00
Survey RVW:	0.75	1.24	1.50	1.86	30.00
Pre-Service Evaluation Time:			25.00		
Pre-Service Positioning Time:			5.00		
Pre-Service Scrub, Dress, Wait Time:			5.00		
Intra-Service Time:	1.00	8.00	10.00	15.00	30.00
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64420	Recommended Physician Work RVU: 1.18		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	13.00	13.00	0.00	
Pre-Service Positioning Time:	1.00	1.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	5.00	6.00	-1.00	
Intra-Service Time:	10.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended post time should not exceed your survey median time)				
7A Local/Simple Procedure				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	5.00	18.00	-13.00	

<u>Post-Operative Visits</u>	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64493	000	1.52	RUC Time

CPT Descriptor Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64483	000	1.90	RUC Time

CPT Descriptor Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
36620	000	1.00	RUC Time	577,293

CPT Descriptor 1 Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
36556	000	1.75	RUC Time	450,710

CPT Descriptor 2 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62322	000	1.55	RUC Time

CPT Descriptor 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

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 23 % of respondents: 38.3 %

Number of respondents who choose 2nd Key Reference Code: 13 % of respondents: 21.6 %

TIME ESTIMATES (Median)

	CPT Code: 64420	Top Key Reference CPT Code: 64493	2nd Key Reference CPT Code: 64483
Median Pre-Service Time	19.00	17.00	24.00
Median Intra-Service Time	10.00	15.00	15.00
Median Immediate Post-service Time	5.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	34.00	42.00	49.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	4%	52%	35%	9%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
9%	61%	30%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	13%	52%	35%
Physical effort required	4%	78%	17%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

13%

35%

52%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More****Overall intensity/complexity**

0%

15%

23%

46%

15%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

8%

46%

46%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

8%

23%

69%

Physical effort required

8%

46%

46%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

8%

15%

77%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64420 (*Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level*) is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64420 is currently a Harvard-valued code that has not been previously surveyed. It was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA), the American Academy of Pain Medicine (AAPM) and the American Academy of Physical Medicine & Rehabilitation (AAPM&R).

October 2018 RUC Meeting Recommendation Rationale

A total of 60 responses were received from a random sample of 2,452 clinicians (2.4 percent response rate). ASA, AAPM and AAPM&R convened an Expert Panel to review the survey data. ***The societies are recommending maintaining the current value of 1.18 wRVUs and time of pre (13/1/5), intra (10 min) and post (10 min).*** This results in an IWPUT of 0.060.

Vignette

The vignette described a typical patient for code 64420 as a 48-year-old female with a 2-year history of rib pain that is interfering with her ability to complete activities of daily living. She has had poor control of her pain despite multiple medication trials and physical therapy. Due to her persistent, debilitating pain, a trial of intercostal nerve block is scheduled to relieve her pain and improve her function. 97% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64420			
Highlights from Survey Data			
	25th Percentile	Median	75th Percentile
Work	1.24	1.50	1.86
Pre		25/5/5	
Intra	8	10	15
Post		10	

After review of the reviewer comments of the societies original recommended wRVU of 1.24 and time inputs, the Expert Panel agreed to recommend the following revised work RVU and time recommendation:

- wRVU
 - 1.18 wRVU (recommending maintaining the current value)
- Time
 - Pre-time: Facility pre-service package #1 -adjusted (13/1/5)
 - Intra-time: 10 minutes (survey median)
 - Post-time 10 minutes (survey median)

Crosswalk

Our recommended work RVU is supported by a crosswalk to code **67810** (*Incisional biopsy of eyelid skin including lid margin*); [wRVU=1.18; time=11/13/3; IWPUT=0.0688; RUC 2011].

The Expert Panel also concluded that recommended wRVU value and align well within and outside of the code family.

Current Value

- The current value of code 64420 is 1.18 wRVU
- The recommended wRVU of 1.18, which is less than the survey 25th percentile of 1.24, maintains this value

Comparison to Other Codes

- The Expert Panel compared the recommendation for 64420 to other codes and identified other 0-day global codes with similar intra-time. These comparisons indicated the code was aligned with other codes of similar time and value.

CPT Code	Long Desc	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm	000	1.14	15	0.059	146,808
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple	000	1.14	15	0.0345	36,331
64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	000	1.18	10	0.060	3,762
67810	Incisional biopsy of eyelid skin including lid margin	000	1.18	13	0.0688	30,330
46606	Anoscopy; with biopsy, single or multiple	000	1.2	11	0.0443	2,185
36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access	000	1.2	15	0.04	5,630
44385	Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	000	1.2	15	0.037	1,359
57100	Biopsy of vaginal mucosa; simple (separate procedure)	000	1.2	15	0.0427	5,797
57500	Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	000	1.2	15	0.06	7,650
12013	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	000	1.22	15	0.0644	50,886
40490	Biopsy of lip	000	1.22	15	0.0577	34,141
32562	Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day	000	1.24	10	0.0654	1,532
49082	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance	000	1.24	10	0.0654	12,016

In summary, for CPT Code 64420 (Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level) *ASA, AAPM, and AAPM&R recommend 1.18 wRVUs and 19/10/10 for time.*

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64420

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty Interventional Pain Management How often? Commonly

Specialty Pain Management How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 11286

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology Frequency 4518 Percentage 40.03 %

Specialty Interventional Pain Management Frequency 1290 Percentage 11.43 %

Specialty Pain Management Frequency 1260 Percentage 11.16 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,762

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization

Specialty Anesthesiology Frequency 1506 Percentage 40.03 %

Specialty Interventional Pain Management Frequency 430 Percentage 11.43 %

Specialty Pain Management Frequency 420 Percentage 11.16 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Minor procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64420

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 64421	Tracking Number	Original Specialty Recommended RVU: 0.60
		Presented Recommended RVU: 0.60
Global Period: ZZZ	Current Work RVU: 1.68	RUC Recommended RVU: 0.60

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each additional level (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old female has a 3-year history of persistent rib pain following a fall that resulted in multiple rib fractures. The pain is interfering with her ability to complete activities of daily living. She has had poor control of her pain despite multiple medication trials and physical therapy. Due to her persistent, debilitating pain, a trial of intercostal nerve blocks involving multiple intercostal spaces is scheduled to relieve her pain and improve her function.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: After the initial intercostal nerve block, additional intercostal nerve blocks are performed at other levels. After cleaning the skin with an antiseptic solution, 1-2 mL of dilute local anesthetic is infiltrated subcutaneously at the planned injection site at the inferior border of the rib. A needle is advanced at an angle of approximately 20° cephalad to the skin till the rib is contacted. With the same angle of insertion, the needle is walked off the inferior border of the rib and advanced 3 mm to place the tip in the space containing the neurovascular bundle between the internal and innermost intercostal muscles. After negative aspiration, local anesthetic is deposited at each of the sites. The needle is removed, and the sites are covered with a sterile occlusive dressing.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Neal Cohen, MD (ASA); Eduardo Fraifeld, MD (AAPM); Matthew Grierson, MD (AAPM&R); Marc Leib, MD (ASA); Gregory Polston, MD (AAPM); Richard Rosenquist, MD (ASA)				
Specialty Society(ies):	American Academy of Pain Medicine; American Academy of Physical Medicine and Rehabilitation; American Society of Anesthesiologists				
CPT Code:	64421				
Sample Size:	2452	Resp N:	60	Response: 2.4 %	
Description of Sample: random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	10.00	21.00	500.00
Survey RVW:	0.60	1.00	1.24	1.50	3.00
Pre-Service Evaluation Time:			0.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	1.00	8.00	10.00	15.00	35.00
Immediate Post Service-Time:	<u>0.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

Select Pre-Service Package

CPT Code:	64421	Recommended Physician Work RVU: 0.60		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	0.00	0.00	0.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	10.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
Select Post-Service Package				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	0.00	0.00	0.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64462	<u>ZZZ</u>	1.10	<u>RUC Time</u>

CPT Descriptor Paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64484	<u>ZZZ</u>	1.00	<u>RUC Time</u>

CPT Descriptor 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)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64484	<u>ZZZ</u>	1.00	<u>RUC Time</u>	450,460

CPT Descriptor 1 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)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64480	<u>ZZZ</u>	1.20	<u>RUC Time</u>	22,183

CPT Descriptor 2 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)

Other Reference CPT Code	Global	Work RVU	Time Source
15274	000	0.80	<u>RUC Time</u>

CPT Descriptor Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 17 **% of respondents:** 28.3 %

Number of respondents who choose 2nd Key Reference Code: 13 **% of respondents:** 21.6 %

TIME ESTIMATES (Median)

	CPT Code: <u>64421</u>	Top Key Reference CPT Code: <u>64462</u>	2nd Key Reference CPT Code: <u>64484</u>
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	10.00	15.00	10.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	10.00	15.00	10.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	35%	29%	35%	0%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
41%	41%	18%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	24%	35%	41%

Physical effort required	24%	53%	24%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

24%

35%

41%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	8%	62%	31%	0%
------------------------------	----	----	-----	-----	----

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

8%

62%

31%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	15%	54%	31%
--------------------------	-----	-----	-----

Physical effort required	0%	85%	15%
--------------------------	----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

8%

46%

46%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code +64421 (Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each additional level (List separately in addition to code for primary procedure) is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide

further definition and descriptor transparency around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code +64421 is currently a Harvard-valued code 0-day global code. The new code has been changed to an add-on code reported with base code 64420. A ZZZ global period has been assigned to the new code. Code +64421 was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA), the American Academy of Pain Medicine (AAPM) and the American Academy of Physical Medicine & Rehabilitation (AAPM&R).

October 2018 RUC Meeting Recommendation Rationale

A total of 60 responses were received from a random sample of 2,452 clinicians (2.4 percent response rate). ASA, AAPM and AAPM&R convened an Expert Panel to review the survey data. ***The societies are recommending 0.60 wRVUs and 10 minutes of intra-time.*** This results in an IWPOT of 0.060.

Vignette

The typical patient presents with persistent, debilitating pain, and receives a trial of intercostal nerve blocks involving multiple intercostal spaces. 97% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

+64421 Highlights from Survey Data			
	25th Percentile	Median	75th Percentile
Work	1.00	1.24	1.50
Intra	8	10	15

After a robust discussion the Expert Panel agreed to recommend:

- wRVU
 - 0.60 wRVUs which is based on a crosswalk
- Time
 - 10 minutes intra time

The Panel noted that the survey intra-time for +64421 was the same as the surveyed intra-time for 64420. Similar intra-service time for the codes was appropriate since they both described a single injection of an intercostal nerve.

The Expert Panel discussed how in general the treatment for pain conditions has become more complex as the opioid crisis has escalated, and treatment and coverage for other non-pharmacologic and non-interventional strategies has been limited. With worsening pain, this impacts mobility, and in general has led to a more sedentary population with increase in co-morbidities of diabetes, hypertension and obesity. These findings, particularly the increase in BMI, have led to increases in the technical skill and judgment necessary to perform the procedure as well as the associated psychological stress to reduce risk of complications, such as pneumothorax or intravascular complication.

In drafting their recommendations, the Expert Panel considered a number of factors.

Crosswalk

- The Expert Panel selected the code 77063 (Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)) as the crosswalk. The ZZZ code has a wRVU of 0.60 wRVUs and intra-time of 8 minutes. It was reviewed by the RUC in 2014. The Expert Panel agreed that +64421 aligned well both for wRVU value and intensity/complexity factors.

Relationship to Base Code

- The Expert Panel tested the appropriateness of the recommended wRVU of 0.60 by backing out the pre and post time from the recommended wRVU for the base code of 64420. This resulted in a wRVU value of 0.67. While this value was a little higher than the recommended value, the Expert Panel found this to be additional evidence of the appropriateness of the recommended wRVU.
 - $1.24 - [(13 \times 0.0224) + (1 \times 0.0224) + (5 \times 0.0081) + (10 \times 0.0224)] = 0.67$

Reference Code

- The Expert Panel also concluded that the recommendation aligned well with the top reference code, +64462 (*Paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure)*) which has a wRVU of 1.10, IWPUT of 0.0733 and intra time of 15 minutes. The Expert Panel noted that the reference code carries more intra time so the higher value was for the reference code was appropriate.

Other Codes in the Somatic Nerve Injection Family

- The Expert Panel also concluded the recommendation maintained rank order in the Somatic Nerve Injection family.

Code#	Description	Proposed wRVU
+64421	N block inj intercost sng, addl level	0.60
64435	N block inj paracervical	0.75
64450	N block other peripheral	0.84
64405	N block inj occipital	0.94
64408	N block inj vagus	0.94
64418	N block inj suprascapular	1.10
64400	N block inj trigeminal	1.14
64430	N block inj pudendal	1.15
64425	N block inj ilio-ing/hypogi	1.19
64420	N block inj intercost sng	1.24
64417	N block inj axillary	1.27
64447	N block inj fem single	1.40
64415	N block inj brachial plexus	1.42
64445	N block inj sciatic sng	1.47
64448	N block inj fem cont inf	1.78
64446	N blk inj sciatic cont inf	1.80
64449	N block inj lumbar plexus	1.80
64416	N block cont infuse b plex	1.81

Rank Order

- The Expert Panel also considered other ZZZ, RUC reviewed codes outside of the Somatic Nerve Injection family with similar intra-time and concluded that the recommendation aligned well with these codes and provided further evidence of the appropriateness of the recommendation.

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
+77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)	ZZZ	0.54	15	0.0330	481,426
+96571	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and	ZZZ	0.55	15	0.0367	3

	gastrointestinal tract)					
+64421	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each additional level (List separately in addition to code for primary procedure)	ZZZ	0.60	10	0.060	17,692
+77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)	ZZZ	0.60	15	0.0370	68,387
+77063*	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	ZZZ	0.60	8	0.0750	2,777,164
+78020	Thyroid carcinoma metastases uptake (List separately in addition to code for primary procedure)	ZZZ	0.60	20	0.0300	1,056
+95887	Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)	ZZZ	0.71	20	0.0355	14,162

* Also, selected as the crosswalk

In summary, for CPT Code +64421 (*Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each additional level (List separately in addition to code for primary procedure)*) **ASA, AAPM, and AAPM&R recommend 0.60 wRVUs and 0/10/0 for time.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 64420, Injection(s), anesthetic agent(s), and/or steroid; intercostal nerve, single level; 0-day global; 1.24 wRVU; time=19/10/10 (recommended at Oct 2018 RUC meeting)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64421

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty Interventional Pain Management How often? Commonly

Specialty Pain Management How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 53076

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology Frequency 16799 Percentage 31.65 %

Specialty Interventional Pain Management Frequency 10483 Percentage 19.75 %

Specialty Pain Management Frequency 9787 Percentage 18.43 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 17,692 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization

Specialty Anesthesiology Frequency 5600 Percentage 31.65 %

Specialty Interventional Pain Management Frequency 3494 Percentage 19.74 %

Specialty Pain Management Frequency 3262 Percentage 18.43 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Minor procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64421

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 64425	Tracking Number	Original Specialty Recommended RVU: 1.19
		Presented Recommended RVU: 1.19
Global Period: 000	Current Work RVU: 1.75	RUC Recommended RVU: 1.19

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old male has a 3-year history of pain in his groin following an open inguinal hernia repair that is interfering with his ability to complete activities of daily living. He has had poor control of his pain despite multiple medication trials and physical therapy. Due to persistent, debilitating pain, a trial of ilioinguinal /iliohypogastric nerve block is scheduled to relieve pain and improve function.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The site of the proposed procedure is identified and marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injectate is prepared. The skin is cleansed with an antiseptic solution, sterile drapes are applied and then the provider performs the universal protocol ("time out") with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks are identified. The anterior superior iliac spine is palpated and the target insertion site is marked 2 cm medial and 2 cm inferior to the anterior superior iliac spine. A local anesthetic skin wheal is created and then a needle is advanced through the external oblique muscle. A loss of resistance is appreciated as the needle passes through the muscle to lie between it and the internal oblique. After the initial loss of resistance, the needle is advanced again until a loss of resistance is encountered as the needle passes through the internal oblique muscle and is in the plane between the internal oblique and the transversus abdominus muscle. Following negative aspiration, a local anesthetic and steroid is injected. The needle is removed, and the site is observed for bleeding and covered with a sterile occlusive dressing.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and for evidence of successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Neal Cohen, MD (ASA); Eduardo Fraifeld, MD (AAPM); Matthew Grierson, MD (AAPM&R); Marc Leib, MD (ASA); Gregory Polston, MD (AAPM); Richard Rosenquist, MD (ASA)				
Specialty Society(ies):	American Academy of Pain Medicine; American Academy of Physical Medicine and Rehabilitation; American Society of Anesthesiologists				
CPT Code:	64425				
Sample Size:	2452	Resp N:	54	Response: 2.2 %	
Description of Sample: random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	8.00	23.00	500.00
Survey RVW:	0.84	1.19	1.30	1.59	30.00
Pre-Service Evaluation Time:			24.00		
Pre-Service Positioning Time:			5.00		
Pre-Service Scrub, Dress, Wait Time:			5.00		
Intra-Service Time:	1.00	10.00	11.00	15.00	31.00
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

5-NF Proc w minimal anes care (if no deduct 1 min)

CPT Code:	64425	Recommended Physician Work RVU: 1.19		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	7.00	7.00	0.00	
Pre-Service Positioning Time:	1.00	0.00	1.00	
Pre-Service Scrub, Dress, Wait Time:	1.00	1.00	0.00	
Intra-Service Time:	11.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
7A Local/Simple Procedure				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	5.00	18.00	-13.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64486	000	1.27	RUC Time

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64493	000	1.52	RUC Time

CPT Descriptor Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36620	000	1.00	RUC Time	577,239

CPT Descriptor 1 Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36556	000	1.75	RUC Time	450,710

CPT Descriptor 2 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

Other Reference CPT Code	Global	Work RVU	Time Source
40490	000	1.22	RUC Time

CPT Descriptor Biopsy of lip

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 25 % of respondents: 46.2 %

Number of respondents who choose 2nd Key Reference Code: 8 % of respondents: 14.8 %

TIME ESTIMATES (Median)

	CPT Code: 64425	Top Key Reference CPT Code: 64486	2nd Key Reference CPT Code: 64493
Median Pre-Service Time	9.00	15.00	17.00
Median Intra-Service Time	11.00	10.00	15.00
Median Immediate Post-service Time	5.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	25.00	35.00	42.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	4%	84%	12%	0%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
0%	80%	20%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	8%	64%	28%
Physical effort required	4%	84%	12%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%

92%

8%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More****Overall intensity/complexity**

0%

38%

25%

25%

13%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

25%

63%

13%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

38%

38%

25%

Physical effort required

13%

75%

13%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

25%

63%

13%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64425 (*Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves*) is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64425 is currently a Harvard-valued code that has not been previously surveyed. It was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA), the American Academy of Pain Medicine (AAPM) and the American Academy of Physical Medicine & Rehabilitation (AAPM&R).

October 2018 RUC Meeting Recommendation Rationale

A total of 54 responses were received from a random sample of 2,452 clinicians (2.2 percent response rate). ASA, AAPM and AAPM&R convened an Expert Panel to review the survey data. ***The societies are recommending 1.19 wRVUs (survey 25th) and time of pre (7/0/1), intra (11 min) and post (10 min).*** This results in an IWPUT of 0.073.

Vignette

The typical patient was describes as experiencing persistent, debilitating pain, a trial of ilioinguinal /iliohypogastric nerve block is scheduled to relieve pain and improve function. 94% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64425 Highlights from Survey Data			
	25th Percentile	Median	75th Percentile
Work	1.19	1.30	1.59
Pre		24/5/5/	
Intra	10	11	15
Post		10	

After a robust discussion the Expert Panel agreed to recommend:

- wRVU
 - 1.19 wRVU (25th percentile)
- Time
 - Pre-time: Non-facility pre-service package #5 -adjusted (7/0/1)
 - Intra-time: 11 minutes (survey median)
 - Post-time 10 minutes (survey median)

The Expert Panel discussed how in general the treatment for pain conditions has become more complex as the opioid crisis has escalated, and treatment and coverage for other non-pharmacologic and non-interventional strategies has been limited. With worsening pain, this impacts mobility, and in general has led to a more sedentary population with increase in co-morbidities of diabetes, hypertension and obesity. These findings, particularly the increase in BMI, have led to increases in the technical skill and judgment necessary to perform the procedure as well as the associated psychological stress to reduce risk of complications, such as pneumothorax or intravascular complication.

The Expert Panel concluded that recommended wRVU value and times appropriately reflect how the service is currently performed and it aligns well within and outside of the code family.

In drafting their recommendations, the Expert Panel considered a number of factors.

Current Value

- The Expert Panel agreed that the 25th percentile of 1.19 wRVUs which is less than the current wRVU of 1.75 is appropriate. The Expert Panel noted that this recommendation decreased the IWPUT to 0.073 from the current IWPUT of 0.0928. Since the code was previously Harvard-valued, they felt the surveyed time more appropriately reflects current practice and the recommended wRVU and resulting IWPUT was appropriate. This position is consistent with the RUC comments on the CY 2019 NPRM for code 95970 where they state that Harvard time “holds zero validity for comparison.”

Reference Code

- The Expert Panel also concluded that the recommendation aligned well with the top reference code, 64486 (*Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)*) which was surveyed in 2014, has a wRVU of 1.27,

IWPUT of 0.0781 and intra time of 10 minutes. The Expert Panel noted that the codes had the same intra time and a slightly higher IWPUT. They concluded the reference code supported the recommendation of 1.19 wRVUs for code 64425.

Other Codes in the Somatic Nerve Injection Family

- The Expert Panel also concluded the recommendation maintained rank order in the Somatic Nerve Injection family.

Code#	Description	Proposed wRVU
+64421	N block inj intercost sng, addl level	0.60
64435	N block inj paracervical	0.75
64450	N block other peripheral	0.84
64405	N block inj occipital	0.94
64408	N block inj vagus	0.94
64418	N block inj suprascapular	1.10
64400	N block inj trigeminal	1.14
64430	N block inj pudendal	1.15
64425	N block inj ilio-ing/hypogi	1.19
64420	N block inj intercost sng	1.24
64417	N block inj axillary	1.27
64447	N block inj fem single	1.40
64415	N block inj brachial plexus	1.42
64445	N block inj sciatic sng	1.47
64448	N block inj fem cont inf	1.78
64446	N blk inj sciatic cont inf	1.80
64449	N block inj lumbar plexus	1.80
64416	N block cont infuse b plex	1.81

Rank Order

- The Expert Panel also considered other 0-day global codes, RUC reviewed codes outside of the Somatic Nerve Injection family with similar intra-time and concluded that the recommendation aligned well with these codes and provided further evidence of the appropriateness of the recommendation.

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
45305	Proctosigmoidoscopy, rigid; with biopsy, single or multiple	000	1.15	10	0.0549	668
44382	Ileoscopy, through stoma; with biopsy, single or multiple	000	1.17	20	0.0262	1,520
67810	Incisional biopsy of eyelid skin including lid margin	000	1.18	13	0.0688	30,330
64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves)	000	1.19	11	0.073	7,404
46606	Anoscopy; with biopsy, single or multiple	000	1.20	11	0.0443	2,185
36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access	000	1.20	15	0.0400	5,630

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
44385	Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	000	1.20	15	0.0370	1,359
57100	Biopsy of vaginal mucosa; simple (separate procedure)	000	1.20	15	0.0427	5,797
57500	Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	000	1.20	15	0.0600	7,650

In summary, for CPT Code 64425 (*Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves*) **ASA, AAPM, and AAPM&R recommend 1.19 wRVUs and 8/11/10 for time.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64425

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty Pain Management How often? Commonly

Specialty Interventional Pain Management How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 22212

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology	Frequency 7923	Percentage 35.66 %
Specialty Pain Management	Frequency 2728	Percentage 12.28 %
Specialty Interventional Pain Management	Frequency 2619	Percentage 11.79 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,404
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization

Specialty Anesthesiology	Frequency 2641	Percentage 35.66 %
Specialty Pain Management	Frequency 909	Percentage 12.27 %
Specialty Interventional Pain Management	Frequency 873	Percentage 11.79 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Minor procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64425

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 64430	Tracking Number H11	Original Specialty Recommended RVU: 1.15
		Presented Recommended RVU: 1.15
Global Period: 000	Current Work RVU: 1.46	RUC Recommended RVU: 1.15

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old female has a 2-year history of pudendal neuralgia that is interfering with her ability to complete activities of daily living. She has had poor control of her pain despite multiple medication trials and physical therapy. Due to her persistent, debilitating pain, a trial of pudendal nerve block is scheduled to relieve her pain and improve her function.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The procedure is thoroughly explained to the patient ensuring the patient's understanding of the procedure and expected outcomes. The risks, benefits, and potential complications of the procedure are discussed. Informed consent is obtained and the appropriate instruments and materials are prepared. The patient changes into a gown and has a pelvic drape. The patient is placed in the dorsal lithotomy position and appropriate pelvic draping is completed.

Description of Intra-Service Work: A time out is performed. A bimanual examination is performed for determination of internal pelvic anatomy. Concentrated digital evaluation of the levator muscles, pelvic ligaments and the ischial spines is performed. The provider proceeds with povidone cleansing of the entire vaginal canal and cervix. The speculum is removed. A 10cc control syringe is filled with local anesthetic with or without epinephrine. A spinal needle is attached to the 10cc syringe. Sterile gloves are donned and the provider again palpates the ischial spine and sacrospinous ligament. Introduction of the needle guide / trumpet is performed aligning with the providers digital palpation of the injection site. The spinal needle is directed into the needle guide and an initial injection of the anesthetic is performed of the vaginal tissue. The needle is advanced through the vaginal epithelium to the sacrospinous ligament. Aspiration is performed to ensure no vascular perforation has occurred and further injection is performed. The needle is advanced again slightly monitoring for loss of resistance, signifying complete penetration of the sacrospinous ligament and entrance into the region of pudendal nerve. Aspiration is again performed to ensure no perforation of the major pelvic vessels. The anesthetic is injected slowly to monitor adverse effects of possible intravascular injection. The trumpet and needle are removed. A speculum is placed and hemostasis is confirmed at the injection site. The operator may choose to use more than 10cc of anesthetic and therefore the syringe may require refilling and repeat injection or a second syringe may be used. If bleeding is encountered, a large procto-swab is held in place to exert pressure on any bleeding sites. Proctoswabs are utilized for cleaning the posterior fourchette of any blood or extruded anesthetic.

Description of Post-Service Work: After the procedure is complete, the provider will evaluate the effects of the anesthetic on the nerve distribution. The provider monitors the patient for possible systemic reactions related to intravascular injection. Write post-procedure orders for care and pain medication. Create procedure note.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	George Hill, MD, Jon Hathaway, MD, Mitch Schuster, MD, Richard Rosenquist, MD, Neil Cohen, MD, Marc Leib, MD, Eduardo Fraifeld, MD and Gregory Polston, MD				
Specialty Society(ies):	ACOG, ASA, AAPM				
CPT Code:	64430				
Sample Size:	5489	Resp N:	67	Response: 1.2 %	
Description of Sample:	Random samples from ACOG (4000), ASA (989) and AAPM (500)				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	5.00	18.00	500.00
Survey RVW:	0.10	1.15	1.50	1.89	3.60
Pre-Service Evaluation Time:			22.00		
Pre-Service Positioning Time:			5.00		
Pre-Service Scrub, Dress, Wait Time:			5.00		
Intra-Service Time:	1.00	5.00	10.00	15.00	35.00
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth)

CPT Code:	64430	Recommended Physician Work RVU: 1.15		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time
Pre-Service Evaluation Time:		13.00	13.00	0.00
Pre-Service Positioning Time:		5.00	1.00	4.00
Pre-Service Scrub, Dress, Wait Time:		5.00	6.00	-1.00
Intra-Service Time:		10.00		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

		Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:		10.00	18.00	-8.00

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64644	000	1.82	RUC Time

CPT Descriptor Chemodenervation of one extremity; 5 or more muscles**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62323	000	1.80	RUC Time

CPT Descriptor 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); with imaging guidance (ie, fluoroscopy or CT)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
23350	000	1.00	RUC Time	37,824

CPT Descriptor 1 Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64644	000	1.82	RUC Time	31,712

CPT Descriptor 2 Chemodenervation of one extremity; 5 or more muscles

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64483	000	1.90	RUC Time

CPT Descriptor Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 9 % of respondents: 13.4 %

Number of respondents who choose 2nd Key Reference Code: 8 % of respondents: 11.9 %

TIME ESTIMATES (Median)

	CPT Code: 64430	Top Key Reference CPT Code: 64644	2nd Key Reference CPT Code: 62323
Median Pre-Service Time	23.00	15.00	20.00
Median Intra-Service Time	10.00	25.00	15.00
Median Immediate Post-service Time	10.00	5.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	43.00	45.00	45.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	33%	67%	0%	0%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
0%	67%	33%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	11%	67%	22%

Physical effort required	11%	44%	44%
--------------------------	-----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

11%

56%

33%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	12%	38%	12%	38%
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Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

13%

38%

50%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	13%	25%	63%
--------------------------	-----	-----	-----

Physical effort required	0%	38%	63%
--------------------------	----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

25%

38%

38%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64430 is part of the larger Somatic Nerve Injection family, which represents revisions 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).

Time

Pre-time package 1: Straightforward Patient/ Straightforward Procedure (No anesthesia care). Added five minutes for the Dorsal Lithotomy position (then reduced by one minute due to survey data). Reduced SDW one minute due to survey data.

Post-time package 7a: 7A Local Anesthesia/ Straightforward Procedure. Reduced time by eight minutes due to survey data.

Other Reference Code

We included 64483 as another reference code on the SOR. The survey respondents chose this code eight times, the same number of respondents that chose CPT Code 62323.

Billed Together

CPT Code 64430 is not typically billed with another service, nor is it typically billed with an E/M (23%).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64430

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty obstetrics/gynecology How often? Commonly

Specialty anesthesiology How often? Commonly

Specialty pain management How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. A national number is not known.

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,388

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Current RUC database indicates 3,388 Medicare claims in 2017.

Specialty obstetrics/gynecology	Frequency 949	Percentage 28.01 %
Specialty anesthesiology	Frequency 712	Percentage 21.01 %
Specialty pain management	Frequency 407	Percentage 12.01 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Minor procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64430

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 64435	Tracking Number H12	Original Specialty Recommended RVU: 0.75
		Presented Recommended RVU: 0.75
Global Period: 000	Current Work RVU: 1.45	RUC Recommended RVU: 0.75

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 34-year-old female with an IUD presented for removal. The IUD string was not identified on exam and initial probing of the cervical canal was not tolerated by the patient. Cervical dilation under cervical anesthesia is required for retrieval.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is;
Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The procedure is thoroughly explained to the patient ensuring the patient's understanding of the need for the procedure. The risks, benefits, and potential complications of the procedure are discussed. Informed consent is obtained and the appropriate instruments and materials are prepared. The patient is placed in the dorsal lithotomy position and appropriate draping is completed.

Description of Intra-Service Work: The provider places a speculum into the vagina. The speculum is positioned so that the cervix is centered in the operative field. The cervix and lateral vagina are cleaned with an appropriate solution. A 10cc syringe is filled with local anesthetic with or without epinephrine. The provider places a single tooth tenaculum at the 12 o'clock position of the cervix to stabilize the organ. A spinal needle is attached to the 10cc syringe. Initial aspirations and then injections of the anesthetic are placed into the cervix at the 3 and 9 o'clock position or the 2, 4, 8, and 10 o'clock positions. The anesthetic is injected slowly to ascertain infiltration of the stroma of the cervix. Hemostasis is confirmed at each injection site after injection. After the procedure, often bleeding is encountered from the injection site causing the need to hold pressure with pronto-swabs until stable. Once the procedure is complete, the operator will wait for complete anesthetic effect.

Description of Post-Service Work: After the procedure is complete, the provider will evaluate the effects of the anesthetic on the nerve distribution to observe possible untoward effects. The provider monitors the patient for possible systemic reactions related to intravascular injection and possible hematoma development in the retroperitoneal space. Write post-procedure orders for care and pain medication. Create procedure note.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	George Hill, MD, Jon Hathaway, MD and Mitch Schuster				
Specialty Society(ies):	ACOG				
CPT Code:	64435				
Sample Size:	4000	Resp N:	42	Response: 1.0 %	
Description of Sample:	Random samples from ACOG (4000)				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	18.00	50.00	500.00
Survey RVW:	0.60	0.75	1.00	1.20	2.75
Pre-Service Evaluation Time:			10.00		
Pre-Service Positioning Time:			3.00		
Pre-Service Scrub, Dress, Wait Time:			3.00		
Intra-Service Time:	1.00	3.00	5.00	10.00	30.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

5-NF Proc w minimal anes care (if no deduct 1 min)

CPT Code:	64435	Recommended Physician Work RVU: 0.75		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	7.00	7.00	0.00	
Pre-Service Positioning Time:	3.00	0.00	3.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	1.00	-1.00	
Intra-Service Time:	5.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) N/A Survey Code is Non-Facility				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	5.00	0.00	5.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
20551	000	0.75	RUC Time

CPT Descriptor Injection(s); single tendon origin/insertion**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
57500	000	1.20	RUC Time

CPT Descriptor Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
20552	000	0.66	RUC Time	371,780

CPT Descriptor 1 Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
23350	000	1.00	RUC Time	37,824

CPT Descriptor 2 Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 12 % of respondents: 28.5 %

Number of respondents who choose 2nd Key Reference Code: 11 % of respondents: 26.1 %

TIME ESTIMATES (Median)

	CPT Code: <u>64435</u>	Top Key Reference CPT Code: <u>20551</u>	2nd Key Reference CPT Code: <u>57500</u>
Median Pre-Service Time	10.00	10.00	9.00
Median Intra-Service Time	5.00	5.00	15.00
Median Immediate Post-service Time	5.00	5.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	20.00	20.00	29.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	50%	50%	0%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	8%	50%	42%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	8%	25%	67%
Physical effort required	8%	42%	50%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

17%

42%

42%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

9%

45%

45%

0%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

45%

36%

18%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

9%

18%

73%

Physical effort required

9%

73%

18%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

18%

45%

36%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64435 is part of the larger Somatic Nerve Injection family, which represents revisions 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).

Time

CPT Code 64435 is typically performed in the non facility setting, with minimal anesthesia care. As such, we selected pre time package 5 and removed 1 minute for no anesthesia care. Three minutes were added to positioning to account for the dorsal lithotomy positioning (survey data was 3 minutes).

Billed Together

CPT Code 64435 is not typically billed with another service, nor is it typically billed with an E/M (0%).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64435

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty obstetrics/gynecology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. A national number is not known

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 78 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Current RUC database (2017 utilization)

Specialty obstetrics/gynecology	Frequency 36	Percentage 46.15 %
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Minor procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64435

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 64445	Tracking Number	Original Specialty Recommended RVU: 1.47
		Presented Recommended RVU: 1.30
Global Period: 000	Current Work RVU: 1.48	RUC Recommended RVU: 1.30

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old female has just undergone a right trimalleolar fracture open reduction and fixation, and the surgeon consults the anesthesiologist for pain management in the recovery room. The planned technique is a sciatic nerve block, to which the patient consents.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is;
Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The site of the proposed injection is identified and marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injectate is prepared. The skin is cleansed with an antiseptic solution and sterile drapes are applied. A universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks are identified. A local anesthetic skin wheal is created and placed at injection site. The skin at the proposed entry site is anesthetized with a small amount of local anesthetic via a small-gauge needle. An insulated stimulating needle is inserted through the skin in the gluteal region. A nerve stimulator is turned on and the patient is monitored for reports of paresthesia or appropriate muscle twitches in the leg in response to nerve stimulation. The current on the nerve stimulator is reduced to confirm proximity of the needle to the sciatic nerve and to reposition if necessary to maintain a muscle twitch in the appropriate distribution with a low current. Once correct needle position is obtained, the needle is aspirated to confirm the absence of blood. Following negative aspiration, administer a small test dose of local anesthetic, monitor the patient's VS, and question the patient about symptoms of intravascular local anesthetic injection. If there are no signs or symptoms of intravascular injection, inject local anesthetic in incremental doses with frequent aspiration to avoid intra-vascular injection. After completion of the injection, remove the needle. Observe the patient for any signs or symptoms of local anesthetic toxicity. After several minutes have passed, evaluate the initial effects of the sciatic nerve block by physical examination to determine if the patient is developing weakness, numbness, and relief of pain in the expected nerve distribution.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and for evidence of successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Neal Cohen, MD (ASA); Matthew Grierson, MD (AAPM&R); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA)				
Specialty Society(ies):	American Academy of Physical Medicine and Rehabilitation; American Society of Anesthesiologists				
CPT Code:	64445				
Sample Size:	6346	Resp N:	68	Response: 1.0 %	
Description of Sample:	random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	24.50	50.50	1000.00
Survey RVW:	0.80	1.30	1.51	1.83	10.00
Pre-Service Evaluation Time:			15.00		
Pre-Service Positioning Time:			3.50		
Pre-Service Scrub, Dress, Wait Time:			4.00		
Intra-Service Time:	1.00	6.00	10.00	13.25	30.00
Immediate Post Service-Time:	6.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

5-NF Proc w minimal anes care (if no deduct 1 min)

CPT Code:	64445	Recommended Physician Work RVU: 1.30		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time
Pre-Service Evaluation Time:		7.00	7.00	0.00
Pre-Service Positioning Time:		1.00	0.00	1.00
Pre-Service Scrub, Dress, Wait Time:		1.00	1.00	0.00
Intra-Service Time:		10.00		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

N/A Survey Code is Non-Facility

		Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:		5.00	0.00	5.00

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64486	000	1.27	RUC Time

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64483	000	1.90	RUC Time

CPT Descriptor Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
23350	000	1.00	RUC Time	37,824

CPT Descriptor 1 Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64644	000	1.82	RUC Time	31,712

CPT Descriptor 2 Chemodenervation of one extremity; 5 or more muscles

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62324	000	1.89	RUC Time

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 19 % of respondents: 27.9 %

Number of respondents who choose 2nd Key Reference Code: 10 % of respondents: 14.7 %

TIME ESTIMATES (Median)

	CPT Code: <u>64445</u>	Top Key Reference CPT Code: <u>64486</u>	2nd Key Reference CPT Code: <u>64483</u>
Median Pre-Service Time	9.00	15.00	24.00
Median Intra-Service Time	10.00	10.00	15.00
Median Immediate Post-service Time	5.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	24.00	35.00	49.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	6%	6%	61%	22%	6%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
26%	42%	32%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	17%	39%	45%

Physical effort required	17%	44%	40%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

12%

56%

34%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	20%	50%	30%	0%
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Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

40%

30%

30%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	10%	50%	40%
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Physical effort required	10%	60%	30%
--------------------------	-----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

30%

50%

20%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64445 (Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single) is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide

further definition and descriptor transparency around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64445 was previously surveyed by the RUC in 2009. It was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA) and the American Academy of Physical Medicine & Rehabilitation (AAPM&R).

October 2018 RUC Meeting Recommendation Rationale

A total of 68 responses were received from a random sample of 6,346 clinicians (1.0 percent response rate). ASA convened an Expert Panel to review the survey data. ***The society is recommending a value of 1.30 wRVUs (25th percentile) and time of pre (7/1/1), intra (10 min) and post (6 min).*** This results in an IWPUP of 0.098.

Vignette

The typical patient has just undergone a right trimalleolar fracture open reduction and fixation, and the surgeon consults the anesthesiologist for pain management in the recovery room. 85% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64445 Highlights from Survey Data			
	25th Percentile	Median	75th Percentile
Work	1.30	1.51	1.83
Pre		15/3.5/4	
Intra	6	10	13.25
Post		6	

After review of the reviewer comments of the societies original recommended wRVU of 1.47 and time inputs, the Expert Panel agreed to recommend the following revised work RVU and time recommendations as interim and to resurvey for the January 2019 RUC meeting:

- wRVU
 - 1.30 wRVU based on survey 25th percentile
- Time
 - Pre-time: Non-facility pre-service package #5 (7/1/1); 1 minute added for positioning
 - Intra-time: 10 minutes (survey median)
 - Post-time 6 minutes (survey median)

Survey 25th Percentile

The specialties societies' recommendation of 1.30 is based on the survey's 25th percentile.

In summary, for CPT code CPT Code 64445 (*Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single*) ***ASA and AAPM&R recommend 1.30 wRVUs and 7/10/6 for time.***

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64445

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty Internal Medicine How often? Commonly

Specialty General Practice How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 358560

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilizationnn

Specialty Anesthesiology	Frequency 132165	Percentage 36.85 %
Specialty Internal Medicine	Frequency 60382	Percentage 16.84 %
Specialty General Practice	Frequency 29079	Percentage 8.10 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

119,520 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilizationnn

Specialty Anesthesiology	Frequency 44055	Percentage 36.85 %
Specialty Internal Medicine	Frequency 20127	Percentage 16.83 %
Specialty General Practice	Frequency 9693	Percentage 8.10 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64445

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 64446	Tracking Number	Original Specialty Recommended RVU: 1.80
		Presented Recommended RVU: 1.70
Global Period: 000	Current Work RVU: 1.81	RUC Recommended RVU: 1.54

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old male suffers a crushed left foot in an automobile accident. He undergoes major reconstruction of his left foot and ankle under general anesthesia. The surgeon requests a block with continuous infusion to manage post-operative pain and facilitate rehabilitation. In order to provide post-operative pain control, a continuous sciatic nerve block is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. An intravenous infusion is initiated and supplemental oxygen is provided. The site of the proposed injection is identified and marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injection is prepared. The skin is cleansed with an antiseptic solution and sterile drapes are applied. A universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks are identified. A local anesthetic skin wheal is created at the planned needle insertion site. A Touhy needle is advanced toward the sciatic nerve. A nerve stimulator is attached to the needle and the needle is advanced until it is close to the nerve. A brisk motor response in the ankle, foot or toes is noted with less than 0.4 mA stimulation. A catheter is then advanced through the Tuohy needle until it is 3 – 10 cm beyond its tip. The electrical connection is then transferred to the catheter and nerve stimulation is again evaluated to confirm that the catheter is lying next to the nerve. The Tuohy needle is removed, the catheter secured in place and 15-20 ml of a local anesthetic is injected through the catheter. Block of the sciatic nerve is then assessed over the next 15-30 minutes and an infusion of a dilute local anesthetic is started. Subcutaneous tunneling, affixation, and dressing of the catheter must be done carefully as this area is prone to bacterial contamination both during and after the procedure.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and for evidence of successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Neal Cohen, MD (ASA); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA)				
Specialty Society(ies):	American Society of Anesthesiologists				
CPT Code:	64446				
Sample Size:	3894	Resp N:	48	Response: 1.2 %	
Description of Sample: random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	20.00	37.00	1000.00
Survey RVW:	1.00	1.80	2.19	2.33	10.00
Pre-Service Evaluation Time:			15.00		
Pre-Service Positioning Time:			4.00		
Pre-Service Scrub, Dress, Wait Time:			5.00		
Intra-Service Time:	1.00	10.00	15.00	19.00	30.00
Immediate Post Service-Time:	6.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64446	Recommended Physician Work RVU: 1.54		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	13.00	13.00	0.00	
Pre-Service Positioning Time:	1.00	1.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	5.00	6.00	-1.00	
Intra-Service Time:	15.00			
Please, pick the <u>post</u>-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended post time should not exceed your survey median time)				
7A Local/Simple Procedure				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	6.00	18.00	-12.00	

<u>Post-Operative Visits</u>	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62325	000	2.20	RUC Time

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62323	000	1.80	RUC Time

CPT Descriptor 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); with imaging guidance (ie, fluoroscopy or CT)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64644	000	1.82	RUC Time	31,712

CPT Descriptor 1 Chemodenervation of one extremity; 5 or more muscles

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64483	000	1.90	RUC Time	1,043,217

CPT Descriptor 2 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62324	000	1.89	RUC Time

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 26 **% of respondents:** 54.1 %

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 16.6 %

TIME ESTIMATES (Median)

	CPT Code: <u>64446</u>	Top Key Reference CPT Code: <u>62325</u>	2nd Key Reference CPT Code: <u>62323</u>
Median Pre-Service Time	19.00	20.00	20.00
Median Intra-Service Time	15.00	15.00	15.00
Median Immediate Post-service Time	6.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	40.00	45.00	45.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	12%	28%	60%	0%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
20%	44%	36%

Technical Skill/Physical Effort

<u>Less</u>	<u>Identical</u>	<u>More</u>
12%	32%	56%

Physical effort required	0%	46%	54%
--------------------------	----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

16%

48%

36%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	13%	88%	0%	0%
------------------------------	----	-----	-----	----	----

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

13%

75%

13%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	25%	63%	13%
--------------------------	-----	-----	-----

Physical effort required	0%	88%	13%
--------------------------	----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

13%

88%

0%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64446 (*Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement)*) is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency around the use of these

codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64446 was previously surveyed by the RUC in 2008. It was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA).

October 2018 RUC Meeting Recommendation Rationale

A total of 48 responses were received from a random sample of 3,894 clinicians (1.2 percent response rate). ASA convened an Expert Panel to review the survey data. ***The society is recommending an interim value of 1.70 wRVUs and time of pre (13/1/5), intra (15 min) and post (6 min).*** This results in an IWPUT of 0.081.

The reviewers indicated that the code was surveyed more than 75% with imaging and recommended that the code should be sent back to CPT, imaging should be bundled and the code should be re-surveyed. The specialty agrees with this recommendation and is why they are recommending an interim value for this code. The interim recommended value is less than the survey 25th percentile.

Vignette

The typical patient is described as receiving a sciatic nerve block for post-operative pain control. 92% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64446			
Highlights from Survey Data			
	25th Percentile	Median	75th Percentile
Work	1.80	2.19	2.33
Pre		15/4/5	
Intra	10	15	19
Post		6	

After review of the reviewer comments, ASA is reducing its original recommendation of 1.80 wRVUs to:

- wRVU
 - 1.70 wRVUs
- Time
- Pre-time: Facility pre-service package #1 -adjusted (13/1/5)
- Intra-time: 15 minutes (survey median)
- Post-time 6 minutes (survey median)

Crosswalk

The interim recommended value is based on a crosswalk. Reviewers note that the intra-service time had decreased by 5 minutes from the previous RUC survey. The Expert Panel considered these comments and selected code **10035** (*Placement of soft tissue localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including image guidance, first lesion*) which has a wRVU of 1.70, time of 20/15/10, IWPUT of 0.0733 and 2015 RUC survey.

The Expert Panel noted that it provided a reasonable increment from 64445 (*Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single*) to account for the “continuous infusion by catheter.”

The Expert Panel also concluded the recommendation maintained rank order in the Somatic Nerve Injection family.

Other Comparison Codes

The Expert Panel also considered other 0-day RUC reviewed codes outside of the Somatic Nerve Injection family with similar intra-time and concluded that the recommendation aligned with these codes

CPT Code	Long Desc	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
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CPT Code: 64446						
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	000	1.64	15	0.0839	1,385
36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older	000	1.7	15	0.0757	148,430
43201	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance	000	1.72	15	0.0716	240
43202	Esophagoscopy, flexible, transoral; with biopsy, single or multiple	000	1.72	15	0.0716	2,369
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	000	1.75	15	0.0841	450,710
57410	Pelvic examination under anesthesia (other than local)	000	1.75	15	0.0345	2,420

In summary, for CPT code CPT Code 64446 (*Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement)*) **ASA recommends 1.70 wRVUs and 19/15/6 for time.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☒ Multiple codes are used to maintain consistency with similar codes.
- ☒ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CPT code 76942-26 (Global: XXX; wRVUs: 0.67; Time: 7/15/5)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64446

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty CRNA How often? Commonly

Specialty Pain Management How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 17631

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology	Frequency 16238	Percentage 92.09 %
Specialty CRNA	Frequency 829	Percentage 4.70 %
Specialty Pain Management	Frequency 291	Percentage 1.65 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,877
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization

Specialty Anesthesiology	Frequency 5413	Percentage 92.10 %
Specialty CRNA	Frequency 276	Percentage 4.69 %
Specialty Pain Management	Frequency 97	Percentage 1.65 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Minor procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64446

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 64447	Tracking Number	Original Specialty Recommended RVU: 1.40
		Presented Recommended RVU: 1.29
Global Period: 000	Current Work RVU: 1.50	RUC Recommended RVU: 1.10

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, single

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old male undergoes a right anterior cruciate ligament repair under general anesthesia. In order to provide postoperative pain control and increase mobility in his knee, a femoral nerve block is performed. This “block” will allow earlier discharge from the recovery room, decreased postoperative pain, and earlier ambulation.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The proposed site of the nerve block is identified and marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injectate is prepared. The skin is cleansed with an antiseptic solution and sterile drapes are applied. A universal protocol (“time out”) is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks are identified. A local anesthetic skin wheal is created and placed at injection site. The skin at the proposed entry site is anesthetized with a small amount of local anesthetic via a small-gauge needle. An insulated stimulating needle is advanced through the skin in the groin. The nerve stimulator is turned on and the patient is monitored for reports of paresthesia or appropriate muscle twitches in the quadriceps in response to nerve stimulation. The current on the nerve stimulator is reduced to confirm proximity of the needle to the femoral nerve and the needle is repositioned if necessary to maintain a muscle twitch in the appropriate distribution with a low current. Once correct needle position is obtained, aspirate the needle to confirm the absence of blood. Following negative aspiration, administer a small test-dose of local anesthetic, monitor the patient’s VS, and question the patient about symptoms of intravascular local anesthetic injection. If there are no signs or symptoms of intravascular injection, inject local anesthetic in incremental doses with frequent aspiration to avoid intravascular injection. After completion of the injection, remove the needle. Observe the patient for any signs or symptoms of local anesthetic toxicity. After several minutes have passed, evaluate the initial effects of the femoral nerve block by physical examination to determine if the patient is developing weakness, numbness, and relief of pain in the expected nerve distribution.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and for evidence of successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Neal Cohen, MD (ASA); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA)				
Specialty Society(ies):	American Society of Anesthesiologists				
CPT Code:	64447				
Sample Size:	3894	Resp N:	62	Response: 1.5 %	
Description of Sample:	random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	13.00	30.00	60.00	1000.00
Survey RVW:	0.80	1.29	1.51	1.80	20.00
Pre-Service Evaluation Time:			12.00		
Pre-Service Positioning Time:			3.00		
Pre-Service Scrub, Dress, Wait Time:			3.00		
Intra-Service Time:	1.00	5.00	6.00	10.00	20.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64447	Recommended Physician Work RVU: 1.10		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	12.00	13.00	-1.00	
Pre-Service Positioning Time:	1.00	1.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	3.00	6.00	-3.00	
Intra-Service Time:	6.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended post time should not exceed your survey median time)				
7A Local/Simple Procedure				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	5.00	18.00	-13.00	

<u>Post-Operative Visits</u>	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64486	000	1.27	RUC Time

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62323	000	1.80	RUC Time

CPT Descriptor 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); with imaging guidance (ie, fluoroscopy or CT)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
23350	000	1.00	RUC Time	37,824

CPT Descriptor 1 Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64483	000	1.90	RUC Time	1,043,217

CPT Descriptor 2 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62324	000	1.89	RUC Time

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 27 % of respondents: 43.5 %

Number of respondents who choose 2nd Key Reference Code: 8 % of respondents: 12.9 %

TIME ESTIMATES (Median)

	CPT Code: <u>64447</u>	Top Key Reference CPT Code: <u>64486</u>	2nd Key Reference CPT Code: <u>62323</u>
Median Pre-Service Time	16.00	15.00	20.00
Median Intra-Service Time	6.00	10.00	15.00
Median Immediate Post-service Time	5.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	27.00	35.00	45.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	12%	58%	27%	4%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
15%	46%	39%

Technical Skill/Physical Effort

<u>Less</u>	<u>Identical</u>	<u>More</u>
19%	50%	31%
12%	69%	19%

Psychological Stress

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

Less

8%

Identical

50%

More

43%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More****Overall intensity/complexity**

0%

13%

63%

25%

0%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

Less

25%

Identical

75%

More

0%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

0%

63%

38%

Physical effort required

25%

63%

13%

Psychological Stress

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

Less

0%

Identical

88%

More

13%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64447 (*Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, single*) is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64447 was previously surveyed by the RUC in 2009. It was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA).

October 2018 RUC Meeting Recommendation Rationale

A total of 62 responses were received from a random sample of 3,894 clinicians (1.5 percent response rate). ASA convened an Expert Panel to review the survey data. ***The society is recommending an interim value of 1.29 wRVUs (survey 25th) and time of pre (13/1/5), intra (6 min) and post (5 min).*** This results in an IWPUR of 0.137.

The reviewers indicated that the code was surveyed more than 75% with imaging and recommended that the code should be sent back to CPT, imaging should be bundled and the code should be re-surveyed. The specialty agrees with this recommendation and is why they are recommending an interim value for this code. The interim recommended value is less than the survey 25th percentile.

Vignette

The typical patient receives a femoral nerve block for postoperative pain control and to increase mobility in their knee. This “block” will allow earlier discharge from the recovery room, decreased postoperative pain, and earlier ambulation. 95% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64447 Highlights from Survey Data			
	25th Percentile	Median	75th Percentile
Work	1.29	1.51	1.80
Pre		12/3/3	
Intra	5	6	10
Post		5	

After review of the reviewer comments, ASA is reducing its original recommendation of 1.50 wRVUs to:

- wRVU
 - 1.29 wRVU based on survey 25th percentile
- Time
 - Pre-time: Facility pre-service package #1 - adjusted (13/1/5)
 - Intra-time: 6 minutes (survey median)
 - Post-time 5 minutes (survey median)

Survey 25th Percentile

The interim recommendation of 1.29 is based on the survey 25th percentile.

Comparison Codes

The Expert Panel also identified two codes as reasonable comparisons. The Expert Panel agreed with the survey respondents that the surveyed code is more intense and complex than these comparison codes. Therefore the recommendation for a slightly higher value for the surveyed code in comparison to the reference codes seemed appropriate.

Code #	Descriptor	2018 wRVU	2018 IWPUR	Intra Time (min)	2017 Utilization
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes	1.27	0.0781	10	7,349

	imaging guidance, when performed)				
67505	Retrobulbar injection; alcohol	1.27	0.0781	10	181

In summary, for CPT code CPT Code 64447 (*Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, single*) **ASA recommends an interim value of 1.29 wRVUs and 19/6/5 for time.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☒ Multiple codes are used to maintain consistency with similar codes.
- ☒ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CPT code 76942-26 (Global: XXX; wRVUs: 0.67; Time: 7/15/5)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64447

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty CRNA How often? Commonly

Specialty Internal Medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 676098

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology Frequency 523232 Percentage 77.38 %

Specialty CRNA Frequency 56522 Percentage 8.36 %

Specialty Internal Medicine Frequency 54967 Percentage 8.13 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
 225,366 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
 Please explain the rationale for this estimate. Based on 2017 Medicare utilization

Specialty Anesthesiology	Frequency 174411	Percentage 77.39 %
Specialty CRNA	Frequency 18841	Percentage 8.36 %
Specialty Internal Medicine	Frequency 18322	Percentage 8.12 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
 Procedures

BETOS Sub-classification:
 Minor procedure

BETOS Sub-classification Level II:
 Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64447

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 64448	Tracking Number	Original Specialty Recommended RVU: 1.78
		Presented Recommended RVU: 1.60
Global Period: 000	Current Work RVU: 1.63	RUC Recommended RVU: 1.55

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter replacement)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male undergoes a right total knee replacement (CPT code 27447) under general anesthesia. The surgeon requests a block with continuous infusion to manage postoperative pain and facilitate rehabilitation. In order to provide postoperative pain control and increased mobility in his knee, a continuous femoral nerve block is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. An intravenous infusion is initiated and supplemental oxygen is provided. The site of the proposed injection is identified and marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injection is prepared. The skin is cleansed with an antiseptic solution and sterile drapes are applied. A universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks are identified. A local anesthetic skin wheal is created. An insulated Touhy needle is inserted through the skin and advanced towards the femoral nerve. Proper location of the needle is confirmed with the use of a nerve stimulator. A catheter is then advanced through the needle to lie next to the femoral nerve. Next, a local anesthetic is injected through the catheter with frequent aspiration and monitoring of the ECG and pulse oximeter to avoid the possibility of intravascular injection. The catheter is then secured in place and a sterile dressing is applied. Then a dilute local anesthetic infusion is initiated. Subcutaneous tunneling, affixation, and dressing of the catheter must be done carefully as this area is prone to bacterial contamination, both during and after the procedure.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and for evidence of successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Neal Cohen, MD (ASA); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA)				
Specialty Society(ies):	American Society of Anesthesiologists				
CPT Code:	64448				
Sample Size:	3894	Resp N:	51	Response: 1.3 %	
Description of Sample:	random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	20.00	30.00	1000.00
Survey RVW:	1.00	1.78	2.00	2.20	12.00
Pre-Service Evaluation Time:			14.00		
Pre-Service Positioning Time:			4.00		
Pre-Service Scrub, Dress, Wait Time:			5.00		
Intra-Service Time:	1.00	8.00	13.00	16.00	30.00
Immediate Post Service-Time:	6.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64448	Recommended Physician Work RVU: 1.55		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	13.00	13.00	0.00	
Pre-Service Positioning Time:	1.00	1.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	5.00	6.00	-1.00	
Intra-Service Time:	13.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended post time should not exceed your survey median time)				
7A Local/Simple Procedure				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	6.00	18.00	-12.00	

<u>Post-Operative Visits</u>	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62325	000	2.20	RUC Time

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62323	000	1.80	RUC Time

CPT Descriptor 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); with imaging guidance (ie, fluoroscopy or CT)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64644	000	1.82	RUC Time	31,712

CPT Descriptor 1 Chemodenervation of one extremity; 5 or more muscles

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64483	000	1.90	RUC Time	1,043,217

CPT Descriptor 2 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62324	000	1.89	RUC Time

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 23 % of respondents: 45.0 %

Number of respondents who choose 2nd Key Reference Code: 12 % of respondents: 23.5 %

TIME ESTIMATES (Median)

	CPT Code: <u>64448</u>	Top Key Reference CPT Code: <u>62325</u>	2nd Key Reference CPT Code: <u>62323</u>
Median Pre-Service Time	19.00	20.00	20.00
Median Intra-Service Time	13.00	15.00	15.00
Median Immediate Post-service Time	6.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	38.00	45.00	45.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	4%	30%	61%	4%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
22%	35%	43%

Technical Skill/Physical Effort

<u>Less</u>	<u>Identical</u>	<u>More</u>
4%	35%	61%

Physical effort required	5%	45%	50%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

22%

30%

48%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	18%	73%	9%	0%
------------------------------	----	-----	-----	----	----

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

27%

45%

27%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	27%	55%	18%
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Physical effort required	9%	73%	18%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

27%

64%

9%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64448 (*Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter replacement)*) is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency around

the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64448 was previously surveyed by the RUC in 2008. It was surveyed for the October 2018 RUC meeting by the American Society for Anesthesiologists (ASA).

October 2018 RUC Meeting Recommendation Rationale

A total of 51 responses were received from a random sample of 3,894 clinicians (1.3 percent response rate). ASA convened an Expert Panel to review the survey data. ***The society is recommending an interim value of 1.60 wRVUs and time of pre (13/1/5), intra (13 min) and post (6 min).*** This results in an IWPUT of 0.086.

The reviewers indicated that the code was surveyed more than 75% with imaging and recommended that the code should be sent back to CPT, imaging should be bundled and the code should be re-surveyed. The specialty agrees with this recommendation and is why they are recommending an interim value for this code. The interim recommended value is less than the survey 25th percentile and the current value of 1.63 wRVUs.

Vignette

The typical patient femoral nerve block to manage postoperative pain and facilitate rehabilitation after a total knee replacement. 88% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64448			
Highlights from Survey Data			
	25th Percentile	Median	75th Percentile
Work	1.78	2.00	2.20
Pre		14/4/5	
Intra	8	13	16
Post		6	

- **After review of the reviewer comments, ASA is reducing its original recommendation of 1.78 wRVUs to:**
- **wRVU**
 - 1.60 wRVU; this recommendation is less than the survey 25th percentile of 1.78 wRVUs and just slightly less than the current value of 1.63 wRVUs
- **Time**
 - Pre-time: Facility pre-service package #1 - adjusted (13/1/5)
 - Intra-time: 13 minutes (survey median)
 - Post-time 6 minutes (survey median)

Crosswalk

The interim recommended value is based on a crosswalk. Reviewers note that the intra-service time had decreased by 2 minutes from the previous RUC survey. The Expert Panel considered these comments and selected code **64488** (*Transversus abdominis plane (TAP) (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance when performed)*) which has a wRVU of 1.60, time of 20/15/10, IWPUT of 0.0733 and 2015 RUC survey.

The Expert Panel also concluded the recommendation maintained rank order in the Somatic Nerve Injection family.

In summary, for CPT code CPT Code 64448 (*Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter replacement)*) **ASA recommends 1.60 wRVUs and 19/13/6 for time.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☒ Multiple codes are used to maintain consistency with similar codes.
- ☒ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CPT code 76942-26 (Global: XXX; wRVUs: 0.67; Time: 7/15/5)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64448

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty CRNA How often? Commonly

Specialty Pain Management How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 128265

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology Frequency 114566 Percentage 89.31 %

Specialty CRNA Frequency 12172 Percentage 9.48 %

Specialty Pain Management Frequency 834 Percentage 0.65 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

42,755 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization

Specialty Anesthesiology Frequency 38189 Percentage 89.32 %

Specialty CRNA Frequency 4057 Percentage 9.48 %

Specialty Pain management Frequency 278 Percentage 0.65 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Minor procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64448

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 64449	Tracking Number	Original Specialty Recommended RVU: 1.80
		Presented Recommended RVU: 1.70
Global Period: 000	Current Work RVU: 1.81	RUC Recommended RVU: 1.55

CPT Descriptor: injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old female undergoes a left total knee replacement (CPT code 27447) under general anesthesia. The surgeon requests a block with a continuous infusion to manage post-operative pain and facilitate rehabilitation. In order to provide post-operative pain control and increased mobility in her knee, a continuous lumbar plexus block is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 61%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. An intravenous infusion is initiated and supplemental oxygen is provided. The site of the proposed injection is identified and marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injectate is prepared. The low back is prepped with a topical antiseptic and sterile drapes are applied. A universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks are identified. A local anesthetic skin wheal is created and placed at injection site. After infiltrating the skin and deeper tissues with local anesthetic using a small gauge needle, a Touhy needle designed to allow the introduction of a catheter is connected to a peripheral nerve stimulator and advanced to obtain stimulation of the lumbar plexus. At this point careful aspiration for blood and CSF is performed. A test dose of local anesthetic is administered to rule out IV or intrathecal injection. Between 15 and 30 ml of dilute local anesthetic is slowly injected through the needle, followed by insertion of an infusion catheter through the needle (about 5 cm past the tip of the needle). The patient is observed for signs of undesired epidural spread and associated hemodynamic changes, and for analgesia of the left leg and hip. The catheter is checked for intravascular and intrathecal placement and secured in place. Once correct function of the catheter is confirmed, a continuous infusion of a dilute local anesthetic is started.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and for evidence of successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Neal Cohen, MD (ASA); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA)				
Specialty Society(ies):	American Society of Anesthesiologists				
CPT Code:	64449				
Sample Size:	3894	Resp N:	36	Response: 0.9 %	
Description of Sample:	random				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	2.00	9.00	1000.00
Survey RVW:	1.00	1.80	2.20	2.41	12.00
Pre-Service Evaluation Time:			15.00		
Pre-Service Positioning Time:			5.00		
Pre-Service Scrub, Dress, Wait Time:			5.00		
Intra-Service Time:	1.00	8.00	14.00	20.00	30.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64449	Recommended Physician Work RVU: 1.55		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	13.00	13.00	0.00	
Pre-Service Positioning Time:	1.00	1.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	5.00	6.00	-1.00	
Intra-Service Time:	14.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended post time should not exceed your survey median time)				
7A Local/Simple Procedure				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	5.00	18.00	-13.00	

<u>Post-Operative Visits</u>	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62325	000	2.20	RUC Time

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62323	000	1.80	RUC Time

CPT Descriptor 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); with imaging guidance (ie, fluoroscopy or CT)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64644	000	1.82	RUC Time	31,712
<u>CPT Descriptor 1</u> Chemodenervation of one extremity; 5 or more muscles				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64483	000	1.90	RUC Time	1,043,217

CPT Descriptor 2 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62324	000	1.89	RUC Time

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 18 % of respondents: 50.0 %

Number of respondents who choose 2nd Key Reference Code: 8 % of respondents: 22.2 %

TIME ESTIMATES (Median)

	CPT Code: <u>64449</u>	Top Key Reference CPT Code: <u>62325</u>	2nd Key Reference CPT Code: <u>62323</u>
Median Pre-Service Time	19.00	20.00	20.00
Median Intra-Service Time	14.00	15.00	15.00
Median Immediate Post-service Time	5.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	38.00	45.00	45.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	6%	29%	41%	24%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
12%	41%	47%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	6%	29%	65%

Physical effort required	0%	47%	53%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

18%

29%

53%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	0%	75%	13%	13%
------------------------------	----	----	-----	-----	-----

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

0%

43%

57%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	0%	43%	57%
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Physical effort required	0%	71%	2900%
--------------------------	----	-----	-------

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%

57%

43%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64449 (*Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)*) is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency

around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64449 was previously surveyed by the RUC in 2008. It was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA).

October 2018 RUC Meeting Recommendation Rationale

A total of 36 responses were received from a random sample of 3,894 clinicians (0.90 percent response rate). ASA convened an Expert Panel to review the survey data. ***The society is recommending a value of 1.70 wRVUs and time of pre (13/1/5), intra (14 min) and post (5 min).*** This results in an IWPUT of 0.088.

Vignette

The typical patient received a lumbar plexus block after knee surgery for post-operative pain management and to facilitate rehabilitation. 61% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64449			
Highlights from Survey Data			
	25th Percentile	Median	75th Percentile
Work	1.80	2.20	2.41
Pre		15/5/5	
Intra	8	14	20
Post		5	

After review of the reviewer comments, ASA is reducing its original recommendation of 1.80 wRVUs to:

- wRVU
 - 1.70 wRVU; this is less than the survey 25h percentile of 1.80 wRVUs and less than the current value of 1.81 wRVUs
- Time
 - Pre-time: Facility pre-service package #1 - adjusted (13/1/5)
 - Intra-time: 14 minutes (survey median)
 - Post-time 5 minutes (survey median)

Currently code 64446 (*Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement)*) and code 64449 have the same value. This recommendation maintains the same value for both codes. Both codes also had similar survey times, providing evidence of the appropriateness of maintaining that relationship.

Crosswalk

The interim recommended value is based on a crosswalk. The Expert Panel selected code **10035** (*Placement of soft tissue localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including image guidance, first lesion*) which has a wRVU of 1.70, time of 20/15/10, IWPUT of 0.0733 and 2015 RUC survey.

The Expert Panel also concluded the recommendation maintained rank order in the Somatic Nerve Injection family.

Other Comparison Codes

The Expert Panel also considered other 0-day RUC reviewed codes outside of the Somatic Nerve Injection family with similar intra-time and concluded that the recommendation aligned with these codes.

CPT Code	Long Desc	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	000	1.64	15	0.0839	1,385

CPT Code: 64449						
36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older	000	1.7	15	0.0757	148,430
43201	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance	000	1.72	15	0.0716	240
43202	Esophagoscopy, flexible, transoral; with biopsy, single or multiple	000	1.72	15	0.0716	2,369
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	000	1.75	15	0.0841	450,710
57410	Pelvic examination under anesthesia (other than local)	000	1.75	15	0.0345	2,420

In summary, for CPT code CPT Code 64449 (*Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)*) **ASA recommends 1.70 wRVUs and 19/14/5 for time.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64449

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty Neurology How often? Commonly

Specialty Family Practice How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 6984

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology	Frequency 5826	Percentage 83.41 %
Specialty Neurology	Frequency 372	Percentage 5.32 %
Specialty Family Practice	Frequency 168	Percentage 2.40 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,328
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization

Specialty Anesthesiology	Frequency 1942	Percentage 83.41 %
Specialty Neurology	Frequency 124	Percentage 5.32 %
Specialty Family Practice	Frequency 56	Percentage 2.40 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64449

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 64450	Tracking Number	Original Specialty Recommended RVU: 0.84
		Presented Recommended RVU: 0.84
Global Period: 000	Current Work RVU: 0.75	RUC Recommended RVU: 0.75

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52-year-old female complains of chronic burning pain and a tingling sensation in the plantar aspect of her right foot. Clinical examination is consistent with tarsal tunnel syndrome. The decision is made to perform a therapeutic injection about the posterior tibial nerve utilizing local anesthetic and a steroid.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The site of the proposed injection is identified and marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injectate is prepared. The skin is cleansed with an antiseptic solution and sterile drapes are applied. A universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks are identified. A local anesthetic skin wheal is created and placed at injection site. Palpate the posterior tibial artery. Direct the needle slightly posterior and inferior to the posterior tibial artery. Prior to injecting, aspirate the needle to ensure that vascular structures are not injected. Redirect the needle proximally and distally and repeat aspiration and injection. The needle is removed, and the site is observed for bleeding and covered with a sterile occlusive dressing. .

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and for evidence of successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Neal Cohen, MD (ASA); Eduardo Fraifeld, MD (AAPM); Matthew Grierson, MD (AAPM&R); Kevin Kerber, MD (AAN); Marc Leib, MD (ASA); Gregory Polston, MD (AAPM); Richard Rosenquist, MD (ASA); Raissa Villanueva, MD (AAN)				
Specialty Society(ies):	American Academy of Neurology; American Academy of Pain Medicine; American Academy of Physical Medicine and Rehabilitation; American Society of Anesthesiologists				
CPT Code:	64450				
Sample Size:	3256	Resp N:	88	Response: 2.7 %	
Description of Sample: random					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	12.00	26.00	60.00	1475.00
Survey RVW:	0.50	1.00	1.34	1.80	6.50
Pre-Service Evaluation Time:			21.00		
Pre-Service Positioning Time:			5.00		
Pre-Service Scrub, Dress, Wait Time:			5.00		
Intra-Service Time:	1.00	5.00	10.00	15.00	45.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the **pre-service time package** that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

5-NF Proc w minimal anes care (if no deduct 1 min)

CPT Code:	64450	Recommended Physician Work RVU: 0.75		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	7.00	7.00	0.00	
Pre-Service Positioning Time:	1.00	0.00	1.00	
Pre-Service Scrub, Dress, Wait Time:	1.00	1.00	0.00	
Intra-Service Time:	5.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
7A Local/Simple Procedure				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	5.00	18.00	-13.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64486	000	1.27	RUC Time

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64493	000	1.52	RUC Time

CPT Descriptor Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
20553	000	0.75	RUC Time	346,970

CPT Descriptor 1 Injection(s); single or multiple trigger point(s), 3 or more muscles

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
23350	000	1.00	RUC Time	37,824

CPT Descriptor 2 Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
20526	000	0.94	RUC Time

CPT Descriptor Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 20 % of respondents: 22.7 %

Number of respondents who choose 2nd Key Reference Code: 18 % of respondents: 20.4 %

TIME ESTIMATES (Median)

	CPT Code: 64450	Top Key Reference CPT Code: 64486	2nd Key Reference CPT Code: 64493
Median Pre-Service Time	9.00	15.00	17.00
Median Intra-Service Time	5.00	10.00	15.00
Median Immediate Post-service Time	5.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	19.00	35.00	42.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	63%	32%	5%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
10%	60%	30%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	5%	80%	15%

Physical effort required	0%	85%	15%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

10%

65%

25%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	11%	56%	33%	0%
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Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

17%

72%

11%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	11%	61%	28%
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Physical effort required	6%	59%	35%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

6%

83%

11%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64450 (*Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch*) is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change

application to provide further definition and descriptor transparency around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64450 was previously surveyed by the RUC in 2011. It was surveyed for the October 2018 RUC meeting by the American Academy of Neurology (AAN), the American Academy of Pain Medicine (AAPM), the American Academy of Physical Medicine & Rehabilitation (AAPM&R) and the American Society of Anesthesiologists (ASA).

October 2018 RUC Meeting Recommendation Rationale

A total of 88 responses were received from a random sample of 3,256 clinicians (2.7 percent response rate). ASA convened an Expert Panel to review the survey data. ***The society is recommending 0.84 wRVUs and time of pre (7/0/1), intra (10 min) and post (5 min).*** This results in an IWPUT of 0.056.

Vignette

The vignette describes a typical patient experiencing a chronic burning pain and a tingling sensation in the plantar aspect of her right foot. Clinical examination is consistent with tarsal tunnel syndrome. The decision is made to perform a therapeutic injection about the posterior tibial nerve utilizing local anesthetic and a steroid.

78% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64450			
Highlights from Survey Data			
	25th Percentile	Median	75th Percentile
Work	1.00	1.34	1.80
Pre		21/5/5	
Intra	5	10	15
Post		5	

The survey 25th percentile is higher than the current value of 0.75 wRVUs. The Expert Panel considered recommending the 25th percentile which they felt to be approximating a reasonable value for the service. They also noted that the intra-time doubled from 5 minutes to 10 minutes since the last survey. The Expert Panel concluded that this increase in intra-time supported a higher wRVU.

After a robust discussion the Expert Panel agreed to recommend:

- wRVU
 - 0.84 work RVUs based on a crosswalk to code 12001
- Time
 - Pre-time: Non-facility pre-service package #5 (7/0/1)
 - Intra-time: 10 minutes (survey median)
 - Post-time 5 minutes (survey median)

The Expert Panel discussed how in general the treatment for pain conditions has become more complex as the opioid crisis has escalated, and treatment and coverage for other non-pharmacologic and non-interventional strategies has been limited. With worsening pain, this impacts mobility, and in general has led to a more sedentary population with increase in co-morbidities of diabetes, hypertension and obesity. These findings, particularly the increase in BMI, have led to increases in the technical skill and judgment necessary to perform the procedure as well as the associated psychological stress to reduce risk of complications, such as pneumothorax or intravascular complication.

The Expert Panel concluded that these values and times appropriately reflected how the service is currently performed. In drafting their recommendations, the Expert Panel considered a number of factors.

Crosswalk

- The Expert Panel selected a value that was less than the survey 25th percentile of 1.00 wRVUs; crosswalking the recommendation of 0.84 wRVUs to code 12001 (*Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less*). This 0-day global code

was reviewed by the RUC in 2010 and also has 10 minutes intra-service. It has an IWPUT of 0.0585. The Expert Panel believes that this is an appropriate crosswalk not only because it matches intra-service time but also because of similarity in complexity and intensity. The Expert Panel does believe that the surveyed code 64450 is a somewhat more intense/complex than 12001.

Reference Code

- The Expert Panel also concluded that the recommendation aligned well with the top reference code 64486 (*Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)*) which has a wRVU of 1.27, IWPOT of 0.0781 and intra time of 10 minutes. The Expert Panel noted that the codes had the same intra time and the reference code had a slightly higher IWPOT. The recommended value represents an appropriate rank order and alignment.

Other Codes in the Somatic Nerve Injection Family

- The Expert Panel also concluded the recommendation maintained rank order in the Somatic Nerve Injection family.

Code#	Description	Proposed wRVU
+64421	N block inj intercost sng, addl level	0.60
64435	N block inj paracervical	0.75
64450	N block other peripheral	0.84
64405	N block inj occipital	0.94
64408	N block inj vagus	0.94
64418	N block inj suprascapular	1.10
64400	N block inj trigeminal	1.14
64430	N block inj pudendal	1.15
64425	N block inj ilio-ing/hypogi	1.19
64420	N block inj intercost sng	1.24
64417	N block inj axillary	1.27
64447	N block inj fem single	1.40
64415	N block inj brachial plexus	1.42
64445	N block inj sciatic sng	1.47
64448	N block inj fem cont inf	1.78
64446	N blk inj sciatic cont inf	1.80
64449	N block inj lumbar plexus	1.80
64416	N block cont infuse b plex	1.81

Rank Order

- The Expert Panel also considered other 0-day, RUC reviewed codes outside of the Somatic Nerve Injection family with similar intra-time and concluded that the recommendation aligned well with these codes and provided further evidence of the appropriateness of the recommendation.

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles	000	0.75	10	0.0441	346,970
20610	Arthrocentesis, aspiration and/or injection, major joint or	000	0.79	5	0.1006	681,9323

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
	bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance					
11901	Injection, intralesional; more than 7 lesions	000	0.80	13	0.046	69,094
11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion	000	0.81	12	0.0488	3,646,411
69100	Biopsy external ear	000	0.81	12	0.0451	155,215
69220	Debridement, mastoidectomy cavity, simple (eg, routine cleaning)	000	0.83	10	0.0651	52,818
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	000	0.84	10	0.056	413,282
65222	Removal of foreign body, external eye; corneal, with slit lamp	000	0.84	7	0.0944	27,017
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	000	0.84	10	0.0585	189,564
45330	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	000	0.84	10	0.0217	54,322
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	000	0.84	15	0.0261	7
51720	Bladder instillation of anticarcinogenic agent (including retention time)	000	0.87	5	0.1199	192,279
20604	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording	000	0.89	10	0.0581	40,141

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
	and reporting					
57160	Fitting and insertion of pessary or other intravaginal support device	000	0.89	15	0.0268	90,878

In summary, for CPT code CPT Code 64450 (*Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch*) **the societies recommend 0.84 wRVUs and 8/10/5 for time.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64450

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty Nurse Practitioners How often? Commonly

Specialty Pain Management How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 945589

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology	Frequency 248974	Percentage 26.33 %
Specialty Nurse Practitioners	Frequency 122927	Percentage 13.00 %
Specialty Pain Management	Frequency 115646	Percentage 12.23 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
 378,236 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
 Please explain the rationale for this estimate. Based on 2017 Medicare utilization

Specialty Anesthesiology	Frequency 99589	Percentage 26.32 %
Specialty Nurse Practitioners	Frequency 49171	Percentage 13.00 %
Specialty Pain Management	Frequency 46258	Percentage 12.22 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
 Procedures

BETOS Sub-classification:
 Minor procedure

BETOS Sub-classification Level II:
 Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64450

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS				
13	ISSUE: Somatic Nerve Injection (as revised 10/6/2018)																																																
14	TAB: 9																																																
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged				SURVEY EXPERIENCE										
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX				
17	1st REF	62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	11	0.107			2.20			45	10	5	5		15				10																													
18	2nd REF	64644	Chemodenervation of one extremity; 5 or more muscles	8	0.055			1.82			45	10	5			25				5																													
19	CURRENT	64400	Injection, anesthetic agent; trigeminal nerve, any division or branch		0.011			1.11			69	16				37				16																													
20	SVY	64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)	56	0.048	0.50	1.14	1.50	2.20	15.00	53	18	5	5	1	5	15	20	60	10																							0	2	10	50	500		
21	SVY- ASA	64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)	31	0.075	0.65	1.46	2.10	2.35	15.00	62	22	5	5	1	14	15	20	60	15																								0	2	5	15	50	
22	SVY- AAN	64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)	25	0.141	0.50	1.00	1.25	1.50	2.50	26	8	3	3	2	5	6	10	20	6																								0	6	61	100	500	
23	REC	64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)		0.117	1.00					20	7	1	1			6			5																													
24																																																	
25						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged				SURVEY EXPERIENCE										
26	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX				
27	1st REF	20556	Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel	92	0.139			0.94			16	6					5			5																													
28	2nd REF	20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	19	0.075			0.66			21	5	1	5			5			5																													
29	CURRENT	64405	Injection, anesthetic agent; greater occipital nerve		0.112			0.94			16	6					5			5																													
30	SVY (April 2017)	64405	Injection, anesthetic agent; greater occipital nerve	3856	0.132	0.50	0.94	1.00	1.29	14.00	22	6	3	3			5			5																							0	12	25	50	500		
31	REC	64405	Injection, anesthetic agent; greater occipital nerve		0.139	0.94					16	5	1				5				5																												
32																																																	
33						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged				SURVEY EXPERIENCE										
34	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX				
35	1st REF	20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	7	0.075			0.66			21	5	1	5			5			5																													
36	2nd REF	64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	5	0.078			1.27			35	5	5	5			10			10																													
37	CURRENT	64408	Injection, anesthetic agent; vagus nerve		0.060			1.41			36	10					16			10																													
38	SVY	64408	Injection, anesthetic agent; vagus nerve	37	0.112	0.75	0.90	1.25	1.90	11.00	37	21	3	2	2	3	5	10	45	6																								0	2	5	15	100	
39	REFERENCE	31575	Laryngoscopy, flexible; diagnostic		0.1172	0.94					19	5	1	3			5			5																													
40	REC	64408	Injection, anesthetic agent; vagus nerve		0.113	0.90					20	7	3				5			5																													
41																																																	
42						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged				SURVEY EXPERIENCE										
43	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX				

SS Rec Summary

[illegible]

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS		
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs			Office					Prolonged				SURVEY EXPERIENCE									
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX		
69	CURRENT	64418	Injection, anesthetic agent; suprascapular nerve		0.065			1.10			32	6	3	3			10			10																											
70	SVY (April - 2016)	64418	Injection, anesthetic agent; suprascapular nerve	139	0.045	0.70	1.00	1.20	1.45	4.00	47	17	5	5	1	5	10	13	45	10																						0	3	7	20	1300	
71	Crosswalk	20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting		0.079	1.10						5	2	5			10			5																											
72	REC	64418	Injection, anesthetic agent; suprascapular nerve		0.065	1.10					32	6	3	3			10			10																											
73																																															
74						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs			Office					Prolonged				SURVEY EXPERIENCE									
75	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX		
76	1st REF	64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level	23	0.066			1.52			42	7	5	5			15			10																											
77	2nd REF	64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluroscopy or CT); lumbar or sacral, single level	13	0.082			1.90			49	13	5	6			15			10																											
78	CURRENT	64420	Injection, anesthetic agent; intercostal nerve, single		0.043			1.18			37	10					17			10																											
79	SVY	64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	60	0.056	0.75	1.24	1.50	1.86	30.00	55	25	5	5	1	8	10	15	30	10																						0	2	10	25	500	
80	SVY- ASA	64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	25	0.114	1.52	1.74	1.92	2.11	30.00	48	18	5	5	1	7	10	15	30	10																						0	2	5	20	25	
81	SVY- AAPM&R	64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	15	0.041	1.30	1.40	1.50	1.50	1.52	58	23	5	5	5	9	15	20	28	10																						0	5	20	39	100	
82	SVY- AAPM	64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	20	0.024	0.75	1.00	1.20	1.23	1.30	56	25	5	5	5	8	10	15	20	11																											

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS		
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged				SURVEY EXPERIENCE								
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX		
96	REC	64421	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each additional level (List separately in addition to code for primary procedure)		0.060	0.60					10				10																																
97																																															
98						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged				SURVEY EXPERIENCE								
99	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX		
100	1st REF	64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	25	0.078				1.27			35	5	5	5				10			10																									
101	2nd REF	64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level	8	0.066				1.52			42	7	5	5				15			10																									
102	CURRENT	64425	Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves		0.093				1.75			31	8							15			8																								
103	SVY	64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves	54	0.035	0.84	1.19	1.30	1.59	30.00	55	24	5	5	1	10	11	15	31	10																			0	3	8	23	500				
104	SVY- ASA	64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves	26	0.051	0.92	1.05	1.30	1.56	30.00	47	20	5	5	1	10	11	15	30	6																			0	0	6	15	500				
105	SVY- AAPM&R	64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves	11	0.023	1.00	1.20	1.50	1.83	2.00	70	30	5	5	5	11	20	20	31	10																			0	3	6	15	50				
106	SVY- AAPM	64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves	17	0.038	0.84	1.20	1.27	1.50	1.90	53	23	5	5	3	9	10	12	25	10																			3	5	12	25	50				
107	REC	64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves		0.081	1.19					25	7	1	1				11			5																										
108																																															
109						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged				SURVEY EXPERIENCE								
110	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX		
111	1st REF	64644	Chemodenervation of one extremity; 5 or more muscles	9	0.055				1.82			45	10	5	0				25			5																									
112	2nd REF	62323	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); with imaging guidance (ie, fluoroscopy or CT)	8	0.080				1.80			45	10	5	5				15			10																									
113	CURRENT	64430	Injection, anesthetic agent; pudendal nerve		0.057				1.46			39	11							17			11																								
114	SVY	64430	Injection, anesthetic agent(s) and/or steroid; pudendal nerve	67	0.063	0.10	1.15	1.50	1.89	3.60	52	22	5	5	1	5	10	15	35	10																			0	2	5	18	500				
115	SVY- ASA	64430	Injection, anesthetic agent(s) and/or steroid; pudendal nerve	31	0.054	1.00	1.30	1.52	1.84	3.00	54	22	5	5	1	10	12	15	30	10																			0	2	6	20	500				
116	SVY- AAPM	64430	Injection, anesthetic agent(s) and/or steroid; pudendal nerve	9	0.063	0.80	1.38	1.80	2.00	2.50	62	29	5	5	5	10	12	18	35	11																			5	7	12	50	250				
117	SVY- ACOG	64430	Injection, anesthetic agent(s) and/or steroid; pudendal nerve	27	0.043	0.70	0.84	1.20	1.80	3.60	48	22	5	3	1	5	8	10	30	10																			0	1	3	6	50				
118	REC	64430	Injection, anesthetic agent(s) and/or steroid; pudendal nerve		0.048	1.15					43	13	5	5				10			10																										
119																																															
120						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged				SURVEY EXPERIENCE								
121	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX		
122	1st REF	20551	Injection(s); single tendon origin/insertion	12	0.083				0.75			20	10							5			5																								
123	2nd REF	57500	Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	11	0.060				1.20			29	7	1	1				15			5																									
124	CURRENT	64435	Injection, anesthetic agent; paracervical (uterine) nerve		0.064				1.45			33	8							17			8																								
125	SVY	64435	Injection, anesthetic agent(s) and/or steroid; paracervical (uterine) nerve	42	0.115	0.60	0.75	1.00	1.20	2.75	26	10	3	3	1	3	5	10	30	5																			0	5	18	50	500				
126	REC	64435	Injection, anesthetic agent(s) and/or steroid; paracervical (uterine) nerve		0.083	0.75					20	7	3	0				5			5																										
127																																															

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS							
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged				SURVEY EXPERIENCE													
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX							
128						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged				SURVEY EXPERIENCE													
129	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX							
130	1st REF	64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	19	0.078			1.27			35	5	5	5			10			10																																
131	2nd REF	64483	Injection(s), anesthetic agent andor steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level	10	0.082			1.90			49	13	5	6			15			10																																
132	CURRENT	64445	Injection, anesthetic agent; sciatic nerve, single		0.054			1.48			48	13	5	5			15			10																																
133	SVY	64445	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single	68	0.093	0.80	1.30	1.51	1.83	10.00	38.5	15	3.5	4	1	6	10	13	30	6																									0	10	25	51	1000			
134	SVY- ASA	64445	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single	57	0.114	0.88	1.35	1.52	1.90	10.00	33	13	3	3	1	6	9	10	20	5																										0	12	30	85	1000		
135	SVY- AAPM&R	64445	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single	11	0.012	0.80	1.24	1.40	1.59	1.92	75	30	5	5	3	8	20	20	30	15																											0	1	12	20	52	
136	Crosswalk	67810	Incisional biopsy of eyelid skin including lid margin		0.069			1.18			27	8	1	2			13			3																																
137	REC	64445	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single		0.088			1.18			24	7	1	1			10			5																																
138																																																				
139						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged				SURVEY EXPERIENCE													
140	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX							
141	1st REF	62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	26	0.107			2.20			45	10	5	5			15			10																																
142	2nd REF	62323	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); with imaging guidance (ie, fluoroscopy or CT)	8	0.080			1.80			45	10	5	5			15			10																																
143	CURRENT	64446	Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement)		0.045			1.81			64	19	5	5			20			15																																
144	SVY	64446	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement)	48	0.106	1.00	1.80	2.19	2.33	10.00	45	15	4	5	1	10	15	19	30	6																											0	4	20	37	1000	
145	Crosswalk	30903	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method		0.072			1.54			39	8	1	5			15			10																																
146	REC	64446	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement)		0.070			1.54			40	13	1	5			15			6																																
147																																																				
148						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged				SURVEY EXPERIENCE													
149	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX							
150	1st REF	64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	27	0.078			1.27			35	5	5	5			10			10																																
151	2nd REF	62323	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); with imaging guidance (ie, fluoroscopy or CT)	8	0.080			1.80			45	10	5	5			15			10																																
152	CURRENT	64447	Injection, anesthetic agent; femoral nerve, single		0.061			1.50			44	13	1	5			15			10																																
153	SVY	64447	Injection(s), anesthetic agent(s) and/or steroid;femoral nerve, single	62	0.173	0.80	1.29	1.51	1.80	20.00	29	12	3	3	1	5	6	10	20	5																												0	13	30	60	1000

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged				SURVEY EXPERIENCE						
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
154	Crosswalk	31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)			1.10					21	5	1	5	7					3																									
155	REC	64447	Injection(s), anesthetic agent(s) and/or steroid;femoral nerve, single		0.112	1.10					27	12	1	3	6					5																									
156																																													
157						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged				SURVEY EXPERIENCE						
158	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
159	1st REF	62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	23	0.107	2.20					45	10	5	5	15					10																									
160	2nd REF	62323	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); with imaging guidance (ie, fluoroscopy or CT)	12	0.080	1.80					45	10	5	5	15					10																									
161	CURRENT	64448	Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)		0.054	1.63					55	19	1	5	15					15																									
162	SVY	64448	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement)	51	0.109	1.00	1.78	2.00	2.20	12.00	42	14	4	5	1	8	13	16	30	6																			0	4	20	30	1000		
163	Crosswalk	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		0.090	1.55					39	10	3	5	11					10																									
164	REC	64448	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement)		0.082	1.55					38	13	1	5	13					6																									
165																																													
166						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged				SURVEY EXPERIENCE						
167	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
168	1st REF	62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	18	0.107	2.20					45	10	5	5	15					10																									
169	2nd REF	62323	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); with imaging guidance (ie, fluoroscopy or CT)	8	0.080	1.80					45	10	5	5	15					10																									
170	CURRENT	64449	Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)		0.049	1.81					60	19	5	5	20					11																									
171	SVY	64449	Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)	36	0.114	1.00	1.80	2.20	2.41	12.00	44	15	5	5	1	8	14	20	30	5																			0	0	2	9	1000		
172	Crosswalk]	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		0.090	1.55					39	10	3	5	11					10																									
173	REC	64449	Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)		0.077	1.55					38	13	1	5	14					5																									

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS			
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs			Office					Prolonged				SURVEY EXPERIENCE										
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX			
174																																																
175						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs			Office					Prolonged				SURVEY EXPERIENCE										
176	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX			
177	1st REF	64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	20	0.078			1.27			35	5	5	5			10			10																												
178	2nd REF	64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level	18	0.066			1.52			42	7	5	5			15			10																												
179	CURRENT	64450	Injection, anesthetic agent; other peripheral nerve or branch		0.083			0.75			20	10					5			5																												
180	SVY	64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	88	0.061	0.50	1.00	1.34	1.80	6.50	46	21	5	5	1	5	10	15	45	5																							0	12	26	60	1475	
181	SVY- ASA	64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	29	0.064	0.50	1.25	1.35	1.84	6.50	45	20	5	5	1	6	10	15	30	5																								0	10	25	60	400
182	SVY- AAPM&R	64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	15	0.084	0.75	1.10	1.60	1.82	2.00	47	20	5	5	1	9	10	19	45	7																								0	11	30	50	200
183	SVY- AAPM	64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	17	0.035	0.68	0.90	1.33	1.80	4.00	56	23	5	5	2	10	12	15	25	11																								5	25	30	50	400
184	SVY- AAN	64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	27	0.084	0.55	0.93	1.15	1.50	2.00	34	13	5	3	1	5	7	10	20	6																								1	8	20	95	1475
185	Crosswalk	20553	Injection(s); single or multiple trigger point(s), 3 or more muscles		0.044			0.75			27	5	2	5			10			5																												
186	REC	64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch		0.090			0.75			19	7	1	1			5			5																												
187																																																
188																																																

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

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

Global Period: 0 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Using the current direct PE inputs of code 64400 as the reference code

3. Is this code(s) typically billed with an E/M service?

No.

Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)

No it is billed with an E/M office visit 32% of the time.

4. What specialty is the dominant provider in the nonfacility? *Neurology – 59%*
What percent of the time does the dominant provider provide the service(s) in the nonfacility? *67%*
Is the dominant provider in the nonfacility different then for the global? *No.*
(Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

We are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies. Based on our Expert Panel review we identified a number of direct PE inputs (largely supplies) that are typically used when providing this service in the non-facility environment that are

not currently included. We have confirmed that the added PE clinical labor tasks, supplies, and equipment are not included in the current inputs or packages and that there is no duplication.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:

N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code). *5 minutes*

The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: *We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: heart rate, blood pressure, body mass index, temperature, and oxidation level.*

9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.

10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

N/A

12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.

N/A

13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:

N/A

14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:

N/A

15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

Table, exam - default

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: N/A

17. If there is any other item on your spreadsheet that needs further explanation please include here:
Consent is obtained in the pre-service period of the service period on the day of the procedure (CA011), in addition to being obtained in the pre-service period (CA004).

18. Please include an explanation of each line item:

Code	Supply	64400
SA041	pack, basic injection	For performing the procedure
SA048	pack, minimum multi-specialty visit	For day of procedure
SK075	skin marking pen, sterile (Skin Scribe)	For performing the procedure
SH023	chlorhexidine 0.12% (Peridex)	For sterile prep
SC028	needle, 18-26g 1.5-3.5in, spinal	For performing the procedure
SH021	bupivacaine 0.25% inj (Marcaine)	For performing the procedure
SC053	syringe 20ml	For performing the procedure
SA088	tray, surgical skin prep, sterile	For sterile prep
SJ081	swab, patient prep, 1.5 ml (chloraprep)	For sterile prep

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single

Global Period: 0 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Using the current direct PE inputs of code 64415 as the reference code

3. Is this code(s) typically billed with an E/M service?

No.

Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)

No it is billed with an E/M office visit 1% of the time.

4. What specialty is the dominant provider in the nonfacility? *Neurology – 34%*
What percent of the time does the dominant provider provide the service(s) in the nonfacility? *This service is provided in the non-facility setting 2% of the time.*

Is the dominant provider in the nonfacility different then for the global? *Yes. For the global, the dominant specialty is Anesthesiology (87%)*

(Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

We are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies. Based on our Expert Panel review we identified a number of direct PE inputs (largely supplies) that are typically used when providing this service in the non-facility environment that are

not currently included. We have confirmed that the added PE clinical labor tasks, supplies, and equipment are not included in the current inputs or packages and that there is no duplication.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*
8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) *5 minutes*
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: *We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: heart rate, blood pressure, body mass index, temperature, and oxidation level.*
9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.
10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*
11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*
12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*
13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

Table, exam – default

Nerve stimulator (eg, for nerve block) – default

ECG, 3-channel (with SpO2, NIBP, temp, respt) – default

Mayo stand - default

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

17. If there is any other item on your spreadsheet that needs further explanation please include here:
Consent is obtained in the pre-service period of the service period on the day of the procedure (CA011), in addition to being obtained in the pre-service period (CA004).

18. Please include an explanation of each line item:

Code	Supply	64415
SA041	pack, basic injection	For performing the procedure
SA048	pack, minimum multi-specialty visit	For day of procedure
SK075	skin marking pen, sterile (Skin Scribe)	For performing the procedure
SH023	chlorhexidine 0.12% (Peridex)	For sterile prep
SH047	lidocaine 1%-2% inj (Xylocaine)	For performing the procedure
SH022	bupivacaine 0.5% inj (Marcaine)	For performing the procedure
SC038	needle, epidural (RK)	For performing the procedure
SC053	syringe 20ml	For performing the procedure
SA088	tray, surgical skin prep, sterile	For sterile prep
SD269	Grounding pad	For performing the procedure
SB019	drape-towel, sterile 18in x 26in	For sterile prep
SJ081	swab, patient prep, 1.5 ml (chloraprep)	For sterile prep

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; axillary nerve

Global Period: 0 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Using the current direct PE inputs of code 64417 as the reference code

3. Is this code(s) typically billed with an E/M service?

No.

Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)

No it is billed with an E/M office visit 2% of the time.

4. What specialty is the dominant provider in the nonfacility? *Neurology – 48%*
What percent of the time does the dominant provider provide the service(s) in the nonfacility? *This service is provided in the non-facility setting less than 10% of the time.*

Is the dominant provider in the nonfacility different then for the global? *For the global, the dominant specialty is Anesthesiology (79%)*

(Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

We are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies. Based on our Expert Panel review we identified a number of direct PE inputs (largely

supplies) that are typically used when providing this service in the non-facility environment that are not currently included. We have confirmed that the added PE clinical labor tasks, supplies, and equipment are not included in the current inputs or packages and that there is no duplication.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*
8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) *5 minutes*
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: *We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: heart rate, blood pressure, body mass index, temperature, and oxidation level.*
9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.
10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*
11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*
12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*
13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:
16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

Table, exam – default

*Nerve stimulator (eg, for nerve block) – default
Mayo stand - default*

17. If there is any other item on your spreadsheet that needs further explanation please include here:
*Consent is obtained in the pre-service period of the service period on the day of the procedure (CA011),
in addition to being obtained in the pre-service period (CA004).*

18. Please include an explanation of each line item:

Code	Supply	64417
SA041	pack, basic injection	For performing the procedure
SA048	pack, minimum multi-specialty visit	For day of procedure
SK075	skin marking pen, sterile (Skin Scribe)	For performing the procedure
SH023	chlorhexidine 0.12% (Peridex)	For sterile prep
SH021	bupivacaine 0.25% inj (Marcaine)	For performing the procedure
SD050	electrode needle, injectable (Myoject)	For performing the procedure
SC038	needle, epidural (RK)	For performing the procedure
SC053	syringe 20ml	For performing the procedure
SA088	tray, surgical skin prep, sterile	For sterile prep
SJ081	swab, patient prep, 1.5 ml (chloraprep)	For sterile prep

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level

Global Period: 0 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Using the current direct PE inputs of code 64420 as the reference code

3. Is this code(s) typically billed with an E/M service?

No.

Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)

No it is billed with an E/M office visit 38% of the time.

4. What specialty is the dominant provider in the nonfacility? *Interventional Pain Management – 17%*
What percent of the time does the dominant provider provide the service(s) in the nonfacility? *47%*
Is the dominant provider in the nonfacility different then for the global? *For the global, the dominant specialty is Anesthesiology (40%)*

(Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) *5 minutes*
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: *We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: heart rate, blood pressure, body mass index, temperature, and oxidation level.*
9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.
10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*
11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*
12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*
13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

Table, exam – default
Mayo stand - default
16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*
17. If there is any other item on your spreadsheet that needs further explanation please include here:
Consent is obtained in the pre-service period of the service period on the day of the procedure (CA011), in addition to being obtained in the pre-service period (CA004).

18. Please include an explanation of each line item:

Code	Supply	64420
SA041	pack, basic injection	For performing the procedure
SA048	pack, minimum multi-specialty visit	For day of procedure
SK075	skin marking pen, sterile (Skin Scribe)	For performing the procedure
SC034	needle, blunt tip	For performing the procedure
SJ053	swab-pad, alcohol	For performing the procedure
SH047	lidocaine 1%-2% inj (Xylocaine)	For performing the procedure
SH022	bupivacaine 0.5% inj (Marcaine)	For performing the procedure
SC051	syringe 10-12ml	For performing the procedure

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each additional level (List separately in addition to code for primary procedure)

Global Period: 0 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Using the current direct PE inputs of code 64421 as the reference code

3. Is this code(s) typically billed with an E/M service?

No.

Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)

No it is billed with an E/M office visit 31% of the time.

4. What specialty is the dominant provider in the nonfacility? *Anesthesiology – 22%*
What percent of the time does the dominant provider provide the service(s) in the nonfacility? *57%*
Is the dominant provider in the nonfacility different then for the global? *No.*
(Please see provided data in PE Subcommittee folder)
5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time. *N/A*
7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) *5 minutes*
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: *We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: heart rate, blood pressure, body mass index, temperature, and oxidation level.*
9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.
10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*
11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*
12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*
13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

Table, exam – default
Mayo stand - default
16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*
17. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*
18. Please include an explanation of each line item:

Code	Supply	64421
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CPT Code: 64421

Specialty Society AAPM, AAPM&R, ASA

SC057	syringe 5-6ml	For performing the procedure
SG051	gauze, non-sterile 4in x 4in	For performing the procedure
SH047	lidocaine 1%-2% inj (Xylocaine)	For performing the procedure
SH022	bupivacaine 0.5% inj (Marcaine)	For performing the procedure
SC053	syringe 20ml	For performing the procedure
SC029	needle, 18-27g	For performing the procedure
SG021	bandage, strip 0.75in x 3in (Bandaïd)	For performing the procedure

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves

Global Period: 0 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Using the current direct PE inputs of code 64425 as the reference code

3. Is this code(s) typically billed with an E/M service?

No.

Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)

No it is billed with an E/M office visit 33% of the time.

4. What specialty is the dominant provider in the nonfacility? *Anesthesiology – 20%*
What percent of the time does the dominant provider provide the service(s) in the nonfacility? *61%*
Is the dominant provider in the nonfacility different then for the global? *No.*
(Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

We are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies. Based on our Expert Panel review we identified a number of direct PE inputs (largely supplies) that are typically used when providing this service in the non-facility environment that are not currently included. We have confirmed that the added PE clinical labor tasks, supplies, and equipment are not included in the current inputs or packages and that there is no duplication.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*
8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) *5 minutes*
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: *We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: heart rate, blood pressure, body mass index, temperature, and oxidation level.*
9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.
10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*
11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*
12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*
13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

Table, exam – default
Mayo stand - default
16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *Consent is obtained in the pre-service period of the service period on the day of the procedure (CA011), in addition to being obtained in the pre-service period (CA004).*

17. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*

18. Please include an explanation of each line item:

Code	Supply	64425
SA041	pack, basic injection	For performing the procedure
SA048	pack, minimum multi-specialty visit	For day of procedure
SK075	skin marking pen, sterile (Skin Scribe)	For performing the procedure
SH023	chlorhexidine 0.12% (Peridex)	For sterile prep
SH047	lidocaine 1%-2% inj (Xylocaine)	For performing the procedure; more injectate is required for this procedure since with this injection a “loss of resistance technique” is used
SH022	bupivacaine 0.5% inj (Marcaine)	For performing the procedure; more injectate is required for this procedure since with this injection a “loss of resistance technique” is used
SC038	needle, epidural (RK)	For performing the procedure; this needle has a blunted end, which is safer for the “loss of resistance technique” used in the injection to avoid injury with an injection that goes too deep
SC051	syringe 10-12ml	For performing the procedure
SA088	tray, surgical skin prep, sterile	For sterile prep
SJ081	swab, patient prep, 1.5 ml (chloraprep)	For sterile prep

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single

Global Period: 0 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Using the current direct PE inputs of code 64445 as the reference code

3. Is this code(s) typically billed with an E/M service?

No.

Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)

No it is billed with an E/M office visit 29% of the time.

4. What specialty is the dominant provider in the nonfacility? *Internal Medicine – 28%*
What percent of the time does the dominant provider provide the service(s) in the nonfacility? *59%*
Is the dominant provider in the nonfacility different then for the global? *For the global, the dominant specialty is Anesthesiology (37%)*

(Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

We are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies. Based on our Expert Panel review we identified a number of direct PE inputs (largely supplies) that are typically used when providing this service in the non-facility environment that are

not currently included. We have confirmed that the added PE clinical labor tasks, supplies, and equipment are not included in the current inputs or packages and that there is no duplication.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*
8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) *5 minutes*
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: *We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: heart rate, blood pressure, body mass index, temperature, and oxidation level.*
9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.
10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*
11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*
12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*
13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:

Table, exam – default

Nerve stimulator (eg, for nerve block) – default

ECG, 3-channel (with SpO2, NIBP, temp, respt) – default

Mayo stand - default

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

17. If there is any other item on your spreadsheet that needs further explanation please include here:
Consent is obtained in the pre-service period of the service period on the day of the procedure (CA011), in addition to being obtained in the pre-service period (CA004).

18. Please include an explanation of each line item:

Code	Supply	64445
SA041	pack, basic injection	For performing the procedure
SA048	pack, minimum multi-specialty visit	For day of procedure
SK075	skin marking pen, sterile (Skin Scribe)	For performing the procedure
SH023	chlorhexidine 0.12% (Peridex)	For sterile prep
SH022	bupivacaine 0.5% inj (Marcaine)	For performing the procedure
SC053	syringe 20ml	For performing the procedure
SA088	tray, surgical skin prep, sterile	For sterile prep
SD050	electrode needle, injectable (Myoject)	For performing the procedure
SJ081	swab, patient prep, 1.5 ml (chloraprep)	For sterile prep

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, single

Global Period: 0 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Using the current direct PE inputs of code 64447 as the reference code

3. Is this code(s) typically billed with an E/M service?

No.

Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)

No it is billed with an E/M office visit 1% of the time.

4. What specialty is the dominant provider in the nonfacility? *Internal Medicine – 61%*
What percent of the time does the dominant provider provide the service(s) in the nonfacility? *This service is provided in the non-facility setting 13% of the time.*

Is the dominant provider in the nonfacility different then for the global? *For the global, the dominant specialty is Anesthesiology (77%)*

(Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time. *N/A*

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*
8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) *5 minutes*
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: *We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: heart rate, blood pressure, body mass index, temperature, and oxidation level.*
9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.
10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*
11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*
12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*
13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:
16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

Table, exam – default

Nerve stimulator (eg, for nerve block) – default

ECG, 3-channel (with SpO2, NIBP, temp, respt) – default

Mayo stand - default

17. If there is any other item on your spreadsheet that needs further explanation please include here:
*Consent is obtained in the pre-service period of the service period on the day of the procedure (CA011),
in addition to being obtained in the pre-service period (CA004).*

18. Please include an explanation of each line item:

Code	Supply	64447
SA041	pack, basic injection	For performing the procedure
SA048	pack, minimum multi-specialty visit	For day of procedure
SK075	skin marking pen, sterile (Skin Scribe)	For performing the procedure
SH023	chlorhexidine 0.12% (Peridex)	For sterile prep
SH047	lidocaine 1%-2% inj (Xylocaine)	For performing the procedure
SH022	bupivacaine 0.5% inj (Marcaine)	For performing the procedure
SC053	syringe 20ml	For performing the procedure
SC051	syringe 10-12ml	For performing the procedure
SA088	tray, surgical skin prep, sterile	For sterile prep
SJ081	swab, patient prep, 1.5 ml (chloraprep)	For sterile prep

CPT Code: 64450

Specialty Society AAN, AAPM, AAPM&R, ASA

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch

Global Period: 0 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Using the current direct PE inputs of code 64450 as the reference code

3. Is this code(s) typically billed with an E/M service?

No.

Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)

No it is billed with an E/M office visit 32% of the time.

4. What specialty is the dominant provider in the nonfacility? *Nurse Practitioners – 20%*
What percent of the time does the dominant provider provide the service(s) in the nonfacility? *63%*
Is the dominant provider in the nonfacility different then for the global? *For the global, the dominant specialty is Anesthesiology (26%)*

(Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

We are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies. Based on our Expert Panel review we identified a number of direct PE inputs (largely supplies) that are typically used when providing this service in the non-facility environment that are

not currently included. We have confirmed that the added PE clinical labor tasks, supplies, and equipment are not included in the current inputs or packages and that there is no duplication.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*
8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) *5 minutes*
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: *We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: heart rate, blood pressure, body mass index, temperature, and oxidation level.*
9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.
10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*
11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*
12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*
13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

Table, exam – default

Mayo stand - default

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

17. If there is any other item on your spreadsheet that needs further explanation please include here:
*Consent is obtained in the pre-service period of the service period on the day of the procedure (CA011),
in addition to being obtained in the pre-service period (CA004).*

18. Please include an explanation of each line item:

Code	Supply	64450
SA041	pack, basic injection	For performing the procedure
SA048	pack, minimum multi-specialty visit	For day of procedure
SK075	skin marking pen, sterile (Skin Scribe)	For performing the procedure
SH023	chlorhexidine 0.12% (Peridex)	For sterile prep
SH047	lidocaine 1%-2% inj (Xylocaine)	For performing the procedure
SH022	bupivacaine 0.5% inj (Marcaine)	For performing the procedure
SC051	syringe 10-12ml	For performing the procedure
SA088	tray, surgical skin prep, sterile	For sterile prep
SJ081	swab, patient prep, 1.5 ml (chloraprep)	For sterile prep

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs**

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

Global Period: 0 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Using the current direct PE inputs of code 64400 as the reference code

3. Is this code(s) typically billed with an E/M service?

No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence:

We are requesting an increase over the current total cost for clinical staff time. Based on our Expert Panel review we identified a number of areas where clinical staff time is involved when providing this service in a facility environment that are not currently included.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*

CPT Code: 64400
Specialty Society AAN, ASA

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here: *N/A*
12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*
13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single

Global Period: 0 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Using the current direct PE inputs of code 64415 as the reference code

3. Is this code(s) typically billed with an E/M service?

No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence:

We are requesting an increase over the current total cost for clinical staff time. Based on our Expert Panel review we identified a number of areas where clinical staff time is involved when providing this service in a facility environment that are not currently included.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*
7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*
8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*
9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

CPT Code: 64415
Specialty Society ASA

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here: *N/A*
12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*
13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*
14. Please include an explanation of each line item: *N/A*

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; axillary nerve

Global Period: 0 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Using the current direct PE inputs of code 64417 as the reference code

3. Is this code(s) typically billed with an E/M service?

No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: *N/A*

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

CPT Code: 64417
Specialty Society ASA

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here: *N/A*
12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*
13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*
14. Please include an explanation of each line item: *N/A*

CPT Code: 64420
Specialty Society AAPM, AAPM&R, ASA

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level

Global Period: 0 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Using the current direct PE inputs of code 64420 as the reference code

3. Is this code(s) typically billed with an E/M service?

No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: *N/A*

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

CPT Code: 64420

Specialty Society AAPM, AAPM&R, ASA

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here: *N/A*
12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*
13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*
14. Please include an explanation of each line item: *N/A*

CPT Code: 64421

Specialty Society AAPM, AAPM&R, ASA

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each additional level (List separately in addition to code for primary procedure)

Global Period: 0 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Using the current direct PE inputs of code 64421 as the reference code

3. Is this code(s) typically billed with an E/M service?

No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: *N/A*

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

CPT Code: 64421

Specialty Society AAPM, AAPM&R, ASA

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here: *N/A*
12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*
13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*
14. Please include an explanation of each line item: *N/A*

CPT Code: 64425
Specialty Society AAPM, AAPM&R, ASA

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves

Global Period: 0 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Using the current direct PE inputs of code 64425 as the reference code

3. Is this code(s) typically billed with an E/M service?

No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: *N/A*

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

CPT Code: 64425

Specialty Society AAPM, AAPM&R, ASA

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here: *N/A*
12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*
13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*
14. Please include an explanation of each line item: *N/A*

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single

Global Period: 0 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Using the current direct PE inputs of code 64445 as the reference code

3. Is this code(s) typically billed with an E/M service?

No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence:

We are requesting an increase over the current total cost for clinical staff time. Based on our Expert Panel review we identified a number of areas where clinical staff time is involved when providing this service in a facility environment that are not currently included.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*
7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*
8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*
9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

CPT Code: 64445
Specialty Society AAPM&R, ASA

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here: *N/A*
12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*
13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*
14. Please include an explanation of each line item: *N/A*

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, single

Global Period: 0 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Using the current direct PE inputs of code 64447 as the reference code

3. Is this code(s) typically billed with an E/M service?

No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence:

We are requesting an increase over the current total cost for clinical staff time. Based on our Expert Panel review we identified a number of areas where clinical staff time is involved when providing this service in a facility environment that are not currently included.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

CPT Code: 64447
Specialty Society ASA

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here: *N/A*
12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*
13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*
14. Please include an explanation of each line item: *N/A*

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs**

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

Global Period: 0 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Using the current direct PE inputs of code 64449 as the reference code

3. Is this code(s) typically billed with an E/M service?

No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: *N/A*

We are requesting an increase over the current total cost for clinical staff time. Based on our Expert Panel review we identified a number of areas where clinical staff time is involved when providing this service in a facility environment that are not currently included.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*

CPT Code: 64449
Specialty Society ASA

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here: *N/A*
12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*
13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*
14. Please include an explanation of each line item: *N/A*

CPT Code: 64450

Specialty Society AAN, AAPM, AAPM&R, ASA

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch

Global Period: 0 Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

Using the current direct PE inputs of code 64450 as the reference code

3. Is this code(s) typically billed with an E/M service?

No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: *N/A*

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

CPT Code: 64450

Specialty Society AAN, AAPM, AAPM&R, ASA

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here: *N/A*
12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*
13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*
14. Please include an explanation of each line item: *N/A*

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor:

Global Period: 000 Meeting Date: September 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

Our specialties formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisors and multiple clinical experts who practice in the areas of oral and maxillofacial surgery and general otolaryngologists. The expert panel members also practice in settings that vary by size, geography, and represent both private and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

We utilized the existing PE inputs as a reference for CPT Code 64408.

3. Is this code(s) typically billed with an E/M service? **No**
Is this code(s) typically billed with the E/M service in the nonfacility? **No**
(Please see provided data in PE Subcommittee folder)
4. What specialty is the dominant provider in the nonfacility? **Otolaryngology**
What percent of the time does the dominant provider provide the service(s) in the nonfacility? **91%**
Is the dominant provider in the nonfacility different then for the global? **No**
(Please see provided data in PE Subcommittee folder)
5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

Pre time: we are requesting five minutes in the non-facility to schedule space for the procedure. This is a necessary activity for staff to complete in order to ensure a time block in the facility to conduct the procedure.

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

Pre time – see rationale above

Intra time – time requested is below existing

Post time – time requested is the same as existing

Supplies – we have removed the injection pack as it included materials not needed for the procedure. We replaced this with the individual items we do need such as the blunt tip needle to draw up the local anesthetic, an alcohol pad to clean the injection site, one spinal needle to inject, gauze to hold pressure after the injection, a Band-Aid for the injection site.

Equipment – is reduced from existing inputs

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: **N/A**
8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code)
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

Staff must take the following vitals: Heart rate, blood pressure and pulse oximetry

9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

Staff are present during the entire procedure, handing the physician the syringe, handing gauze and holding pressure to control bleeding and prevent a hematoma and passing the dressing supply.

10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. **N/A**
11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

Existing PE was all lumped into the assist during procedure line item. We have divided out clinical staff activities for the necessary activities and assigned the standard time for those activities per the PE guidelines. The intra time for this procedure is only 5 minutes, so the prior 28 minutes for intra assisting was clearly not accounting for only directly assisting during the procedure.

12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. **N/A**
13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**

14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**

15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:

The only equipment recommended is the exam chair EF008. The formula chosen is the “default” PE formula, as it is not highly technical equipment.

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: **N/A**

17. If there is any other item on your spreadsheet that needs further explanation please include here: **N/A**

18. Please include an explanation of each line item:

Line 33 – greet patient, gown them and ensure any records needed are available.

Line 34 – obtain 3 vitals: Heart rate, blood pressure and pulse oximetry

Line 35 – provide education and consent to patient prior to procedure.

Line 37 – prepare the room for the patient’s arrival and set up materials needed for procedure.

Line 49 – the staff are assisting directly during the entire 5 minute procedure handing the physician the syringe, handing gauze and holding pressure to control bleeding and prevent a hematoma and passing the dressing supply.

Line 60 – patients are monitored for 30 minutes after the procedure, so the standard time of 15 minutes per hour was reduced to accurately reflect 30 minutes of monitoring (7.5 rounded up).

Line 63 – staff clean the room and chair after the procedure.

Line 67 – check dressings, wounds – ensure there is no hematoma after procedure

Line 73 – review home care instructions – review potential signs to look for and what the patient will experience the days following procedure. Also when to remove bandaid and when they can shower, etc.

Line 84 – conducting phone calls a day or two after procedure to make sure the patient is doing well and no complications have arisen.

Line 103 – multi-specialty pack – used for prepping the room during procedure, gowning, and maintaining a safe environment (gloves).

Line 104 – spinal needle – used to inject the vagus nerve

Line 105 – needle, blunt tip – used to draw up the bupivacaine

Line 106 – syringe – used to draw up the bupivacaine

Line 107 – bupivacaine – local anesthetic to numb around the vagus nerve

Line 108 – alcohol swab – used to clean the injection site before and after the procedure.

Line 109 – Bandaid – used to cover the injection site after the procedure.

Line 110 – gauze non-sterile – used to apply pressure after the injection is complete.

Line 119 – exam chair – required for the procedure as the patient sits in it during the injection and the headrest is used for positioning the neck.

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor:

Global Period: 000 Meeting Date: Septemr 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

Our specialties formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisors and multiple clinical experts who practice in the areas of oral and maxillofacial surgery and general otolaryngologists. The expert panel members also practice in settings that vary by size, geography, and represent both private and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

We utilized the existing PE inputs as a reference for CPT Code 64408.

3. Is this code(s) typically billed with an E/M service? **No**
4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: **N/A**
5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: **N/A**
6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: **N/A**
7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

We are requesting the addition of 5 minutes of pre time for staff to schedule space in the facility for this procedure. We are also recommending removal of the 3 minutes for coordinating post procedure services and moving that time in the post period to conduct patient communications, as the staff call to check on the patient a few days after the procedure to ensure no complications have arisen.

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. **N/A**

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**
10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**
11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here: **N/A**
12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: **N/A**
13. If there is any other item on your spreadsheet that needs further explanation please include here: **N/A**
14. Please include an explanation of each line item:

Line 17 – scheduling space in the facility requires staff time to ensure there is room to perform the procedure when performed in the facility setting.

Line 84 – conducting phone calls a day or two after procedure to make sure the patient is doing well and no complications have arisen.

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

Global Period: 000

REVISED

Meeting Date: October 2018

CPT Long Descriptor(s):

64430 *Injection, anesthetic agent; pudendal nerve*

64435 *Injection, anesthetic agent; paracervical (uterine) nerve*

-
- 1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:**

ACOG, ASA and AAPM convened a panel that included a number of experts familiar with these services to evaluate the direct practice expense inputs for these injection procedures.

- 2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:**

CPT Codes 64430 and 64435 are existing CPT codes. As such, we included the current direct practice expense inputs on the PE spreadsheet.

- 3. Is this code(s) typically billed with an E/M service?
Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)**

These services are not typically reported with E/M:

64430 – 23%

64435 – 0%

These services are not typically reported with E/M in the nonfacility:

64430 – 43%

64435 – 0%

- 4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different then for the global?
(Please see provided data in PE Subcommittee folder)**

OB/GYN is the dominant provider in the nonfacility:

64430 – 28%

64435 – 46%

OB/GYN is also the dominant provider for the globals in the nonfacility:

64430 – 39%

64435 – 67%

5. **If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:**

N/A

6. **If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.**

N/A

7. **If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:**

N/A

8. **How much time was allocated to clinical activity, *obtain vital signs (CA010)* prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code)**
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

Prior to CMS increasing the vital signs to 5 minutes there were 3 minutes for obtain vital signs. We are recommending 5 minutes for obtain vital signs, based on the vital signs standards (4-6). The vital signs for these procedures include: height, weight, blood pressure and heart rate.

9. **Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time or Perform procedure/service---NOT directly related to physician work time:***

Nurse supplies physician with needed supplies and instruments. Assists with fluid management. Chaperone.

Note: Patient is in dorsal lithotomy position throughout the procedure.

- 10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.**

N/A

- 11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:**

N/A

- 12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.**

N/A

- 13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:**

We are recommending a new supply item, “Paracerv/Pudendal Block Tray, Sterile (Medline Item #BXT4540AH)” which is specifically designed for vaginal injection procedures. The needle guide is utilized to safely locate insertion of the needle for anesthetic delivery. It appears the existing CMS inputs do not describe this safety guide technology.

- 14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:**

N/A

- 15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:**

EF023 table, exam – Default

EQ168 light, exam – Default

EF027 table, instrument, mobile - Default

**Note: Because we are using the default equipment formula, CA022 time is not included in the equipment formulas. However, the patient does recover in the room, so that time is not being captured.*

- 16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:**

The patient recovers for approximately 15 minutes after the procedure, with the nurse coming to check in on the patient. We are requesting 3 minutes for post procedure monitoring (instead of 3.75 minutes).

**See note in #15.*

Post procedure phone call is to check on the effects of the medication, muscle weakness, etc.

CPT Code: 64430 (ACOG, ASA, AAPM)
64435 (ACOG)

17. If there is any other item on your spreadsheet that needs further explanation please include here:

N/A

18. Please include an explanation of each line item:

SA048	pack, minimum multi-specialty visit	Patient gown, exam table paper, pillow case
SA051	pack, pelvic exam	SJ032 lubricating jelly SK052 pad, mini SD118 specula, vaginal SJ052 swab, procto
SB006	drape, non-sterile, sheet 40in x 60in	Patient drape
SH021	bupivacaine 0.25% inj (Marcaine)	Anesthetic injected
SJ052	Swab, procto	Hemostasis and fluid management (2 additional from the SA051)
SJ043	Povidone swabsticks	Sterilization of the operative site
NEW	Paracerv/Pudendal Block Tray, Sterile	Kit includes: 20g 6" needle w/ 1/4" spacer, 10cc control syringe, 22g 1 1/2" needle, needle guide, gauze sponge and underpad

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs**

Global Period: 000

Meeting Date: October 2018

CPT Long Descriptor(s):

64430 *Injection, anesthetic agent; pudendal nerve*

64435 *Injection, anesthetic agent; paracervical (uterine) nerve*

- 1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:**

ACOG, ASA and AAPM convened a panel that included a number of experts familiar with these services to evaluate the direct practice expense inputs for these injection procedures.

- 2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:**

CPT Codes 64430 and 64435 are existing CPT codes. As such, we included the current direct practice expense inputs on the PE spreadsheet.

- 3. Is this code(s) typically billed with an E/M service?**

These services are not typically reported with E/M:

64430 – 23%

64435 – 0%

- 4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:**

We are recommending 8 minutes of pre service time for these 000 day services.

- CA001 Complete pre-service diagnostic and referral forms – 3 min
Anesthesia requires CBC, pregnancy test
- CA004 Provide pre-service education/obtain consent – 5 min
Consent is completed in the office and sent to the hospital

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence:

N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:

N/A

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

N/A

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.

N/A

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:

N/A

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:

N/A

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

N/A

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:

N/A

CPT Code: 64430 (ACOG, ASA and AAPM)
64435 (ACOG)

13. If there is any other item on your spreadsheet that needs further explanation please include here:

N/A

14. Please include an explanation of each line item:

N/A

A		B	D	E	F	I		J	K	L	M	N	O	P
1	RUC Practice Expense Spreadsheet					CURRENT			RECOMMENDED		CURRENT		RECOMMENDED	
2	REVISED	<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>				64400			64400		64408		64408	
3		RUC Collaboration Website				Injection, anesthetic agent; trigeminal nerve, any division or branch			Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic,		Injection, anesthetic agent; vagus nerve		Injection, anesthetic agent; vagus nerve	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation. American Academy of Neurology.	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per									
5		LOCATION				Non Fac	Facility		Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD				0	0				0	0		
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				\$ 41.92	\$ 6.29		\$ 33.32	\$ 4.44	\$ 35.54	\$ 10.36	\$ 20.32	\$ 2.96
8		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	65.0	17.0		33.0	12.0	47.0	28.0	33.0	8.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	8.0	14.0		3.0	9.0	16.0	25.0	0.0	5.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	54.0	0.0		27.0	0.0	28.0	0.0	30.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	3.0	3.0		3.0	3.0	3.0	3.0	3.0	3.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE				\$ 24.05	\$ 6.29		\$ 12.21	\$ 4.44	\$ 17.39	\$ 10.36	\$ 12.21	\$ 2.96
13		PRE-SERVICE PERIOD												
14		Start: Following visit when decision for surgery or procedure made												
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37		3			0				
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37					3				
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37		3			3				5
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37	5	5		0	0				
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37	3	3		3	3				
20	CA006	Confirm availability of prior images/studies	L051B	RN/Diagnostic	0.51									
21	CA007	Review patient clinical extant information and	L037D	RN/LPN/MTA	0.37									
22	CA008	Perform regulatory mandated quality assurance	L037D	RN/LPN/MTA	0.37						16	25		
29		End: When patient enters office/facility for surgery/procedure												
30		SERVICE PERIOD												
31		Start: When patient enters office/facility for surgery/procedure:												
32		Pre-Service (of service period)												
33	CA009	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA	0.37	3			3				3	
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37	5			5				3	
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37				3				3	
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37									
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37	5			2				2	
38	CA013	Prepare room, equipment and supplies	L051B	RN/Diagnostic	0.51									
39	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37									
40	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37									
41	CA016	Prepare, set-up and start IV, initial positioning and	L037D	RN/LPN/MTA	0.37	2			2					
42	CA016	Prepare, set-up and start IV, initial positioning and	L051B	RN/Diagnostic	0.51									
43	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37									
50		Intra-service (of service period)												
51	CA018	Assist physician or other qualified healthcare	L037D	RN/LPN/MTA	0.37	0			6				5	

A		B		D		E		F		I		J		K		L		M		N		O		P		
1	RUC Practice Expense Spreadsheet										CURRENT		RECOMMENDED		CURRENT		CURRENT		RECOMMENDED							
	REVISED		*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.								64400		64400		64408		64408									
2			RUC Collaboration Website								Injection, anesthetic agent; trigeminal nerve, any division or branch		Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic,		Injection, anesthetic agent; vagus nerve		Injection, anesthetic agent; vagus nerve									
3	Clinical Activity Code		Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology.		Clinical Staff Type Code		Clinical Staff Type		Clinical Staff Type Rate Per																	
4			LOCATION								Non Fac		Facility		Non Fac		Facility		Non Fac		Facility		Non Fac		Facility	
5			GLOBAL PERIOD								0		0		0		0		0		0		0		0	
6			TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME								\$ 41.92		\$ 6.29		\$ 33.32		\$ 4.44		\$ 35.54		\$ 10.36		\$ 20.32		\$ 2.96	
7			TOTAL CLINICAL STAFF TIME		L037D		RN/LPN/MTA		0.37		65.0		17.0		33.0		12.0		47.0		28.0		33.0		8.0	
8			TOTAL PRE-SERVICE CLINICAL STAFF TIME		L037D		RN/LPN/MTA		0.37		8.0		14.0		3.0		9.0		16.0		25.0		0.0		5.0	
9			TOTAL SERVICE PERIOD CLINICAL STAFF TIME		L037D		RN/LPN/MTA		0.37		54.0		0.0		27.0		0.0		28.0		0.0		30.0		0.0	
10			TOTAL POST-SERVICE CLINICAL STAFF TIME		L037D		RN/LPN/MTA		0.37		3.0		3.0		3.0		3.0		3.0		3.0		3.0		3.0	
11	Supply Code		MEDICAL SUPPLIES		PRICE		UNIT																			
12			TOTAL COST OF SUPPLY QUANTITY x PRICE								\$ 17.55		\$ -		\$ 21.01		\$ -		\$ 17.55		\$ -		\$ 7.87		\$ -	
13	SA041		pack, basic injection		11.67		pack				1				1				1							
14	SA048		pack, minimum multi-specialty visit		1.143		pack				1				1				1				1			
15	SA051		pack, pelvic exam		1.172		pack																			
16	SC040		needle, Kopan		18.75		item																			
17	SK075		skin marking pen, sterile (Skin Scribe)		1.048		item								1											
18	SH023		chlorhexidine 0.12% (Peridex)		0.408		oz								1											
19	SC028		needle, 18-26g 1.5-3.5in, spinal		3.314		item				1				1				1				1			
20	SC034		needle, blunt tip		0.33		item												new				1			
21	SC057		syringe 5-6ml		0.15		item				1								1				1			
22	SH021		bupivacaine 0.25% inj (Marcaine)		0.254		ml				5				5				5				5			
23	SB006		drape, non-sterile, sheet 40in x 60in		0.222		item																			
24	SJ052		swab, procto 16in		0.117		item																			
25	SJ043		povidone swabsticks (3 pack uou)		0.409		item																			
26	1		Invoice #1850307197		5.24		item																			
27	SJ053		swab-pad, alcohol		0.013		item												new				2			
28	SG021		bandage, strip 0.75in x 3in (Bandaid)		0.043																					

	A	B	Q	R	S	T	U	V	W	X	Y	Z	AA
1	RUC Practice Expense Spreadsheet		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED
2	REVISED	*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.	64415		64415		64417		64417		64420		64420
3		RUC Collaboration Website	Injection, anesthetic agent; brachial plexus, single		Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single		Injection, anesthetic agent; axillary nerve		Injection(s), anesthetic agent(s) and/or steroid; axillary nerve		Injection, anesthetic agent; intercostal nerve, single		Injection, anesthetic agent; intercostal nerve, single
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology.											
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac
6		GLOBAL PERIOD	0	0			0	0			0	0	
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 49.78	\$ -	\$ 49.95	\$ 4.44	\$ 60.79	\$ 6.29	\$ 69.95	\$ 4.44	\$ 40.05	\$ 6.29	\$ 35.67
8		TOTAL CLINICAL STAFF TIME	39.0	0.0	47.0	12.0	58.0	17.0	45.0	12.0	60.0	17.0	52.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	3.0	9.0	8.0	14.0	3.0	9.0	8.0	14.0	3.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	36.0	0.0	41.0	0.0	47.0	0.0	39.0	0.0	49.0	0.0	46.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	3.0	0.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE	\$ 14.43	\$ -	\$ 17.39	\$ 4.44	\$ 21.46	\$ 6.29	\$ 16.65	\$ 4.44	\$ 22.20	\$ 6.29	\$ 19.24
13		PRE-SERVICE PERIOD											
14		Start: Following visit when decision for surgery or procedure is made											
15	CA001	Complete pre-service diagnostic and referral forms				0		3		0		3	
16	CA002	Coordinate pre-surgery services (including test results)				3				3			
17	CA003	Schedule space and equipment in facility				3		3		3		3	
18	CA004	Provide pre-service education/obtain consent			0	0	5	5	0	0	5	5	0
19	CA005	Complete pre-procedure phone calls and prescription			3	3	3	3	3	3	3	3	3
20	CA006	Confirm availability of prior images/studies											
21	CA007	Review patient clinical extant information and											
22	CA008	Perform regulatory mandated quality assurance											
29		End: When patient enters office/facility for surgery/procedure											
30		SERVICE PERIOD											
31		Start: When patient enters office/facility for surgery/procedure											
32		Pre-Service (of service period)											
33	CA009	Greet patient, provide gowning, ensure appropriate	3		3		3		3		3		3
34	CA010	Obtain vital signs	5		5		5		5		5		5
35	CA011	Provide education/obtain consent			3				3				3
36	CA012	Review requisition, assess for special needs											
37	CA013	Prepare room, equipment and supplies	2		0		5		0		5		2
38	CA013	Prepare room, equipment and supplies											
39	CA014	Confirm order, protocol exam											
40	CA015	Setup scope (nonfacility setting only)											
41	CA016	Prepare, set-up and start IV, initial positioning and	2		0		2		0		2		2
42	CA016	Prepare, set-up and start IV, initial positioning and											
43	CA017	Sedate/apply anesthesia											
50		Intra-service (of service period)											
51	CA018	Assist physician or other qualified healthcare	0		12		12		10				10
52	CA019	Assist physician or other qualified healthcare	10								11		
53	CA020	Assist physician or other qualified healthcare											
54	CA021	Perform procedure/service---NOT directly related to											
61	CA021	Perform procedure/service---NOT directly related to											
62		Post-Service (of service period)											
63	CA022	Monitor patient following procedure/service,	0		15		15		15		15		15
64	CA023	Monitor patient following procedure/service, no	8										
65	CA024	Clean room/equipment by clinical staff	3		0		3		0		3		3
66	CA024	Clean room/equipment by clinical staff											
67	CA025	Clean scope											
68	CA026	Clean surgical instrument package											
69	CA027	Complete post-procedure diagnostic forms, lab and x-											
70	CA028	Review/read post-procedure x-ray, lab and pathology									2		
71	CA029	Check dressings, catheters, wounds	1		1		1		1		1		1
72	CA030	Technologist QC's images in PACS, checking for all											
73	CA031	Review examination with interpreting MD/DO											
74	CA031	Review examination with interpreting MD/DO											
75	CA032	Scan exam documents into PACS. Complete exam in											
76	CA032	Scan exam documents into PACS. Complete exam in											
77	CA033	Perform regulatory mandated quality assurance											
78	CA034	Document procedure (nonPACS) (e.g. mandated											
79	CA035	Review home care instructions, coordinate	2		2		1		2		2		2
80	CA036	Discharge day management	n/a		n/a		n/a		n/a		n/a		n/a
87		End: Patient leaves office											
88		POST-SERVICE PERIOD											
89		Start: Patient leaves office/facility											
90	CA037	Conduct patient communications	3		3	3	3	3	3	3	3	3	3
91	CA038	Coordinate post-procedure services											
92		Office visits: List Number and Level of Office Visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
93		99211 16 minutes											
94		99212 27 minutes											
95		99213 36 minutes											
96		99214 53 minutes											
97		99215 63 minutes											
98	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
105		End: with last office visit before end of global period											

	A	B	Q	R	S	T	U	V	W	X	Y	Z	AA
1	RUC Practice Expense Spreadsheet		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMM
	REVISED	<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>	64415		64415		64417		64417		64420		644
2													
3		RUC Collaboration Website	Injection, anesthetic agent; brachial plexus, single		Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single		Injection, anesthetic agent; axillary nerve		Injection(s), anesthetic agent(s) and/or steroid; axillary nerve		Injection, anesthetic agent; intercostal nerve, single		Inject
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation. American Academy of Neurology.											anestheti
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac
6		GLOBAL PERIOD	0	0			0	0			0	0	
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 49.78	\$ -	\$ 49.95	\$ 4.44	\$ 60.79	\$ 6.29	\$ 69.95	\$ 4.44	\$ 40.05	\$ 6.29	\$ 35.67
8		TOTAL CLINICAL STAFF TIME	39.0	0.0	47.0	12.0	58.0	17.0	45.0	12.0	60.0	17.0	52.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	3.0	9.0	8.0	14.0	3.0	9.0	8.0	14.0	3.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	36.0	0.0	41.0	0.0	47.0	0.0	39.0	0.0	49.0	0.0	46.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	3.0	0.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
106	Supply Code	MEDICAL SUPPLIES											
107		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ 34.67	\$ -	\$ 31.28	\$ -	\$ 39.01	\$ -	\$ 52.06	\$ -	\$ 17.55	\$ -	\$ 15.06
108	SA041	pack, basic injection	1		1		1	0	1		1		1
109	SA048	pack, minimum multi-specialty visit			1		1	0	1		1		1
110	SA051	pack, pelvic exam											
111	SC040	needle, Kopan											
112	SK075	skin marking pen, sterile (Skin Scribe)			1				1				1
113	SH023	chlorhexidine 0.12% (Peridex)			1				1				
114	SC028	needle, 18-26g 1.5-3.5in, spinal									1		
115	SC034	needle, blunt tip											1
116	SC057	syringe 5-6ml									1		
117	SH021	bupivacaine 0.25% inj (Marcaine)					20	0	20		5		
118	SB006	drape, non-sterile, sheet 40in x 60in											
119	SJ052	swab, procto 16in											
120	SJ043	povidone swabsticks (3 pack uou)											
121	1	Invoice #1850307197											
122	SJ053	swab-pad, alcohol											1
123	SG021	bandage, strip 0.75in x 3in (Bandaid)											
124	SG056	gauze, sterile 4in x 4in (10 pack uou)			2				2				
125	SH047	lidocaine 1%-2% inj (Xylocaine)			5								5
126	SD050	electrode needle, injectable (Myoject)	1				1		1				
127	SH022	bupivacaine 0.5% inj (Marcaine)	30		30								5
128	SC038	needle, epidural (RK)			1				1				
129	SC053	syringe 20ml			2		2		2				
130	SC051	syringe 10-12ml											1
131	SA088	tray, surgical skin prep, sterile			0				0				
132	SD269	Grounding pad			0								
133	SB019	drape-towel, sterile 18in x 26in			4								
134	SC029	needle, 18-27g											
135	SG021	bandage, strip 0.75in x 3in (Bandaid)											
136	SJ081	swab, patient prep, 1.5 ml (chloraprep)			0				0				
137	SB005	cover-condom, transducer or ultrasound probe											
138	SJ033	lubricating jelly (Surgilube)											
139	SM012	disinfectant spray (Transeptic)											
140	SM021	sanitizing cloth-wipe (patient)											
141		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A											
143	Equipment Code	EQUIPMENT											
144		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ 0.68	\$ -	\$ 1.27	\$ -	\$ 0.32	\$ -	\$ 1.24	\$ -	\$ 0.30	\$ -	\$ 1.36
145	EF023	table, exam	36		24		89		22				29
146	EQ168	light, exam											
147	EF027	table, instrument, mobile											
148	EQ211	pulse oximeter w-printer											
149	EF008	chair with headrest, exam, reclining											
150	EQ184	nerve stimulator (eg, for nerve block)	36		0		29		0				
151	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)	36		84				82				89
152	EF018	stretcher									60		
153	EF015	mayo stand			24				22				29
154	ED050	Technologist PACS workstation											
155	ED053	Professional PACS Workstation											
156	EQ250	ultrasound unit, portable											
157													
158		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A											

	A	B	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL
1	RUC Practice	Expense Spreadsheet	ENDED	CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CURRENT	
2	REVISED	<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>	620	64421		64421		64425		64425		64430	
3		RUC Collaboration Website	on(s),	Injection, anesthetic		Injection(s),		Injection, anesthetic		Injection(s),		Injection, anesthetic	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation. American Academy of Neurology.	agent(s) steroid; al nerve, level	agent; intercostal nerves, multiple, regional block		anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each		agent; ilioinguinal, iliohypogastric nerves		anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves		agent; pudendal nerve	
5		LOCATION	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD		ZZZ	ZZZ			0	0			0	0
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 4.44	\$ 51.53	\$ 6.29	\$ 6.48	\$ -	\$ 37.78	\$ 6.29	\$ 48.54	\$ 4.44	\$ 54.02	\$ 6.29
8		TOTAL CLINICAL STAFF TIME	12.0	72.0	17.0	10.0	0.0	54.0	17.0	53.0	12.0	53.0	17.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	9.0	8.0	14.0	0.0	0.0	8.0	14.0	3.0	9.0	8.0	14.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	61.0	0.0	10.0	0.0	43.0	0.0	47.0	0.0	42.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	3.0	3.0	3.0	0.0	0.0	3.0	3.0	3.0	3.0	3.0	3.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE	\$ 4.44	\$ 26.64	\$ 6.29	\$ 3.70	\$ -	\$ 19.98	\$ 6.29	\$ 19.61	\$ 4.44	\$ 19.61	\$ 6.29
13		PRE-SERVICE PERIOD											
14		Start: Following visit when decision for surgery or pr											
15	CA001	Complete pre-service diagnostic and referral forms	0		3				3		0		3
16	CA002	Coordinate pre-surgery services (including test results)	3								3		
17	CA003	Schedule space and equipment in facility	3		3				3		3		3
18	CA004	Provide pre-service education/obtain consent	0	5	5			5	5	0	0	5	5
19	CA005	Complete pre-procedure phone calls and prescription	3	3	3			3	3	3	3	3	3
20	CA006	Confirm availability of prior images/studies											
21	CA007	Review patient clinical extant information and											
22	CA008	Perform regulatory mandated quality assurance											
29		End: When patient enters office/facility for surgery/pr											
30		SERVICE PERIOD											
31		Start: When patient enters office/facility for surgery/p											
32		Pre-Service (of service period)											
33	CA009	Greet patient, provide gowning, ensure appropriate		3				3		3		3	
34	CA010	Obtain vital signs		5				5		5		3	
35	CA011	Provide education/obtain consent								3			
36	CA012	Review requisition, assess for special needs											
37	CA013	Prepare room, equipment and supplies		5				3		2		5	
38	CA013	Prepare room, equipment and supplies											
39	CA014	Confirm order, protocol exam											
40	CA015	Setup scope (nonfacility setting only)											
41	CA016	Prepare, set-up and start IV, initial positioning and		2				2		2		2	
42	CA016	Prepare, set-up and start IV, initial positioning and											
43	CA017	Sedate/apply anesthesia											
50		Intra-service (of service period)											
51	CA018	Assist physician or other qualified healthcare		0		10		0		11			
52	CA019	Assist physician or other qualified healthcare		23				9					
53	CA020	Assist physician or other qualified healthcare										9	
54	CA021	Perform procedure/service---NOT directly related to											
61	CA021	Perform procedure/service---NOT directly related to											
62		Post-Service (of service period)											
63	CA022	Monitor patient following procedure/service,		15				15		15		15	
64	CA023	Monitor patient following procedure/service, no											
65	CA024	Clean room/equipment by clinical staff		3				3		3		3	
66	CA024	Clean room/equipment by clinical staff											
67	CA025	Clean scope											
68	CA026	Clean surgical instrument package											
69	CA027	Complete post-procedure diagnostic forms, lab and x-											
70	CA028	Review/read post-procedure x-ray, lab and pathology		2									
71	CA029	Check dressings, catheters, wounds		1				1		1		2	
72	CA030	Technologist QC's images in PACS, checking for all											
73	CA031	Review examination with interpreting MD/DO											
74	CA031	Review examination with interpreting MD/DO											
75	CA032	Scan exam documents into PACS. Complete exam in											
76	CA032	Scan exam documents into PACS. Complete exam in											
77	CA033	Perform regulatory mandated quality assurance											
78	CA034	Document procedure (nonPACS) (e.g. mandated											
79	CA035	Review home care instructions, coordinate		2				2		2			
80	CA036	Discharge day management		n/a		n/a		n/a		n/a		n/a	
87		End: Patient leaves office											
88		POST-SERVICE PERIOD											
89		Start: Patient leaves office/facility											
90	CA037	Conduct patient communications	3	3	3			3	3	3	3	3	3
91	CA038	Coordinate post-procedure services											
92		Office visits: List Number and Level of Office Visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
93		99211 16 minutes											
94		99212 27 minutes											
95		99213 36 minutes											
96		99214 53 minutes											
97		99215 63 minutes											
98	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
105		End: with last office visit before end of global period											

	A	B	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL
1	RUC Practice	Expense Spreadsheet	ENDED	CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CURRENT	
2	REVISED	<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>	620	64421		64421		64425		64425		64430	
3		RUC Collaboration Website	on(s),	Injection, anesthetic agent; intercostal nerves, multiple, regional block		Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each		Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves		Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves		Injection, anesthetic agent; pudendal nerve	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology.	agent(s) steroid; al nerve, level										
5		LOCATION	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD		ZZZ	ZZZ			0	0			0	0
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 4.44	\$ 51.53	\$ 6.29	\$ 6.48	\$ -	\$ 37.78	\$ 6.29	\$ 48.54	\$ 4.44	\$ 54.02	\$ 6.29
8		TOTAL CLINICAL STAFF TIME	12.0	72.0	17.0	10.0	0.0	54.0	17.0	53.0	12.0	53.0	17.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	9.0	8.0	14.0	0.0	0.0	8.0	14.0	3.0	9.0	8.0	14.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	61.0	0.0	10.0	0.0	43.0	0.0	47.0	0.0	42.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	3.0	3.0	3.0	0.0	0.0	3.0	3.0	3.0	3.0	3.0	3.0
106	Supply Code	MEDICAL SUPPLIES											
107		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ -	\$ 24.58	\$ -	\$ 1.76	\$ -	\$ 17.55	\$ -	\$ 27.55	\$ -	\$ 34.16	\$ -
108	SA041	pack, basic injection		1				1		1		1	
109	SA048	pack, minimum multi-specialty visit		1				1		1		1	
110	SA051	pack, pelvic exam										1	
111	SC040	needle, Kopan										1	
112	SK075	skin marking pen, sterile (Skin Scribe)								1			
113	SH023	chlorhexidine 0.12% (Peridex)								1			
114	SC028	needle, 18-26g 1.5-3.5in, spinal		3				1					
115	SC034	needle, blunt tip											
116	SC057	syringe 5-6ml						1		1		1	
117	SH021	bupivacaine 0.25% inj (Marcaine)		5				5				5	
118	SB006	drape, non-sterile, sheet 40in x 60in											
119	SJ052	swab, procto 16in											
120	SJ043	povidone swabsticks (3 pack uou)											
121	1	Invoice #1850307197											
122	SJ053	swab-pad, alcohol											
123	SG021	bandage, strip 0.75in x 3in (Bandaid)											
124	SG056	gauze, sterile 4in x 4in (10 pack uou)				1				2			
125	SH047	lidocaine 1%-2% inj (Xylocaine)				2				10			
126	SD050	electrode needle, injectable (Myoject)											
127	SH022	bupivacaine 0.5% inj (Marcaine)				2				10			
128	SC038	needle, epidural (RK)								1			
129	SC053	syringe 20ml		1		1							
130	SC051	syringe 10-12ml								1			
131	SA088	tray, surgical skin prep, sterile								0			
132	SD269	Grounding pad											
133	SB019	drape-towel, sterile 18in x 26in											
134	SC029	needle, 18-27g				1							
135	SG021	bandage, strip 0.75in x 3in (Bandaid)				1							
136	SJ081	swab, patient prep, 1.5 ml (chloraprep)								0			
137	SB005	cover-condom, transducer or ultrasound probe											
138	SJ033	lubricating jelly (Surgilube)											
139	SM012	disinfectant spray (Transeptic)											
140	SM021	sanitizing cloth-wipe (patient)											
141		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A											
143	Equipment Code	EQUIPMENT											
144		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ -	\$ 0.30	\$ -	\$ 1.02	\$ -	\$ 0.25	\$ -	\$ 1.38	\$ -	\$ 0.26	\$ -
145	EF023	table, exam				10		85		30		87	
146	EQ168	light, exam											
147	EF027	table, instrument, mobile											
148	EQ211	pulse oximeter w-printer											
149	EF008	chair with headrest, exam, reclining											
150	EQ184	nerve stimulator (eg, for nerve block)											
151	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)				70				90			
152	EF018	stretcher		60	0								
153	EF015	mayo stand				10				30			
154	ED050	Technologist PACS workstation											
155	ED053	Professional PACS Workstation											
156	EQ250	ultrasound unit, portable											
157													
158		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A											

	A	B	AM	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW
1	RUC Practice Expense Spreadsheet		RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CUR
	REVISED	<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>							64445		64445		644
2			64430		64435		64435						
3		RUC Collaboration Website	Injection, anesthetic agent(s) and/or steroid; pudendal nerve		Injection, anesthetic agent; paracervical (uterine) nerve		Injection, anesthetic agent(s) and/or steroid; paracervical (uterine) nerve		Injection, anesthetic agent; sciatic nerve, single		Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single		Injection, , agent; fem sin
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology.											
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac
6		GLOBAL PERIOD			0		0		0		0		0
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 23.78	\$ 4.07	\$ 54.02	\$ 6.29	\$ 21.89	\$ 4.07	\$ 50.94	\$ -	\$ 59.66	\$ 4.44	\$ 50.55
8		TOTAL CLINICAL STAFF TIME	34.0	11.0	53.0	17.0	29.0	11.0	42.0	0.0	52.0	12.0	41.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	8.0	8.0	14.0	0.0	8.0	0.0	0.0	3.0	9.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	31.0	0.0	42.0	0.0	26.0	0.0	39.0	0.0	46.0	0.0	38.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	3.0	3.0	3.0	3.0	3.0	3.0	3.0	0.0	3.0	3.0	3.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE	\$ 12.58	\$ 4.07	\$ 19.61	\$ 6.29	\$ 10.73	\$ 4.07	\$ 15.54	\$ -	\$ 19.24	\$ 4.44	\$ 15.17
13		PRE-SERVICE PERIOD											
14		Start: Following visit when decision for surgery or pr											
15	CA001	Complete pre-service diagnostic and referral forms		3		3		3				0	
16	CA002	Coordinate pre-surgery services (including test results)										3	
17	CA003	Schedule space and equipment in facility				3						3	
18	CA004	Provide pre-service education/obtain consent		5	5	5		5			0	0	
19	CA005	Complete pre-procedure phone calls and prescription			3	3					3	3	
20	CA006	Confirm availability of prior images/studies											
21	CA007	Review patient clinical extant information and											
22	CA008	Perform regulatory mandated quality assurance											
29		End: When patient enters office/facility for surgery/pr											
30		SERVICE PERIOD											
31		Start: When patient enters office/facility for surgery/p											
32		Pre-Service (of service period)											
33	CA009	Greet patient, provide gowning, ensure appropriate	3		3		3		3		3		3
34	CA010	Obtain vital signs	5		3		5		5		5		5
35	CA011	Provide education/obtain consent	3				3				3		
36	CA012	Review requisition, assess for special needs											
37	CA013	Prepare room, equipment and supplies	2		5		2		2		2		2
38	CA013	Prepare room, equipment and supplies											
39	CA014	Confirm order, protocol exam											
40	CA015	Setup scope (nonfacility setting only)											
41	CA016	Prepare, set-up and start IV, initial positioning and	2		2		2		2		2		2
42	CA016	Prepare, set-up and start IV, initial positioning and											
43	CA017	Sedate/apply anesthesia											
50		Intra-service (of service period)											
51	CA018	Assist physician or other qualified healthcare	10				5		0		10		0
52	CA019	Assist physician or other qualified healthcare							11				10
53	CA020	Assist physician or other qualified healthcare			9								
54	CA021	Perform procedure/service---NOT directly related to											
61	CA021	Perform procedure/service---NOT directly related to											
62		Post-Service (of service period)											
63	CA022	Monitor patient following procedure/service,	3		15		3		10		15		10
64	CA023	Monitor patient following procedure/service, no											
65	CA024	Clean room/equipment by clinical staff	3		3		3		3		3		3
66	CA024	Clean room/equipment by clinical staff											
67	CA025	Clean scope											
68	CA026	Clean surgical instrument package											
69	CA027	Complete post-procedure diagnostic forms, lab and x-											
70	CA028	Review/read post-procedure x-ray, lab and pathology											
71	CA029	Check dressings, catheters, wounds			2				1		1		1
72	CA030	Technologist QC's images in PACS, checking for all											
73	CA031	Review examination with interpreting MD/DO											
74	CA031	Review examination with interpreting MD/DO											
75	CA032	Scan exam documents into PACS. Complete exam in											
76	CA032	Scan exam documents into PACS. Complete exam in											
77	CA033	Perform regulatory mandated quality assurance											
78	CA034	Document procedure (nonPACS) (e.g. mandated											
79	CA035	Review home care instructions, coordinate							2		2		2
80	CA036	Discharge day management	n/a		n/a		n/a		n/a		n/a		n/a
87		End: Patient leaves office											
88		POST-SERVICE PERIOD											
89		Start: Patient leaves office/facility											
90	CA037	Conduct patient communications	3	3	3	3	3	3	3		3	3	3
91	CA038	Coordinate post-procedure services											
92		Office visits: List Number and Level of Office Visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
93		99211 16 minutes											
94		99212 27 minutes											
95		99213 36 minutes											
96		99214 53 minutes											
97		99215 63 minutes											
98	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
105		End: with last office visit before end of global period											

	A	B	AM	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW
1	RUC Practice	Expense Spreadsheet	RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CUR
	REVISED	<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>							64445		64445		644
2			64430		64435		64435						
3		RUC Collaboration Website											
	Clinical Activity Code	Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation. American Academy of Neurology.	Injection, anesthetic agent(s) and/or steroid; pudendal nerve		Injection, anesthetic agent; paracervical (uterine) nerve		Injection, anesthetic agent(s) and/or steroid; paracervical (uterine) nerve		Injection, anesthetic agent; sciatic nerve, single		Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single		Injection, agent; femoral sin
4													
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac
6		GLOBAL PERIOD			0		0		0		0		0
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 23.78	\$ 4.07	\$ 54.02	\$ 6.29	\$ 21.89	\$ 4.07	\$ 50.94	\$ -	\$ 59.66	\$ 4.44	\$ 50.55
8		TOTAL CLINICAL STAFF TIME	34.0	11.0	53.0	17.0	29.0	11.0	42.0	0.0	52.0	12.0	41.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	8.0	8.0	14.0	0.0	8.0	0.0	0.0	3.0	9.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	31.0	0.0	42.0	0.0	26.0	0.0	39.0	0.0	46.0	0.0	38.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	3.0	3.0	3.0	3.0	3.0	3.0	3.0	0.0	3.0	3.0	3.0
106	Supply Code	MEDICAL SUPPLIES											
107		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ 10.96	\$ -	\$ 34.16	\$ -	\$ 10.96	\$ -	\$ 34.67	\$ -	\$ 39.01	\$ -	\$ 34.67
108	SA041	pack, basic injection			1				1		1		1
109	SA048	pack, minimum multi-specialty visit	1		1		1				1		
110	SA051	pack, pelvic exam	1		1		1						
111	SC040	needle, Kopan			1								
112	SK075	skin marking pen, sterile (Skin Scribe)									1		
113	SH023	chlorhexidine 0.12% (Peridex)									1		
114	SC028	needle, 18-26g 1.5-3.5in, spinal											
115	SC034	needle, blunt tip											
116	SC057	syringe 5-6ml			1								
117	SH021	bupivacaine 0.25% inj (Marcaine)	10		5		10						
118	SB006	drape, non-sterile, sheet 40in x 60in	1				1						
119	SJ052	swab, procto 16in	2				2						
120	SJ043	povidone swabsticks (3 pack uou)	1				1						
121	1	Invoice #1850307197	1				1						
122	SJ053	swab-pad, alcohol											
123	SG021	bandage, strip 0.75in x 3in (Bandaid)											
124	SG056	gauze, sterile 4in x 4in (10 pack uou)									2		
125	SH047	lidocaine 1%-2% inj (Xylocaine)									15		
126	SD050	electrode needle, injectable (Myoject)							1		1		1
127	SH022	bupivacaine 0.5% inj (Marcaine)							30		15		30
128	SC038	needle, epidural (RK)											
129	SC053	syringe 20ml									2		
130	SC051	syringe 10-12ml											
131	SA088	tray, surgical skin prep, sterile									0		
132	SD269	Grounding pad											
133	SB019	drape-towel, sterile 18in x 26in											
134	SC029	needle, 18-27g											
135	SG021	bandage, strip 0.75in x 3in (Bandaid)											
136	SJ081	swab, patient prep, 1.5 ml (chloraprep)									0		
137	SB005	cover-condom, transducer or ultrasound probe											
138	SJ033	lubricating jelly (Surgilube)											
139	SM012	disinfectant spray (Transeptic)											
140	SM021	sanitizing cloth-wipe (patient)											
141		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A											
	Equipment Code	EQUIPMENT											
143													
144		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ 0.24	\$ -	\$ 0.26	\$ -	\$ 0.20	\$ -	\$ 0.73	\$ -	\$ 1.42	\$ -	\$ 0.71
145	EF023	table, exam	28		87		23		39		29		38
146	EQ168	light, exam	28				23						
147	EF027	table, instrument, mobile	28				23						
148	EQ211	pulse oximeter w-printer											
149	EF008	chair with headrest, exam, reclining											
150	EQ184	nerve stimulator (eg, for nerve block)							39		29		38
151	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)							39		89		38
152	EF018	stretcher											
153	EF015	mayo stand									29		
154	ED050	Technologist PACS workstation											
155	ED053	Professional PACS Workstation											
156	EQ250	ultrasound unit, portable											
157													
158		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A											

A		B	AX	AY	AZ	BA	BB	BC	BD	BE	BF	BG	BH
1	RUC Practice	Expense Spreadsheet	RENT	RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED	
2	REVISED	<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>	147	64447		64449		64449		64450		64450	
3		<i>RUC Collaboration Website</i>	anesthetic	Injection(s),		Injection, anesthetic		Injection(s),		Injection, anesthetic		Injection(s),	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology.	oral nerve, gle	anesthetic agent(s) and/or steroid;femoral nerve, single		agent; lumbar plexus, posterior approach, continuous infusion by catheter (including		anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion		agent; other peripheral nerve or branch		anesthetic agent(s) and/or steroid; other peripheral nerve or branch	
5		LOCATION	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	0			0	0			0	0		
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ -	\$ 36.67	\$ 4.44	\$ -	\$ 2.22	\$ -	\$ 4.44	\$ 33.11	\$ 6.29	\$ 35.39	\$ 4.44
8		TOTAL CLINICAL STAFF TIME	0.0	41.0	12.0	0.0	6.0	0.0	12.0	50.0	17.0	47.0	12.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	3.0	9.0	0.0	0.0	0.0	9.0	8.0	14.0	3.0	9.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	35.0	0.0	0.0	6.0	0.0	0.0	39.0	0.0	41.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	3.0	3.0	0.0	0.0	0.0	3.0	3.0	3.0	3.0	3.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE	\$ -	\$ 15.17	\$ 4.44	\$ -	\$ 2.22	\$ -	\$ 4.44	\$ 18.50	\$ 6.29	\$ 17.39	\$ 4.44
13		PRE-SERVICE PERIOD											
14		Start: Following visit when decision for surgery or pr											
15	CA001	Complete pre-service diagnostic and referral forms			0				0		3		0
16	CA002	Coordinate pre-surgery services (including test results)			3				3				3
17	CA003	Schedule space and equipment in facility			3				3		3		3
18	CA004	Provide pre-service education/obtain consent		0	0				0	5	5	0	0
19	CA005	Complete pre-procedure phone calls and prescription		3	3				3	3	3	3	3
20	CA006	Confirm availability of prior images/studies											
21	CA007	Review patient clinical extant information and											
22	CA008	Perform regulatory mandated quality assurance											
29		End: When patient enters office/facility for surgery/pr											
30		SERVICE PERIOD											
31		Start: When patient enters office/facility for surgery/p											
32		Pre-Service (of service period)											
33	CA009	Greet patient, provide gowning, ensure appropriate		3						3		3	
34	CA010	Obtain vital signs		5						5		5	
35	CA011	Provide education/obtain consent		3								3	
36	CA012	Review requisition, assess for special needs											
37	CA013	Prepare room, equipment and supplies		0						5		2	
38	CA013	Prepare room, equipment and supplies											
39	CA014	Confirm order, protocol exam											
40	CA015	Setup scope (nonfacility setting only)											
41	CA016	Prepare, set-up and start IV, initial positioning and		0						2		2	
42	CA016	Prepare, set-up and start IV, initial positioning and											
43	CA017	Sedate/apply anesthesia											
50		Intra-service (of service period)											
51	CA018	Assist physician or other qualified healthcare		6			0			0		5	
52	CA019	Assist physician or other qualified healthcare								3			
53	CA020	Assist physician or other qualified healthcare											
54	CA021	Perform procedure/service---NOT directly related to											
61	CA021	Perform procedure/service---NOT directly related to											
62		Post-Service (of service period)											
63	CA022	Monitor patient following procedure/service,		15						15		15	

	A	B	AX	AY	AZ	BA	BB	BC	BD	BE	BF	BG	BH
1	RUC Practice	Expense Spreadsheet	RENT	RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED	
2	REVISED	<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>	147	64447		64449		64449		64450		64450	
3		RUC Collaboration Website	anesthetic	Injection(s),		Injection, anesthetic		Injection(s),		Injection, anesthetic		Injection(s),	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology.	oral nerve, gle	anesthetic agent(s) and/or steroid;femoral nerve, single		agent; lumbar plexus, posterior approach, continuous infusion by catheter (including		anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion		agent; other peripheral nerve or branch		anesthetic agent(s) and/or steroid; other peripheral nerve or branch	
5		LOCATION	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	0			0	0			0	0		
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ -	\$ 36.67	\$ 4.44	\$ -	\$ 2.22	\$ -	\$ 4.44	\$ 33.11	\$ 6.29	\$ 35.39	\$ 4.44
8		TOTAL CLINICAL STAFF TIME	0.0	41.0	12.0	0.0	6.0	0.0	12.0	50.0	17.0	47.0	12.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	3.0	9.0	0.0	0.0	0.0	9.0	8.0	14.0	3.0	9.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	35.0	0.0	0.0	6.0	0.0	0.0	39.0	0.0	41.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	3.0	3.0	0.0	0.0	0.0	3.0	3.0	3.0	3.0	3.0
106	Supply Code	MEDICAL SUPPLIES											
107		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ -	\$ 20.34	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 14.23	\$ -	\$ 16.72	\$ -
108	SA041	pack, basic injection		1						1		1	
109	SA048	pack, minimum multi-specialty visit		1						1		1	
110	SA051	pack, pelvic exam											
111	SC040	needle, Kopan											
112	SK075	skin marking pen, sterile (Skin Scribe)		1								1	
113	SH023	chlorhexidine 0.12% (Peridex)		1								1	
114	SC028	needle, 18-26g 1.5-3.5in, spinal											
115	SC034	needle, blunt tip											
116	SC057	syringe 5-6ml								1			
117	SH021	bupivacaine 0.25% inj (Marcaine)								5			
118	SB006	drape, non-sterile, sheet 40in x 60in											
119	SJ052	swab, procto 16in											
120	SJ043	povidone swabsticks (3 pack uou)											
121	1	Invoice #1850307197											
122	SJ053	swab-pad, alcohol											
123	SG021	bandage, strip 0.75in x 3in (Bandaid)											
124	SG056	gauze, sterile 4in x 4in (10 pack uou)		2								2	
125	SH047	lidocaine 1%-2% inj (Xylocaine)		5								5	
126	SD050	electrode needle, injectable (Myoject)											
127	SH022	bupivacaine 0.5% inj (Marcaine)		30								5	
128	SC038	needle, epidural (RK)											
129	SC053	syringe 20ml		2									
130	SC051	syringe 10-12ml		1								1	
131	SA088	tray, surgical skin prep, sterile		0								0	
132	SD269	Grounding pad											
133	SB019	drape-towel, sterile 18in x 26in											
134	SC029	needle, 18-27g											
135	SG021	bandage, strip 0.75in x 3in (Bandaid)											
136	SJ081	swab, patient prep, 1.5 ml (chloraprep)		0								0	
137	SB005	cover-condom, transducer or ultrasound probe											
138	SJ033	lubricating jelly (Surgilube)											
139	SM012	disinfectant spray (Transeptic)											
140	SM021	sanitizing cloth-wipe (patient)											
141		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A											
143	Equipment Code	EQUIPMENT											
144		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ -	\$ 1.16	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.38	\$ -	\$ 1.27	\$ -
145	EF023	table, exam		18						79		24	
146	EQ168	light, exam											
147	EF027	table, instrument, mobile											
148	EQ211	pulse oximeter w-printer											
149	EF008	chair with headrest, exam, reclining											
150	EQ184	nerve stimulator (eg, for nerve block)		0						79			
151	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)		78								84	
152	EF018	stretcher											
153	EF015	mayo stand		18								24	
154	ED050	Technologist PACS workstation											
155	ED053	Professional PACS Workstation											
156	EQ250	ultrasound unit, portable											
157													
158		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A											

	A	B	BI	BJ
1	RUC Practice Expense Spreadsheet		REFERENCE	
2	REVISED	<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>	76942	
3		RUC Collaboration Website	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology.		
5		LOCATION	Non Fac	Facility
6		GLOBAL PERIOD		
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 20.19	\$ -
8		TOTAL CLINICAL STAFF TIME	26.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	2.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	24.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE	\$ 13.26	\$ -
13		PRE-SERVICE PERIOD		
14		Start: Following visit when decision for surgery or pr		
15	CA001	Complete pre-service diagnostic and referral forms		
16	CA002	Coordinate pre-surgery services (including test results)		
17	CA003	Schedule space and equipment in facility		
18	CA004	Provide pre-service education/obtain consent		
19	CA005	Complete pre-procedure phone calls and prescription		
20	CA006	Confirm availability of prior images/studies	2	
21	CA007	Review patient clinical extant information and		
22	CA008	Perform regulatory mandated quality assurance		
29		End: When patient enters office/facility for surgery/pr		
30		SERVICE PERIOD		
31		Start: When patient enters office/facility for surgery/p		
32		Pre-Service (of service period)		
33	CA009	Greet patient, provide gowning, ensure appropriate		
34	CA010	Obtain vital signs		
35	CA011	Provide education/obtain consent		
36	CA012	Review requisition, assess for special needs		
37	CA013	Prepare room, equipment and supplies		
38	CA013	Prepare room, equipment and supplies	2	
39	CA014	Confirm order, protocol exam		
40	CA015	Setup scope (nonfacility setting only)		
41	CA016	Prepare, set-up and start IV, initial positioning and		
42	CA016	Prepare, set-up and start IV, initial positioning and	2	
43	CA017	Sedate/apply anesthesia		
50		Intra-service (of service period)		
51	CA018	Assist physician or other qualified healthcare		
52	CA019	Assist physician or other qualified healthcare		
53	CA020	Assist physician or other qualified healthcare		
54	CA021	Perform procedure/service---NOT directly related to		
61	CA021	Perform procedure/service---NOT directly related to	15	
62		Post-Service (of service period)		
63	CA022	Monitor patient following procedure/service,		
64	CA023	Monitor patient following procedure/service, no		
65	CA024	Clean room/equipment by clinical staff		
66	CA024	Clean room/equipment by clinical staff	2	
67	CA025	Clean scope		
68	CA026	Clean surgical instrument package		
69	CA027	Complete post-procedure diagnostic forms, lab and x-		
70	CA028	Review/read post-procedure x-ray, lab and pathology		
71	CA029	Check dressings, catheters, wounds		
72	CA030	Technologist QC's images in PACS, checking for all		
73	CA031	Review examination with interpreting MD/DO		
74	CA031	Review examination with interpreting MD/DO	2	
75	CA032	Scan exam documents into PACS. Complete exam in		
76	CA032	Scan exam documents into PACS. Complete exam in	1	
77	CA033	Perform regulatory mandated quality assurance		
78	CA034	Document procedure (nonPACS) (e.g. mandated		
79	CA035	Review home care instructions, coordinate		
80	CA036	Discharge day management		
87		End: Patient leaves office		
88		POST-SERVICE PERIOD		
89		Start: Patient leaves office/facility		
90	CA037	Conduct patient communications		
91	CA038	Coordinate post-procedure services		
92		Office visits: List Number and Level of Office Visits	# visits	# visits
93		99211 16 minutes		
94		99212 27 minutes		
95		99213 36 minutes		
96		99214 53 minutes		
97		99215 63 minutes		
98	CA039	Post-operative visits (total time)	0.0	0.0
105		End: with last office visit before end of global period		

	A	B	BI	BJ
1	RUC Practice Expense Spreadsheet		REFERENCE	
	REVISED	*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.		
2			76942	
3		RUC Collaboration Website	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology.		
5		LOCATION	Non Fac	Facility
6		GLOBAL PERIOD		
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 20.19	\$ -
8		TOTAL CLINICAL STAFF TIME	26.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	2.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	24.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0
106	Supply Code	MEDICAL SUPPLIES		
107		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ 2.71	\$ -
108	SA041	pack, basic injection		
109	SA048	pack, minimum multi-specialty visit		
110	SA051	pack, pelvic exam		
111	SC040	needle, Kopan		
112	SK075	skin marking pen, sterile (Skin Scribe)		
113	SH023	chlorhexidine 0.12% (Peridex)		
114	SC028	needle, 18-26g 1.5-3.5in, spinal		
115	SC034	needle, blunt tip		
116	SC057	syringe 5-6ml		
117	SH021	bupivacaine 0.25% inj (Marcaine)		
118	SB006	drape, non-sterile, sheet 40in x 60in		
119	SJ052	swab, procto 16in		
120	SJ043	povidone swabsticks (3 pack uou)		
121	1	Invoice #1850307197		
122	SJ053	swab-pad, alcohol		
123	SG021	bandage, strip 0.75in x 3in (Bandaid)		
124	SG056	gauze, sterile 4in x 4in (10 pack uou)		
125	SH047	lidocaine 1%-2% inj (Xylocaine)		
126	SD050	electrode needle, injectable (Myoject)		
127	SH022	bupivacaine 0.5% inj (Marcaine)		
128	SC038	needle, epidural (RK)		
129	SC053	syringe 20ml		
130	SC051	syringe 10-12ml		
131	SA088	tray, surgical skin prep, sterile		
132	SD269	Grounding pad		
133	SB019	drape-towel, sterile 18in x 26in		
134	SC029	needle, 18-27g		
135	SG021	bandage, strip 0.75in x 3in (Bandaid)		
136	SJ081	swab, patient prep, 1.5 ml (chloraprep)		
137	SB005	cover-condom, transducer or ultrasound probe	1	
138	SJ033	lubricating jelly (Surgilube)	4	
139	SM012	disinfectant spray (Transeptic)	10	
140	SM021	sanitizing cloth-wipe (patient)	2	
141		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A		
143	Equipment Code	EQUIPMENT		
144		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ 4.22	\$ -
145	EF023	table, exam		
146	EQ168	light, exam		
147	EF027	table, instrument, mobile		
148	EQ211	pulse oximeter w-printer		
149	EF008	chair with headrest, exam, reclining		
150	EQ184	nerve stimulator (eg, for nerve block)		
151	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)		
152	EF018	stretcher		
153	EF015	mayo stand		
154	ED050	Technologist PACS workstation	15	
155	ED053	Professional PACS Workstation	19	
156	EQ250	ultrasound unit, portable	24	
157				
158		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A		

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Harvard Valued – Utilization Over 30,000

April 2016

Injection Anesthetic Agent

In October 2015, AMA staff re-ran the Harvard valued codes with utilization over 30,000 based on 2014 Medicare claims data and this service was identified.

64418 Injection, anesthetic agent; suprascapular nerve

The RUC reviewed the survey results from 139 physicians for CPT code 64418 and determined that the survey median and 25th percentile work RVUs did not adequately account for the work required to perform this service. Therefore, the RUC recommends crosswalking code 64418 to code 20611 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting* (work RVU = 1.10 and 10 minutes intra-service time).

The RUC reviewed the pre-service time for CPT code 66418 and agreed that pre-time package 6A (Procedure with local/topical anesthesia care requiring wait time for anesthesia to take effect) is appropriate. However, the RUC did not agree with the specialties recommended pre-time inputs and determined that the pre-time needed to be decreased further to account for overlap in time with an Evaluation and Management service that typically reported with this service. Therefore, the RUC recommends 6 minutes of evaluation time, 3 minutes of positioning time, 3 minutes of scrub dress and wait time, 10 minutes intra-service time and 10 minutes immediate post-service time. The RUC confirmed that 10 minutes of immediate post-service time is required to assess the patient for pain relief, respiratory, hemodynamic, mental orientation, and extremity vascular status changes; required as a result of the risk of intra-vascular injection or pneumothorax. The physician also assesses any impact on the patient's activities of daily living including eating, bathing, brushing teeth and hair and overhead activities. The physician performs both strength testing and functional assessments to evaluate weakness in the limb that was injected as a result of anesthetic response. The RUC noted that the majority of nerve block codes that were recently reviewed include 10 minutes of immediate post-service time.

The RUC noted that the recommended work RVU of 1.10 and 32 minutes of total time for CPT 66418 is relative compared to the top two key reference services 64450 *Injection, anesthetic agent; other peripheral nerve or branch* (work RVU = 0.75 and 20 minutes total time) and 64486 *Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)* (work RVU = 1.27 and 35 minutes of total time). The RUC noted that the recommendation is comparable to other nerve block codes 64405 *Injection, anesthetic agent; greater occipital nerve* (work RVU = 0.94 and 22 minutes total time) and 64415 *Injection, anesthetic agent; brachial plexus, single* (work RVU = 1.48 and 44 minutes total time). **The RUC recommends a work RVU of 1.10 for CPT code 64418.**

Practice Expense

One minor modification was made to correct the equipment minutes calculation. The Practice Expense Subcommittee reviewed the clinical staff time inputs to ensure that there were no duplicative times with the Evaluation and Management visit. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Work Neutrality

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

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
64418	Injection, anesthetic agent; suprascapular nerve	000	1.10

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 64418	Tracking Number	Original Specialty Recommended RVU: 1.20
		Presented Recommended RVU: 1.20
Global Period: 000		RUC Recommended RVU: 1.10
CPT Descriptor: Injection, anesthetic agent; suprascapular nerve		

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52-year-old woman with a frozen shoulder is unable to tolerate physical therapy due to pain. She is referred for a suprascapular nerve block to provide pain relief so that she can undergo physical therapy.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 38%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 15%

Description of Pre-Service Work: Review records, communicate with other professionals, patient, and family; and obtain consent. Perform a focused History and Physical examination of the patient to confirm indications for procedure, potential contraindications, existing neurological deficits, and bleeding disorders. The pre-operative work also includes dressing, scrubbing, and waiting before the procedure; preparing the patient and equipment for the procedure; obtaining vital signs and positioning the patient in the sitting position.

Description of Intra-Service Work: Universal protocol is followed with confirmation of patient identifiers, procedure site, and laterality. The injection site overlying the scapular notch is identified. After sterile preparation of the skin, a local anesthetic skin wheal is placed at the site of injection. A needle is inserted toward the scapular notch. Once correct needle position is achieved, the needle is aspirated to confirm the absence of blood or air. Following negative aspiration, a small test-dose of local anesthetic is administered. The patient is queried about symptoms of intravascular local anesthetic injection. If there are no signs or symptoms of intravascular injection, the planned local anesthetic volume is injected in incremental doses with frequent aspiration to avoid intravascular injection. After completion of the injection, the needle is removed. The patient is evaluated for the initial effects of the block by physical examination to determine if the patient is developing weakness or numbness, and is evaluated for relief of pain in the expected nerve distribution.

Description of Post-Service Work: The patient is observed post-procedure for pain relief, respiratory, hemodynamic, mental orientation, or extremity vascular status changes. In addition, the limb that has received the nerve block is protected to prevent injury. The patient is provided education on the signs and symptoms of potential complications and the need to protect the anesthetized extremity. The physician communicates findings with the patient and other professionals (including written and telephone reports and orders).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	05/2016				
Presenter(s):	Marc Leib, MD, Richard Rosenquist, MD, Matthew Grierson, MD, Barry Smith, MD				
Specialty(s):	ASA, AAPM&R, AAPM				
CPT Code:	64418				
Sample Size:	3500	Resp N:	139	Response:	3.9 %
Description of Sample:	Random Sample				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	7.00	20.00	1300.00
Survey RVW:	0.70	1.00	1.20	1.45	4.00
Pre-Service Evaluation Time:			17.00		
Pre-Service Positioning Time:			5.00		
Pre-Service Scrub, Dress, Wait Time:			5.00		
Intra-Service Time:	1.00	5.00	10.00	13.00	45.00
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

6A-NF Proc w local/topical anes care req wait time

CPT Code:	64418	Recommended Physician Work RVU: 1.10		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	6.00	17.00	-11.00	
Pre-Service Positioning Time:	3.00	1.00	2.00	
Pre-Service Scrub, Dress, Wait Time:	3.00	5.00	-2.00	
Intra-Service Time:	10.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) 7A Local/Simple Procedure				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	10.00	18.00	-8.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64450	000	0.75	RUC Time

CPT Descriptor Injection, anesthetic agent; other peripheral nerve or branch**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64486	000	1.27	RUC Time

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
30901	000	1.10	RUC Time	108,336

CPT Descriptor 1 Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
12013	000	1.22	RUC Time	51,998

CPT Descriptor 2 Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
40490	000	1.22	RUC Time

CPT Descriptor Biopsy of lip**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 39 % of respondents: 28.0 %

Number of respondents who choose 2nd Key Reference Code: 31 % of respondents: 22.3 %

TIME ESTIMATES (Median)

	CPT Code: <u>64418</u>	Top Key Reference CPT Code: <u>64450</u>	2nd Key Reference CPT Code: <u>64486</u>
Median Pre-Service Time	12.00	10.00	15.00
Median Intra-Service Time	10.00	5.00	10.00
Median Immediate Post-service Time	10.00	5.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	32.00	20.00	35.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Intensity & Complexity Rating Scale: (much less= -2.00, somewhat less= -1.00, identical= 0.00, somewhat more= 1.00, much more= 2.00)

	<u>Top Key Ref Code</u>	<u>2nd Key Ref Code</u>
--	------------------------------------	---

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	0.23	0.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	0.26	0.29
Urgency of medical decision making	0.00	-0.03

Technical Skill/Physical Effort (Mean)

Technical skill required	0.46	0.55
Physical effort required	0.15	0.13

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	0.21	0.19
Outcome depends on the skill and judgment of physician	0.38	0.42
Estimated risk of malpractice suit with poor outcome	0.28	0.29

INTENSITY/COMPLEXITY MEASURES**Top Key
Ref Code****2nd Key
Ref Code****Time Segment (Mean)**

Overall intensity/complexity	0.41	0.29
------------------------------	------	------

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

In October 2015, AMA staff re-ran the Harvard valued codes with utilization over 30,000 based on 2014 Medicare claims data and this service was identified. The RUC determined that this service was to be placed on the next level of interest form to survey for April 2016.

Survey Sample and Process

The survey request was sent to a random selection from the membership database of the American Academy of Physician Medicine & Rehabilitation (AAPM&R). The American Society of Anesthesiologists (ASA) took a random sample of subspecialty pain medicine doctors from the ASA membership database. The standard RUC survey was conducted using a vignette drafted by the societies involved since 64418 had not previously been RUC reviewed. The Research Subcommittee reviewed and approved the vignette.

Pre-Service Time Package 6A

We recommend pre-time package 6A (NF Procedure w local/topical anesthesia care requiring wait time for anesthesia to take effect) as this procedure is performed in the physician's office 89% of the time according to the 2014 Medicare data. We recommend reducing the package pre-service evaluation time from 17 minutes to 8 minutes to account for overlap in time with an E/M service that is reported more than 50% of the time with 64418 on the same day. We also recommend increasing the package pre-service positioning time from 1 minute to 3 minutes. This is a reduction from the survey respondents' 5 minutes, as the Expert Panel indicated that 5 minutes overstated the positioning time, while the standard 1 minute in the pre-time package underestimates the time needed to position the patient. Additional positioning time is necessary because there is increased difficulty in identifying the target injection site, requiring manipulation of the patient's position to achieve the appropriate outcome. The Expert Panel agreed that the standard 5 minute scrub, dress and wait time in the pre-service package is appropriate.

Post-Service Time Package

We recommend post-service time package 7A (Local/Simple Procedure). We recommend reducing the package post-time from 18 minutes to 10 minutes, which corresponds with our survey data. In the post-service period the physician returns to the room following the initial injection to evaluate the patient for pain relief, respiratory, hemodynamic, mental orientation, and extremity vascular status changes; required as a result of the risk of intra-vascular injection or

pneumothorax. The physician must proceed with caution to protect the shoulder post injection as an injury to the suprascapular nerve will have an impact on the patient's activities of daily living including eating, bathing, brushing teeth and hair and overhead activities. Both strength testing and functional assessments are performed to evaluate weakness in the limb that was injected as a result of anesthetic response. The physician then evaluates for appropriateness of functional bracing of the shoulder.

Key Reference Codes

The recommended work RVU of 1.20 for 64418 fits well above the top key reference service (64450), since 64418 is more difficult to palpate the vessels around the suprascapular notch (compared to the posterior tibial vessels). Also, an injury to the suprascapular nerve will have a much greater impact on the patient than an injury to the posterior tibial nerve at the level of the ankle. It also fits well just below the second key reference code (64486). TAP block includes and is typically performed with image guidance. It also fits well with other injection codes and other codes in the RBRVS with similar IWPUTs, total time, and intra time.

MPC Comparison

MPC	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	1.07	0.068	24	7	12	5
30901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method	1.10	0.081	26	11	10	5
64418	Injection, anesthetic agent; suprascapular nerve	1.10	0.065	32	12	10	10
40490	Biopsy of lip	1.22	0.058	34	14	15	5
12013	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	1.22	0.064	27	7	15	5

Other Comparison Codes

Code	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	1.07	0.068	24	7	12	5
12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm	1.14	0.059	27	7	15	5
64418	Injection, anesthetic agent; suprascapular nerve	1.10	0.065	32	12	10	10
40490	Biopsy of lip	1.22	0.058	34	14	15	5
49082	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance	1.24	0.065	40	20	10	10
67505	Retrobulbar injection; alcohol	1.27	0.078	35	20	10	5
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	1.27	0.078	35	15	10	10

Recommendation

We recommend a work RVU of 1.20 for 64418. This value maintains the RUC and specialty accepted intensity/complexity rank order and relativity for code 64418 with many other injections codes requiring 10 minutes of intra-service time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☒ Other reason (please explain) Typically reported with an E&M service.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. For Medicare patients, 64418 is typically reported with an E&M service.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64418

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Sometimes

Specialty Physical Medicine and Rehabilitation How often? Sometimes

Specialty Interventional Pain Management & Pain Management How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 92955

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency is estimated at 3 times Medicare frequency.

Specialty Anesthesiology Frequency 26588 Percentage 28.60 %

Specialty Physical Medicine and Rehabilitation Frequency 11807 Percentage 12.70 %

Specialty Interventional Pain Management & Pain Medicine Frequency 20590 Percentage 22.15 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 30,985 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2014 Data RUC Database

Specialty Anesthesiology	Frequency 8862	Percentage 28.60 %
Specialty Physical Medicine and Rehabilitation	Frequency 3957	Percentage 12.77 %
Specialty Interventional Pain Management and Pain Medicine	Frequency 6865	Percentage 22.15 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Minor procedure

BETOS Sub-classification Level II:

Musculoskeletal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64418

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN		
13	ISSUE: Injection Anesthesia Agent (Suprascapular)																																									
14	TAB: 28																																									
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged							
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57		
17	1st REF	64450	Injection, anesthetic agent; other	48	0.083			0.75			20	10	0	0			5			5																						
18	2nd REF	64486	Transversus abdominis plane (TAP) block		0.078			1.27			35	5	5	5			10			10																						
19	CURRENT	64418	Injection, anesthetic agent; suprascapular		0.041			1.32			44	13	0	0			18			13																						
20	SVY	64418	Injection, anesthetic agent; suprascapular	139	0.044	0.70	1.00	1.20	1.45	4.00	47	17	5	5	1	5	10	13	45	10																						
21	REC	64418	Injection, anesthetic agent; suprascapular	139	0.065	1.10					32	6	3	3			10			10																						
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28
Tab Number

Injection Anesthetic Agent (64418)
Issue

64418
Code Range

Attestation Statement

This form needs to be completed by any **RUC Advisor** whose specialty society is developing a recommendation to be reviewed by the RUC.

As a RUC Advisor, I attest that the integrity of the RUC survey, summary of recommendation forms and practice expense recommendations are based on accurate and complete data to the best of my knowledge. As a RUC advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair , AMA Representative and Alternate AMA Representative.)



Signature

Marc Leib, MD, JD
Printed Signature

American Society of Anesthesiologists
Specialty Society

April 4, 2016
Date

28
Tab Number

Injection Anesthetic Agent (64418)
Issue

64418
Code Range

Attestation Statement

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Signature

Richard Rosenquist, MD
Printed Signature

American Society of Anesthesiologists
Specialty Society

April 4, 2016
Date

28
Tab Number

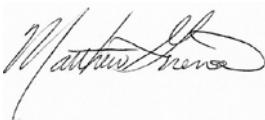
Injection Anesthetic Agent (64418)
Issue

64418
Code Range

Attestation Statement

This form needs to be completed by any **RUC Advisor** whose specialty society is developing a recommendation to be reviewed by the RUC.

As a RUC Advisor, I attest that the integrity of the RUC survey, summary of recommendation forms and practice expense recommendations are based on accurate and complete data to the best of my knowledge. As a RUC advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair , AMA Representative and Alternate AMA Representative.)

A handwritten signature in black ink, appearing to read "Matthew Grierson".

Signature

Matthew Grierson, MD
Printed Signature

American Academy of Physical Medicine & Rehabilitation
Specialty Society

April 4, 2016
Date

28
Tab Number

Injection Anesthetic Agent (64418)
Issue

64418
Code Range

Attestation Statement

This form needs to be completed by any **RUC Advisor** whose specialty society is developing a recommendation to be reviewed by the RUC.

As a RUC Advisor, I attest that the integrity of the RUC survey, summary of recommendation forms and practice expense recommendations are based on accurate and complete data to the best of my knowledge. As a RUC advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair , AMA Representative and Alternate AMA Representative.)



Signature

Barry Smith, MD
Printed Signature

American Academy of Physical Medicine & Rehabilitation
Specialty Society

April 4, 2016
Date

28
Tab Number

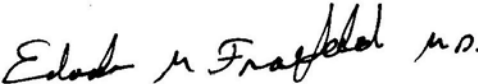
Injection Anesthetic Agent (64418)
Issue

64418
Code Range

Attestation Statement

This form needs to be completed by any **RUC Advisor** whose specialty society is developing a recommendation to be reviewed by the RUC.

As a RUC Advisor, I attest that the integrity of the RUC survey, summary of recommendation forms and practice expense recommendations are based on accurate and complete data to the best of my knowledge. As a RUC advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair , AMA Representative and Alternate AMA Representative.)



Signature

Eduardo Fraifeld
Printed Signature

American Academy of Pain Medicine
Specialty Society

April 5, 2016
Date

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs**

CPT Long Descriptor: Injection, anesthetic agent; suprascapular nerve

Global Period: 000

Meeting Date: April 2016

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The Advisors from the participating specialties reviewed the current PE details for 64418 and made adjustments as appropriate.
2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: Current inputs for 64418 are used as reference.
3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: N/A
4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: N/A
5. Please describe in detail the clinical activities of your staff: N/A

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs**

CPT Long Descriptor: Injection, anesthetic agent; suprascapular nerve

Global Period: 000 Meeting Date: April 2016

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The Advisors from the participating specialties reviewed the current PE details for 64418 and made adjustments as appropriate.
2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: Current inputs for 64418 are used as reference.
3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: Not applicable.
4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

Supplies

The Expert Panel that reviewed the supplies did not believe that this procedure required a pack, minimum multi-specialty visit.

Additionally, the Panel believed that the pack, basic injection, did not accurately reflect the supplies need for this procedure and we are recommending only the inputs that are necessary to perform this procedure in a sterile environment including:

- 5ml - bupivacaine 0.25% inj (Marcaine)
- 1 - cap, surgical
- 1 - mask, surgical
- 1 - gloves, sterile
- 1 - drape, sterile barrier 16in x 29in
- 1 - drape, sterile, for Mayo stand
- 1 - swab, patient prep, 1.5 ml (chloraprep)
- 1 - needle, 18-27g
- 1 - needle, 18-26g 1.5-3.5in, spinal
- 2 - syringe 5-6ml
- 5ml - lidocaine 1%-2% inj (Xylocaine)
- 1 - gauze, sterile 4in x 4in
- 1 - bandage, strip 0.75in x 3in (Bandaaid)

Equipment

Mayo stand - The removable instrument tray (mayo stand) is set adjacent to the injection; it provides a place for sterile instruments and supplies used during the injection.

Light, exam – The exam light is used to accurately visualize the injection site.

5. Please describe in detail the clinical activities of your staff:

Pre-Service Period Clinical Labor Activities:

Service Period Clinical Labor Activities:

Pre-service

During the service period clinical staff will provide pre-service education, prepare the room, equipment, and supplies, and prepare and position patient. The 2 minutes included with an E/M service does not include setting up supplies for the injection which will include preparing the exam light and mayo stand with syringes, needles, drapes, and etc. to maintain a sterile field; 5 minutes additional time is recommended for these activities.

Intra-service

Clinical staff assists the physician for 100% of the intra-service time.

Post-service

Clinical staff provides 1:1 monitoring of the patient following the injection to monitor the patient for vasovagal response, mental status, and check vital signs. Clinical staff also fits the patient for the bracing and demonstrate proper use of the device. Finally, clinical staff will check the injection site, provide written and verbal post-injection and follow-up instructions on care of the injection site and activity restrictions.

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F	G
1				REFERENCE CODE			
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.			64418		64418	
3	Meeting Date: April 2016 Tab: 28 Specialty: ASA, AAPM&R, AAPM	CMS Code	Staff Type	Injection, anesthetic agent; suprascapular nerve		Injection, anesthetic agent; suprascapular nerve	
4	LOCATION			Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			0	0	0	0
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	56.0	17.0	20.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	8.0	14.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	45.0	0.0	20.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	3.0	3.0	0.0	0.0
10	PRE-SERVICE						
11	Start: Following visit when decision for surgery or procedure made						
12	Complete pre-service diagnostic & referral forms			0	3	0	0
13	Coordinate pre-surgery services			0	0	0	0
14	Schedule space and equipment in facility			0	0	0	0
15	Provide pre-service education/obtain consent			5	5	0	0
16	Follow-up phone calls & prescriptions			3	3	0	0
17	Other Clinical Activity - specify:			0	0	0	0
18	End: When patient enters office/facility for surgery/procedure						
19	SERVICE PERIOD						
20	Start: When patient enters office/facility for surgery/procedure:						
21	Greet patient, provide gowning, ensure appropriate medical records are available			3	0	0	0
22	Obtain vital signs			3	0	0	0
23	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0	0	3	0
24	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2	0	2	0
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	2	0	0	0
28	Intra-service						
29	Assist physician in performing procedure	L037D	RN/LPN/MTA	12	0	10	0
30	Post-Service			0	0		
32	Monitor pt. following procedure/check tubes, monitors, drains, multitasking 1:4 (not related to moderate sedation)			0	0	0	0
33	Monitor pt. following procedure/check tubes, monitors, drains, no multitasking 1:1 (not related to moderate sedation)	L037D	RN/LPN/MTA	15	0	3	0
34	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3	0	0	0
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3	0	2	0
44	End: Patient leaves office						
45	POST-SERVICE Period						
46	Start: Patient leaves office/facility						
47	Conduct phone calls/call in prescriptions			3	3	0	0
56	End: with last office visit before end of global period						

	A	B	C	D	E	F	G
1				REFERENCE CODE			
2	*Please note: If a supply has a purchase price of \$100 or more please bold the item name and CMS code.			64418		64418	
3	Meeting Date: April 2016 Tab: 28 Specialty: ASA, AAPM&R, AAPM	CMS Code	Staff Type	Injection, anesthetic agent; suprascapular nerve		Injection, anesthetic agent; suprascapular nerve	
4	LOCATION			Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			0	0	0	0
57	MEDICAL SUPPLIES*	CODE	UNIT				
58	pack, minimum multi-specialty visit	SA048	pack	1	0	0	0
59	pack, basic injection	SA041	pack	1	0	0	0
60	syringe 10-12ml	SC051	item	1	0	0	0
61	electrode needle, injectable (Myoject)	SD050	item	1	0	0	0
62	bupivacaine 0.25% inj (Marcaine)	SH021	ml	10	0	5	0
63	cap, surgical	SB001	item	0	0	1	0
64	mask, surgical	SB033	item	0	0	1	0
65	gloves, sterile	SB024	pair	0	0	1	0
66	drape, sterile barrier 16in x 29in	SB007	item	0	0	1	0
67	drape, sterile, for Mayo stand	SB012	item	0	0	1	0
68	swab, patient prep, 1.5 ml (chloraprep)	SJ081	item	0	0	1	0
69	needle, 18-27g	SC029	item	0	0	1	0
70	needle, 18-26g 1.5-3.5in, spinal	SC028	item	0	0	1	0
71	syringe 5-6ml	SC057	item	0	0	2	0
72	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	0	0	5	0
73	gauze, sterile 4in x 4in	SG055	item	0	0	1	0
74	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	0	0	1	0
75	EQUIPMENT	CODE					
76	nerve stimulator (eg, for nerve block)	EQ184		28	0	0	0
77	table, exam	EF023		88	0	20	0
78	mayo stand	EF015		0	0	20	0
79	light, exam	EQ168		0	0	20	0
80							

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS 000-Day Global Typically Reported with an E/M

April 2017

Injection - Greater Occipital Nerve

In the Final Rule for 2017, CMS finalized the list of 000-day global services reported with an E/M 50 percent of the time or more, on the same day of service, same patient, by the same physician, that have not been reviewed in the last five years with Medicare utilization greater than 20,000. CPT code 64405 was identified on this list.

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

The RUC compared the survey code to the top two key reference services 20526 *Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel* (work RVU = 0.94) and 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66) and noted that the current work RVU of the survey code is appropriately equal to carpal tunnel and higher than the other injections. The 2nd key reference code 20526 represents identical overall work and total time. For additional support, the RUC compared the survey code to several multi-specialty point of comparison CPT codes: 67820 *Correction of trichiasis; epilation, by forceps only* (work RVU = 0.71), 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU = 0.84), 51720 *Bladder instillation of anticarcinogenic agent (including retention time)* (work RVU = 0.87) and 20527 *Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)* (work RVU = 1.00), and agreed that the survey 25th percentile of 0.94 places survey code 64405 in proper rank order. The RUC determined that the key reference services and comparable MPC codes support maintaining the current value for the survey code.

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

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

Practice Expense

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

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
64405	Injection, anesthetic agent; greater occipital nerve	000	0.94 (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 64405	Tracking Number	Original Specialty Recommended RVU: 0.94
		Presented Recommended RVU: 0.94
Global Period: 000	Current Work RVU: 0.94	RUC Recommended RVU: 0.94
CPT Descriptor: Injection, anesthetic agent; greater occipital nerve		

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with frequent headaches and a normal neurologic examination has tenderness over the left occipital notch, where palpation triggers the pain. For both diagnostic and therapeutic purposes, an injection of local anesthetic and anti-inflammatory is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is;
Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the patient's history to ensure she is suitable for the procedure (eg, not on anticoagulants and no history of allergic reaction to agents being used). Discuss the procedure with the patient, including alternatives and risks. Obtain informed consent. Palpate the upper cervical region near the lower extent of the skull dorsal to the mastoid process along the course of the greater occipital nerve and mark the proposed needle entry site. Examine the area of the scalp closely for infection. Clean the skin overlying the proposed injection site and prepare for injection. Prepare a syringe with a mix of a local anesthetic agent and an anti-inflammatory drug. Don gloves. Perform a pre-procedural time out.

Description of Intra-Service Work: Palpate the upper cervical region along the course of the greater occipital nerve. Penetrate the skin with the needle and inject the contents of the syringe along the course of the nerve following negative aspiration. Because of the significant vascularity of the scalp, make the injection with repeated, intermittent aspirations as the needle is repositioned along the course of the nerve.

Description of Post-Service Work: Apply pressure to the injection site to stop any bleeding after the injection, clean the injection area, and apply a bandage as necessary. Wait for the local anesthetic to work, inquiring if the patient has numbness in the distribution of the occipital nerve and if she has relief of her pain. Monitor the patient for any potential complications from the injection, including syncopal episode, intravascular injection, or evidence of distal particulate steroid injection. Discuss follow-up recommendations with the patient. Complete all appropriate medical records.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2017				
Presenter(s):	Kevin Kerber, MD; J. Mark Bailey, DO, PhD; Richard Rosenquist, MD; Neal Cohen, MD, MPH; Marc Leib, MD, JD; Matthew Grierson, MD; Gregory Polston, M.D				
Specialty(s):	American Academy of Neurology (AAN), American Academy of Pain Medicine (AAPM), American Academy of Physical Medicine & Rehabilitation (AAPM&R), American Society of Anesthesiologists (ASA)				
CPT Code:	64405				
Sample Size:	3856	Resp N:	175	Response:	4.5 %
Description of Sample:	AAN: A sample of members from the Headach and Pain sections (current US members.) AAPM, AAPM&R, ASA: A sample of current US active members from each specialty society.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	12.00	25.00	50.00	500.00
Survey RVW:	0.50	0.94	1.00	1.29	14.00
Pre-Service Evaluation Time:			6.00		
Pre-Service Positioning Time:			3.00		
Pre-Service Scrub, Dress, Wait Time:			3.00		
Intra-Service Time:	0.00	4.00	5.00	10.00	30.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

5-NF Proc w minimal anes care (if no deduct 1 min)

CPT Code:	64405	Recommended Physician Work RVU: 0.94		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	5.00	7.00	-2.00	
Pre-Service Positioning Time:	1.00	0.00	1.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	1.00	-1.00	
Intra-Service Time:	5.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
N/A Survey Code is Non-Facility				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	5.00	0.00	5.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
20526	000	0.94	RUC Time

CPT Descriptor Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
20552	000	0.66	RUC Time

CPT Descriptor Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
12001	000	0.84	RUC Time	188,177

CPT Descriptor 1 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
67820	000	0.71	RUC Time	247,521

CPT Descriptor 2 Correction of trichiasis; epilation, by forceps only

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 92 % of respondents: 52.5 %

Number of respondents who choose 2nd Key Reference Code: 19 % of respondents: 10.8 %

TIME ESTIMATES (Median)

	CPT Code: 64405	Top Key Reference CPT Code: 20526	2nd Key Reference CPT Code: 20552
Median Pre-Service Time	6.00	6.00	11.00
Median Intra-Service Time	5.00	5.00	5.00
Median Immediate Post-service Time	5.00	5.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	16.00	16.00	21.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	2%	48%	43%	7%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
The number of possible diagnosis and/or the number of management options that must be considered	1%	34%	65%
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	10%	26%	64%
Urgency of medical decision making	7%	63%	30%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	7%	62%	31%
Physical effort required	1%	76%	23%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
The risk of significant complications, morbidity and/or mortality	17%	25%	58%
Outcome depends on the skill and judgment of physician	9%	43%	48%
Estimated risk of malpractice suit with poor outcome	27%	32%	41%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	5%	42%	47%	5%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
The number of possible diagnosis and/or the number of management options that must be considered	16%	32%	53%
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	11%	53%	37%
Urgency of medical decision making	21%	63%	16%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	5%	26%	68%
Physical effort required	5%	74%	21%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
The risk of significant complications, morbidity and/or mortality	11%	47%	42%
Outcome depends on the skill and judgment of physician	5%	37%	58%
Estimated risk of malpractice suit with poor outcome	16%	53%	32%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The American Society of Anesthesiologists (ASA), the American Academy of Pain Management (AAPM), the American Association of Physical Medicine & Rehabilitation (AAPM&R), and the American Academy of Neurology (AAN), conducted joint surveys of their memberships in March 2017 for CPT code 64405. A joint ASA, AAPM, AAPM&R and AAN expert panel ("joint panel") consisting of physician advisors reviewed the survey work and time data and developed recommendations through participation in conference calls and e-mail discussions.

There were 175 responses (82 from ASA, 16 from AAPM, 27 from AAPM&R, 50 from AAN) to the survey request with a median performance rate of 25; 97% of the survey respondents found the vignette to be typical. The RUC summary contains a breakout of ASA, AAPM, AAPM&R, and AAN respondents. The number of responses meet RUC criteria and the vast majority of respondents perform this service.

Code 64405 was identified by CMS in the 2017 final rule on a list of 000-day global services reported with an E/M 50 percent of the time or more, on the same day of service, same patient, by the same physician. 2015 data reflect that 64405 is billed with an office E/M 50% of the time. It was last reviewed in 2010 and currently has times of 7/5/10/22 and an RVU of 0.94.

First, the joint panel reviewed the survey data. The survey median and 25th percentile RVU were 1.00 and 0.94 respectively. The total survey time for this service of 22 minutes (12/5/5) which is identical to the current time. The panel agreed this was appropriate because the service has not changed since the last survey. Based on the preservice times, the panel selected preservice time package 5.

Next, the panel reviewed the key reference service 20526, Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel, which was chosen by more than half the respondents. It has times of 6/5/5/16 and an RVU of 0.94. This RVU is identical to the 25th percentile of the survey.

The panel also reviewed several comparator codes (noted in the table below) and agree that the survey 25 fifth percentile of 0.94 places 64405 in proper rank order to all the codes reviewed. Most importantly, 64405 is most similar to 20526 and 20527 in intensity and has longer total time than both.

CPT Code	Description	RVU	Pre-service time	Intra-service time	Post-service time	Total time	RUC review
20522	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	0.66	11	5	5	21	2016
67820	Correction of trichiasis; epilation, by forceps only	0.71	8	5	2	15	2005
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	0.84	7	10	5	22	2010
51720	Bladder instillation of antineoplastic agent (including retention time)	0.87	9	5	5	19	2016
20526	Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel	0.94	6	5	5	16	2002
64405	Injection, anesthetic agent; greater occipital nerve	0.94	12	5	5	22	2010

20527	Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)	1.00	8	5	5	18	2011
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The joint panel note that 64405 is a more intense procedure than both 12001 and 67802 and has an identical total time to 12001 and is longer than 67820. Furthermore, the intensity / complexity measure responses from the survey further support the expert panel's recommendation of the survey 25th percentile because they are higher than both of the key reference services.

In summary, the main reference service and a review of other services with similar times and intensities, supports the survey 25th percentile RVU of 0.94. This is appropriate because the service has not changed since the last survey. This survey also provides strong validation for the 2010 survey. The joint panel reviewed the survey data by specialty and agreed it was remarkably consistent for both median time and median RVU across all specialties further supporting recommending the 25th percentile, thereby maintaining the current RVU.

Recommendations

In summary, we recommend the 25th percentile RVU of 0.94 and a preservice time of 12 minutes, an intra-service time of 5 minutes and a post-service time of 5 minutes for 64405.

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☒ Other reason (please explain) According to the 2015 Medicare same day billing occurrences claims data, 64405 is reported with an office E/M code 50% of the time.

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64405

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty Pain Management / Interventional PM How often? Commonly

Specialty Anesthesiology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 439188

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We anticipate 4 times the annual Medicare utilization; based on 2015 utilization data.

Specialty Neurology	Frequency 166892	Percentage 38.00 %
Specialty Pain Management / Interventional PM	Frequency 101014	Percentage 23.00 %
Specialty Anesthesiology	Frequency 65880	Percentage 15.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
109,797 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2015 Medicare utilization data from the RUC database.

Specialty Neurology	Frequency 41723	Percentage 38.00 %
Specialty Pain Management / Interventional PM	Frequency 25254	Percentage 23.00 %
Specialty Anesthesiology	Frequency 16470	Percentage 15.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Minor procedure

BETOS Sub-classification Level II:

Musculoskeletal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64405

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
13	ISSUE: Greater Occipital Nerve Block																			
14	TAB: 17																			
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
17	1st REF	20526	Injection, therapeutic (eg, local anesthetic, corticosteroid).	92	0.139			0.94			16	6					5			5
18	2nd REF	20552	Injection(s); single or multiple trigger point(s), 1 or 2	19	0.075			0.66			21	5	1	5			5			5
19	CURRENT	64405	Injection, anesthetic agent; greater occipital nerve		0.112			0.94			22	7					5			10
20	SVY Total	64405	Injection, anesthetic agent; greater occipital nerve	175	0.132	0.50	0.94	1.00	1.29	14.00	22	6	3	3	0	4	5	10	30	5
25	REC	64405	Injection, anesthetic agent; greater occipital nerve		0.139	0.94					16	5	1			5				5
26																				
27																				

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection, anesthetic agent; greater occipital nerve

Global Period: 000 Meeting Date: April 2017

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel: The joint societies convened a panel of experts, including advisors who are familiar with the service. The panel of experts reviewed and collaborated via email and phone call to review existing direct practice expense inputs for code 64405 and the key reference code, 20526. Based on this review and its expertise, the panel made modifications as necessary. The panel of experts is recommending a reduced total clinical staff time stemming in large part from the fact that we have reduced the preservice clinical staff time to zero from the current input of 8 minutes. The intraservice time has also been reduced from 36 minutes to 27 minutes. The panel also eliminated a number of the supplies currently attributed to this service as they were felt to not be necessary.
2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here: The expert panel agreed that using the key reference service, 20526, as a reference code for comparison would provide a helpful reference point for practice expense review. The reference code describes a very similar procedure with identical intraservice clinical staff time.
3. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: N/A
4. Please provide rationale for the minutes you are recommending for clinical activities that do not have PE Subcommittee standards: The expert panel is recommending 5 minutes for CA018 assist physician or other qualified healthcare professional – directly related to physician work time (100% of physician intra-service time). The clinical staff assists the physician or qualified health care professional during the entirety of the injection in order to ensure the patient remains in the proper position and that the physician or qualified health care professional has access to necessary supplies. The expert panel is recommending 3 minutes for CA023 monitor patient following procedure/service, no multitasking. The patient must be closely monitored in the minutes immediately following the procedure to ensure the patient is not experiencing any abnormal responses to the injection.
5. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: The expert panel is recommending an increase in the number of needles from 1 to 2. One needle of a larger gauge is needed to draw up medication. A second, smaller gauge needle is used for comfort to perform the injection. The expert panel recommends adding an exam light, EQ168 for the procedure. The injection site for this procedure is often obstructed by hair. A light ensures that the site is visible so the physician can appropriately place the needle for the injection.
6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Spreadsheet Update Workgroup and listed in tab 2, please explain the difference here: N/A
7. Please describe in detail the clinical activities of your staff below:

Pre-Service Period Clinical Activities: (0 minutes)

There are no clinical activities performed by staff during the pre-service period.

Service Period Clinical Activities: (27 total minutes)

Pre-Service (of Service Period): (13 minutes) Clinical staff greets the patient and provides the patient with gowning. The appropriate medical records in reference to the planned injection are reviewed. Pre-service education is provided Clinical staff reviews the patient's understanding of the risks and benefits of the procedure, then obtains and documents patient consent. The patient's vital signs are taken, including temperature, blood pressure and pulse to ensure that the patient is in appropriate condition to receive the injection. The room is prepared and the appropriate injection equipment (sterile trays, needles and medications) is obtained.

Intra-Service (of Service Period): (5 minutes) The clinical staff is present for the entire procedure, assisting the physician by providing sterile supplies as appropriate. Clinical staff also provides reassurance and distraction to the patient as necessary.

Post-Service (of Service Period): (9 minutes) After the procedure, clinical staff observes the patient to verify that they are comfortable and the injection site is checked a few minutes following the injection to monitor the patient for an allergic reaction or vasovagal event. Following completion of the procedure by the physician, the room is cleaned and the instructions given by the physician are reviewed again with the patient. The patient is escorted out of the office. Relevant forms are completed and replacement supplies are ordered.

Post-Service Period Clinical Activities: (3 minutes) Although this code is a zero-day global service, an average of one phone call is received specific to the injection. The clinical staff answers this call and addresses questions.

8. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*: The clinical staff helps to ensure that the patient's positioning remains consistent. The clinical staff also makes certain that all necessary supplies, including injectate and gauze are readily available to the physician or other qualified healthcare professional to ensure that the service can be provided without interruption.

9. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

10. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

N/A

11. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.

N/A

12. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:
N/A

13. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:
N/A

14. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:
N/A

15. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:

Rows 24, 54 and 94 of the PE spreadsheet reflect the current RUC database PE time for code 64405. This PE does not coincide with a RUC review, therefore detailed information about minutes attributed to specific tasks was not available. Please note that line 54 reflects the current PE minutes for the entire service period including pre, intra and post service (of service period).

16. If there is any other item on your spreadsheet that needs further explanation please include here:
N/A

	A	B	D	E	F	G	H	I	J	K
1	RUC Practice	Expense Spreadsheet			REFERENCE CODE		CURRENT		RECOMMENDED	
2		*Please see brief summaries of the			CPT Code # 20526		CPT Code # 64405		CPT Code # 64405	
3		RUC Collaboration Website			Injection, therapeutic (eg local anesthetic, corticosteroid), carpal tunnel		Injection, anesthetic agent; greater occipital nerve		Injection, anesthetic agent; greater occipital nerve	
4	Clinical Activity Code	Meeting Date: April 2017 Tab: 17 Specialty: AAN, AAPM, AAPM&R, ASA	Clinical Staff Type Code	Clinical Staff Type						
5		LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD								
7		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	29.0	0.0	47.0	17.0	18.0	0.0
8		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.0	0.0	8.0	14.0	0.0	0.0
9		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/MTA	26.0	0.0	36.0	0.0	18.0	0.0
10		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	3.0	0.0	3.0	3.0	0.0	0.0
11		PRE-SERVICE PERIOD								
12		Start: Following visit when decision for surgery or procedure made								
13	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA				3		
14	CA002	Coordinate pre-surgery services (including test	L037D	RN/LPN/MTA						
15	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA				3		
16	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			5	5		
17	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA			3	3		
18	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA						
19	CA007	Review patient clinical extant information and	L037D	RN/LPN/MTA						
20	CA008	Perform regulatory mandated quality assurance	L037D	RN/LPN/MTA						
26		End: When patient enters office/facility for surgery/procedure								
27		SERVICE PERIOD								
28		Start: When patient enters office/facility for surgery/procedure:								
29		Pre-Service (of service period)								
30	CA009	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA	2		3			
31	CA010	Obtain vital signs	L037D	RN/LPN/MTA			3			
32	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	3				3	
33	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA						
34	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	5		3		2	
35	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA						
36	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA						
37	CA016	Prepare, set-up and start IV, initial positioning and	L037D	RN/LPN/MTA	2		2		2	
38	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA						
45		Intra-service (of service period)								
46	CA018	Assist physician or other qualified healthcare	L037D	RN/LPN/MTA	5		6		5	
47	CA019	Assist physician or other qualified healthcare	L037D	RN/LPN/MTA						
48	CA020	Assist physician or other qualified healthcare	L037D	RN/LPN/MTA						
49	CA021	Perform procedure/service---NOT directly related to	L037D	RN/LPN/MTA						
55		Post-Service (of service period)								
56	CA022	Monitor patient following procedure/service,	L037D	RN/LPN/MTA	3		15			
57	CA023	Monitor patient following procedure/service, no	L037D	RN/LPN/MTA					3	
58	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	3		3			
59	CA025	Clean scope	L037D	RN/LPN/MTA						
60	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA						
61	CA027	Complete post-procedure diagnostic forms, lab and x-	L037D	RN/LPN/MTA						
62	CA028	Review/read post-procedure x-ray, lab and pathology	L037D	RN/LPN/MTA						
63	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA			1		1	
64	CA030	Technologist QC's images in PACS, checking for all	L037D	RN/LPN/MTA						
65	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA						
66	CA032	Scan exam documents into PACS. Complete exam in	L037D	RN/LPN/MTA						
67	CA033	Perform regulatory mandated quality assurance	L037D	RN/LPN/MTA						
68	CA034	Document procedure (nonPACS) (e.g. mandated	L037D	RN/LPN/MTA						
69	CA035	Review home care instructions, coordinate	L037D	RN/LPN/MTA	3				2	
70	CA036	Discharge day management	L037D	RN/LPN/MTA	n/a		n/a		n/a	
77		End: Patient leaves office								
78		POST-SERVICE PERIOD								
79		Start: Patient leaves office/facility								
80	CA037	Conduct patient communications	L037D	RN/LPN/MTA	3		3	3		
81	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA						
82		Office visits: List Number and Level of Office Visits	MINUTES		# visits	# visits	# visits	# visits	# visits	# visits
83		99211 16 minutes	16							
84		99212 27 minutes	27							
85		99213 36 minutes	36							
86		99214 53 minutes	53							
87		99215 63 minutes	63							
88	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.0	0.0	0.0	0.0	0.0	0.0
95		End: with last office visit before end of global								
96	Medical	MEDICAL SUPPLIES	PRICE	UNIT						
97	SA048	pack, minimum multi-specialty visit	1.143	pack			1			
98	SB011	drape, sterile, fenestrated 16in x 29in	0.557	item	1		1			
99	SB024	gloves, sterile	0.84	pair	1		2		1	
100	SB028	gown, surgical, sterile	4.671	item			1			
101	SB044	underpad 2ft x 3ft (Chux)	0.23	item			2			
102	SG055	gauze, sterile 4in x 4in	0.159	item	1		2		1	
103	SC029	needle, 18-27g	0.089	item	2		1		2	
104	SC055	syringe 3ml	0.096	item			1			
105	SC057	syringe 5-6ml	0.15	item			1			
106	SC051	syringe 10-12ml	0.184	item	1		1		1	
107	SG009	applicator, sponge-tipped	0.139	item			1		1	
108	SH021	bupivacaine 0.25% inj (Marcaine)	0.254	ml			5		5	
109	SH047	lidocaine 1%-2% inj (Xylocaine)	0.035	ml	2		2			
110	SJ041	povidone soln (Betadine)	0.008	ml	10		10		10	
111		Other supply item: please include the name of the								
112	Equipment	EQUIPMENT	PRICE	EQUIPMENT						
113	EF023	table, exam	1338.17	Non-highly			36		18	
114	EQ168	light, exam	1630.12	Non-highly					0	

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2018

Genicular Injection and RFA

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.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Nervous System Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic <i>(For destruction by neurolytic agent or chemodenervation, see 62280-62282, 64600-64681)</i> <i>(For epidural or subarachnoid injection, see 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327)</i> <i>(64479-64487, 64490-64495 are unilateral procedures. For bilateral procedures, use modifier 50)</i> Somatic Nerves <i>64400 Injection, anesthetic agent; trigeminal nerve, any division or branch</i>				

(f)64450	G1	Injection, anesthetic agent; other peripheral nerve or branch	000	0.75 (See Tab 9 October 2018)
●64454	G2	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches including imaging guidance, when performed (Do not report 64454 in conjunction with 64624) (64454 requires injecting all of the following genicular nerve branches: superolateral, superomedial, and inferomedial. If all three of these genicular nerve branches are not injected, report 64454 with modifier 52)	000	Resurvey for January 2019
Destruction by Neurolytic Agent (eg, Chemical, Thermal, Electrical or Radiofrequency), Chemodenervation <i>Codes 64600-64681 include the injection of other therapeutic agents (eg, corticosteroids). Do not report diagnostic/therapeutic injections separately. Do not report a code labeled as destruction when using therapies that are not destructive of the target nerve (eg, pulsed radiofrequency), use 64999. For codes labeled as chemodenervation, the supply of the chemodenervation agent is reported separately.</i> <i>(For chemodenervation of internal anal sphincter, use 46505)</i> <i>(For chemodenervation of the bladder, use 52287)</i> <i>(For chemodenervation for strabismus involving the extraocular muscles, use 67345)</i> <i>(For chemodenervation guided by needle electromyography or muscle electrical stimulation, see 95873, 95874)</i> Somatic Nerves 64600 <i>Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch</i>				
(f)64640	G3	Destruction by neurolytic agent; other peripheral nerve or branch	010	Resurvey for January 2019
●64624	G4	Destruction by neurolytic agent genicular nerve branches including imaging guidance, when performed (64624 requires the destruction of each of the following genicular nerve branches: superolateral, superomedial, and inferomedial. If a neurolytic agent for the purposes of destruction is not applied to all of these nerve branches, report 64624 with modifier 52) (Do not report 64624 in conjunction with 64454)	010	Resurvey for January 2019

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS/Other – Utilization over 30,000/ Harvard Valued – Utilization over 30,000

October 2018

Lower Gastrointestinal Tract Imaging

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

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

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 IWP/UT. 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 IWP/UTs, 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 IWP/UT. 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 IWPUT 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.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Radiology/Diagnostic Radiology (Diagnostic Imaging)				
Gastrointestinal Tract				
▲ 74250	J8	Radiologic examination, small intestine, <u>includes multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study</u> <u>(Do not report 74250 in conjunction with 74248, 74251)</u>	XXX	0.81
▲ 74251	J9	<u>double-contrast (eg, high-density barium and air via enteroclysis tube) study, including glucagon, when administered</u> <u>(For placement of enteroclysis tube, see 44500, 74340)</u> <u>(Do not report 74251 in conjunction with 74248, 74250)</u>	XXX	1.17
D 74260	-	Duodenography, hypotonic <u>(74260 has been deleted. To report, use 74251)</u>	XXX	N/A (2018 work RVU = 0.50)
▲ 74270	J10	Radiologic examination, colon, <u>including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study enema, with or without KUB</u> <u>(Do not report 74270 in conjunction with 74280)</u>	XXX	1.04

▲74280	J11	air double-contrast with specific (eg, high density barium and air) study, with or without including glucagon, when administered <u>(Do not report 74280 in conjunction with 74270)</u>	XXX	1.26
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**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 74250	Tracking Number J8	Original Specialty Recommended RVU: 0.81
		Presented Recommended RVU: 0.81
Global Period: XXX	Current Work RVU: 0.47	RUC Recommended RVU: 0.81

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 77-year-old male in the emergency department with a history of prior abdominal surgery presents with abdominal pain and distension. A single-contrast small intestine study is requested for evaluation of possible small bowel obstruction due to adhesions.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the reason for the examination and any pertinent clinical history. Confirm that single contrast only examination is appropriate. Determine the type of contrast to use. Review any prior applicable plain film or imaging studies. Provide patient with examination instructions and confirm understanding.

Description of Intra-Service Work: Position the patient. Direct the administration of oral contrast by the patient. After allowing time for contrast to reach the small bowel, take a spot radiograph of the abdomen. Evaluate proximal, mid, and distal small bowel segments under fluoroscopy and take multiple additional spot views. Continue to perform intermittent fluoroscopy and spot radiographs until the contrast has reached the colon. Direct the patient to various positions to better visualize small bowel loops in all four abdominal quadrants. Use paddle palpation to assist visualization of small bowel segments. Supervise the acquisition of overhead radiographs obtained by the technologist. Compare the current imaging to all pertinent available prior studies. Dictate a report.

Description of Post-Service Work: Review, edit, and sign report for the medical record. Discuss findings with the patient and referring provider as needed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Kurt Schoppe, MD; Daniel Wessell, MD; Andrew Moriarity, MD				
Specialty(s):	American College of Radiology				
CPT Code:	74250				
Sample Size:	1500	Resp N:	47	Response: 3.1 %	
Description of Sample:	The ACR surveyed a total of 1500 members (a random sample of 750 members and a separate random sample of 750 members who perform x-ray or GI procedures).				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	20.00	49.00	200.00
Survey RVW:	0.33	0.81	1.09	1.27	3.00
Pre-Service Evaluation Time:			3.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	2.00	8.00	15.00	18.00	90.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	74250	Recommended Physician Work RVU: 0.81		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	3.00	0.00	3.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	15.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	5.00	0.00	5.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74160	XXX	1.27	RUC Time

CPT Descriptor Computed tomography, abdomen; with contrast material(s)**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74170	XXX	1.40	RUC Time

CPT Descriptor Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
76700	XXX	0.81	RUC Time	969,254

CPT Descriptor 1 Ultrasound, abdominal, real time with image documentation; complete

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92002	XXX	0.88	RUC Time	221,254

CPT Descriptor 2 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99231	XXX	0.76	RUC Time

CPT Descriptor Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 12 **% of respondents:** 25.5 %

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 19.1 %

TIME ESTIMATES (Median)

	CPT Code: <u>74250</u>	Top Key Reference CPT Code: <u>74160</u>	2nd Key Reference CPT Code: <u>74170</u>
Median Pre-Service Time	3.00	3.00	5.00
Median Intra-Service Time	15.00	15.00	18.00
Median Immediate Post-service Time	5.00	5.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	23.00	23.00	28.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	17%	33%	25%	17%	8%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	67%	17%	17%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	42%	25%	33%
Physical effort required	8%	17%	75%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	50%	33%	17%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	11%	78%	11%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	22%	33%	44%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	22%	0%	78%
Physical effort required	11%	11%	78%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	33%	44%	22%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

CPT codes 74250 and 74270 were identified on the screen for CMS/Other codes with utilization over 30,000. The family was expanded to include three other x-ray codes pertaining to the lower gastrointestinal tract, 74251, 74260, and 74280. These codes were referred to the April 2018 CPT meeting. One of the codes, 74260 (*Duodenography, hypotonic*), was deleted, as it is an infrequently performed procedure. The descriptors for the remaining four codes were editorially revised to clarify the procedures, as shown below, and the family was surveyed for the October 2018 RUC.

- **74250** (*Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study*),
- **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*),
- **74270** (*Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study*), and
- **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*).

Survey Process

The ACR surveyed a total of 1500 members (a random sample of 750 members and a separate random sample of 750 members who perform x-ray or gastrointestinal procedures).

Compelling Evidence:

The society is recommending compelling evidence for the entire family of codes to support the proposed wRVUs and times. The two codes identified on the screen, 74250 and 74270, are both CMS/Other, and were valued using flawed methodology. CPT code 74251 was most recently reviewed in July 1993, likely as part of the initial first 5-year review cycle. CPT code 74280 was most recently reviewed in September 2011, and since that time, there have been advances in technology which changed the typical patient. For all four codes in this family, there have been significant changes in the patient population and physician work over the past two decades as detailed below individually.

- **74250** – This is a CMS/Other code, and therefore, the times and values were established using a flawed methodology. Healthy, routine patients are increasingly evaluated with deep endoscopy and/or capsule endoscopy, while patients undergoing radiologic small bowel examinations are increasingly evaluated in the post-operative period to evaluate for both immediate and long-term surgical complications, frequently after multiple operations have been performed. This code is now more typically performed on a complicated patient in the hospital.
- **74251** – This code was most recently reviewed in July 1993, likely as part of the initial first 5-year review cycle. Since that time, healthy, routine patients are increasingly evaluated with deep endoscopy and/or capsule endoscopy, while patients undergoing radiologic small bowel examinations are increasingly evaluated in the post-operative period to evaluate for both immediate and long-term surgical complications, frequently after multiple operations have been performed. This code is now most often used for problem-solving chronic, unexplained symptoms when other investigations have been inconclusive, and is predominately performed in the inpatient setting (69% of claims).
- **74270** – This is a CMS/Other code, and therefore, the times and values were established using a flawed methodology. Many of these patients are now evaluated with CT and managed

accordingly. This code is now most frequently used to evaluate complex pre-operative anatomy, post-operative complications, or indeterminate CT findings.

- **74280** – This code was most recently reviewed in September 2011, and since that time, there have been advances in technology which changed the typical patient. Most patients are typically first evaluated by colonoscopy and, increasingly, CT colonography. 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. While previously used as a screening exam for the colon, that indication is now less than 6% of the claims.

Work RVU Recommendation:

The expert panel recommends a work RVU of 0.81 for CPT code 74250, which is the 25th percentile survey value, and above the current CMS/Other value.

Time Recommendation:

The expert panel recommends the following median survey times: 3 minutes of pre-service time, 15 minutes of intra-service time, and 5 minutes of post-service time. This is a total time of 23 minutes compared to the existing CMS/Other total time of 10 minutes.

Key Reference Services

The most commonly chosen reference codes by survey participants are two CT of the abdomen procedures:

- **74160** (*Computed tomography, abdomen; with contrast material(s)*), chosen by 26% of respondents, and
- **74170** (*Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections*), chosen by 19% of respondents.

The recommended wRVU and survey times are appropriate compared to the most commonly chosen key reference service, 74160 (*Computed tomography, abdomen; with contrast material(s)*), which has identical times. The small intestine study 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 supported by the higher IWPUR and survey respondents indicating somewhat less intensity of 74250 compared to 74160.

The recommended value and service times are also appropriately lower compared to the second key reference service, 74170 (*Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections*), which has 3 minutes more intra-service time. 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.

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWPUR	% chosen
74250	X-Ray, small intestine; single-contrast study	0.81	23	3	15	5	0.042	
74160	CT, abdomen; w/contrast	1.27	23	3	15	5	0.073	26%
74170	CT, abdomen; w/o & w/contrast	1.40	28	5	18	5	0.065	19%

MPC Codes

The surveyed code compares well with three MPC codes:

- **99231** (Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.)
- **76700** (Ultrasound, abdominal, real time with image documentation; complete)
- **92002** (Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient)

CPT code 74250 has 5 more minutes of intra-service time compared to 99231, supporting the slightly higher recommended wRVU. While CPT code 74250 requires slightly more intra-service time than CPT code 76700, it includes periods of less intensive work, supporting the identical wRVU recommendation and lower IWP/UT. Similarly, the surveyed code has similar times but overall less intense work when compared to evaluation of the eye, CPT code 92002, supporting a lower recommended wRVU and IWP/UT. The relationships are summarized in the following table.

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWP/UT
99231	Subseq. hospital care, per day, for E&M of pt w/MDM of low complexity. Typically, 15 minutes bedside with patient.	0.76	20	5	10	5	0.054
74250	X-Ray, small intestine; single-contrast study	0.81	23	3	15	5	0.042
76700	US, abdominal, real time with image documentation; complete	0.81	21	5	11	5	0.053
92002	Ophthalmological services: medical exam & eval w/initiation of dx and treatment program; intermed., new pt	0.88	25	5	15	5	0.044

Summary

The survey results and comparison with applicable codes support the 25th percentile survey value for 74250 (Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study). The recommendation maintains relativity within the lower gastrointestinal tract family and greater RBRVS.

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWP/UT
74250	X-Ray, small intestine; single-contrast study	0.81	23	3	15	5	0.042
74270	X-ray, colon; single-contrast study	1.04	24	4	15	5	0.056
74251	X-ray, small intestine; double-contrast study	1.17	32	5	22	5	0.043
74280	X-ray, colon; double-contrast study	1.26	29	4	20	5	0.053

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 74250

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 161007

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 74250 is estimated to be provided 161,007 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 154836 Percentage 96.16 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 53,669 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 74250 is estimated to be provided 53,669 times nationally in a one-year period to Medicare patients.

Specialty Diagnostic Radiology Frequency 51612 Percentage 96.16 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Imaging

BETOS Sub-classification:

Standard imaging

BETOS Sub-classification Level II:

Contrast Gastrointestinal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 74250

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 74251	Tracking Number J9	Original Specialty Recommended RVU: 1.17
		Presented Recommended RVU: 1.17
Global Period: XXX	Current Work RVU: 0.69	RUC Recommended RVU: 1.17

CPT Descriptor: 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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old male with abdominal pain and weight loss. Double-contrast small intestine study is requested for evaluation of suspected malabsorption syndrome.

Percentage of Survey Respondents who found Vignette to be Typical: 62%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the reason for the examination and any pertinent clinical history. Confirm that double contrast examination and enteroclysis tube placement are appropriate. Determine the type of contrast to use and if glucagon is indicated. Review any prior applicable plain film or imaging studies. Provide patient with examination instructions and confirm understanding.

Description of Intra-Service Work: Position the patient. Insert the enteric catheter. Monitor the advancement of the catheter under fluoroscopy until the catheter tip is positioned in the duodenum. Administer barium through the catheter using a syringe until barium reaches the distal small bowel. Administer air through the catheter using a pump. Evaluate proximal, mid, and distal small bowel loops under fluoroscopy and take multiple spot views. Continue to perform intermittent fluoroscopy and spot radiographs until the contrast has reached the colon. Direct the patient to various positions to better visualize small bowel segments through the abdomen and in any particular area of interest. Use paddle palpation to assist visualization and separation of bowel segments. Remove the enteric catheter. Supervise the acquisition of overhead radiographs obtained by the technologist. Compare the current imaging to all pertinent available prior studies. Dictate a report.

Description of Post-Service Work: Review, edit, and sign report for the medical record. Discuss the findings with the patient and referring provider as needed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Kurt Schoppe, MD; Daniel Wessell, MD; Andrew Moriarity, MD				
Specialty(s):	American College of Radiology				
CPT Code:	74251				
Sample Size:	1500	Resp N:	47	Response: 3.1 %	
Description of Sample:	The ACR surveyed a total of 1500 members (a random sample of 750 members and a separate random sample of 750 members who perform x-ray or GI procedures).				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	0.00	1.00	20.00
Survey RVW:	0.45	1.17	1.45	2.00	4.35
Pre-Service Evaluation Time:			5.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	5.00	19.00	22.00	35.00	120.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	74251	Recommended Physician Work RVU: 1.17		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	5.00	0.00	5.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	22.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	5.00	0.00	5.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74170	XXX	1.40	RUC Time

CPT Descriptor Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74160	XXX	1.27	RUC Time

CPT Descriptor Computed tomography, abdomen; with contrast material(s)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
70460	XXX	1.13	RUC Time	32,094

CPT Descriptor 1 Computed tomography, head or brain; with contrast material(s)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
70470	XXX	1.27	RUC Time	110,713

CPT Descriptor 2 Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99213	XXX	0.97	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 34 **% of respondents:** 72.3 %

Number of respondents who choose 2nd Key Reference Code: 4 **% of respondents:** 8.5 %

TIME ESTIMATES (Median)

	CPT Code: <u>74251</u>	Top Key Reference CPT Code: <u>74170</u>	2nd Key Reference CPT Code: <u>74160</u>
Median Pre-Service Time	5.00	5.00	3.00
Median Intra-Service Time	22.00	18.00	15.00
Median Immediate Post-service Time	5.00	5.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	32.00	28.00	23.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	15%	32%	53%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	21%	32%	47%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	0%	3%	97%
Physical effort required	0%	3%	97%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	12%	26%	62%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	50%	0%	25%	25%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	50%	25%	25%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	0%	0%	100%
Physical effort required	25%	0%	75%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	50%	0%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

CPT codes 74250 and 74270 were identified on the screen for CMS/Other codes with utilization over 30,000. The family was expanded to include three other x-ray codes pertaining to the lower gastrointestinal tract, 74251, 74260, and 74280. These codes were referred to the April 2018 CPT meeting. One of the codes, 74260 (*Duodenography, hypotonic*), was deleted, as it is an infrequently performed procedure. The descriptors for the remaining four codes were editorially revised to clarify the procedures, as shown below, and the family was surveyed for the October 2018 RUC.

- **74250** (*Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study*),
- **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*),
- **74270** (*Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study*), and
- **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*).

Survey Process

The ACR surveyed a total of 1500 members (a random sample of 750 members and a separate random sample of 750 members who perform x-ray or gastrointestinal procedures).

Compelling Evidence:

The society is recommending compelling evidence for the entire family of codes to support the proposed wRVUs and times. The two codes identified on the screen, 74250 and 74270, are both CMS/Other, and were valued using flawed methodology. CPT code 74251 was most recently reviewed in July 1993, likely as part of the initial first 5-year review cycle. CPT code 74280 was most recently reviewed in September 2011, and since that time, there have been advances in technology which changed the typical patient. For all four codes in this family, there have been significant changes in the patient population and physician work over the past two decades as detailed below individually.

- **74250** – This is a CMS/Other code, and therefore, the times and values were established using a flawed methodology. Healthy, routine patients are increasingly evaluated with deep endoscopy and/or capsule endoscopy, while patients undergoing radiologic small bowel examinations are increasingly evaluated in the post-operative period to evaluate for both immediate and long-term surgical complications, frequently after multiple operations have been performed. This code is now more typically performed on a complicated patient in the hospital.
- **74251** – This code was most recently reviewed in July 1993, likely as part of the initial first 5-year review cycle. Since that time, healthy, routine patients are increasingly evaluated with deep endoscopy and/or capsule endoscopy, while patients undergoing radiologic small bowel examinations are increasingly evaluated in the post-operative period to evaluate for both immediate and long-term surgical complications, frequently after multiple operations have been performed. This code is now most often used for problem-solving chronic, unexplained symptoms when other investigations have been inconclusive, and is predominately performed in the inpatient setting (69% of claims).
- **74270** – This is a CMS/Other code, and therefore, the times and values were established using a flawed methodology. Many of these patients are now evaluated with CT and managed

accordingly. This code is now most frequently used to evaluate complex pre-operative anatomy, post-operative complications, or indeterminate CT findings.

- **74280** – This code was most recently reviewed in September 2011, and since that time, there have been advances in technology which changed the typical patient. Most patients are typically first evaluated by colonoscopy and, increasingly, CT colonography. 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. While previously used as a screening exam for the colon, that indication is now less than 6% of the claims.

Work RVU Recommendation:

The expert panel recommends a work RVU of 1.17 for CPT code 74251, which is the 25th percentile survey value, and above the current value.

Time Recommendation:

The expert panel recommends the following median survey times: 5 minutes of pre-service time, 22 minutes of intra-service time, and 5 minutes of post-service time. This is a total time of 32 minutes compared to the existing time of 38 minutes.

Key Reference Services

The most commonly chosen reference codes by survey participants are two CT of the abdomen procedures:

- **74170** (*Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections*), chosen by 72% of respondents, and
- **74160** (*Computed tomography, abdomen; with contrast material(s)*), chosen by 9% of respondents.

While the survey respondents reported a greater intra-service and total time for 74251, there are periods of less intense work compared to the most commonly chosen key reference services, 74170 and 74160, resulting in an appropriately lower wRVU and IWP/UT. The small bowel examination 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.

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWP/UT	% chosen
74251	X-ray, small intestine; double-contrast study	1.17	32	5	22	5	0.043	
74160	CT, abdomen; w/contrast	1.27	23	3	15	5	0.073	9%
74170	CT, abdomen; w/o & w/contrast	1.40	28	5	18	5	0.065	72%

MPC Codes

The surveyed code compares well with three MPC codes:

- **99213** (*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.*)
- **70460** (*Computed tomography, head or brain; with contrast material(s)*)

- **70470** (*Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections*)

CPT code 74251 is bracketed by two radiology MPC codes, 70460 and 70470, which both have less time but appropriately higher IWPUs, considering the intense work required to evaluate the brain and intracranial structures. CPT code 74251 also has more intra-service and overall time than MPC code 99213, supporting the higher wRVU recommendation. The relationships are summarized in the following table.

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWPUT
99213	Office or OP visit for E&M of established pt w/MDM of low complexity. Typically, 15 minutes face-to-face with patient.	0.97	23	3	15	5	0.053
70460	CT, head or brain; w/contrast	1.13	22	5	12	5	0.076
74251	X-ray, small intestine; double-contrast study	1.17	32	5	22	5	0.043
70470	CT head or brain; w/o & w/contrast	1.27	25	5	15	5	0.070

Summary

The survey results and comparison with applicable codes support the 25th percentile survey value for 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 recommendation maintains relativity within the lower gastrointestinal tract family and greater RBRVS.

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWPUT
74250	X-Ray, small intestine; single-contrast study	0.81	23	3	15	5	0.042
74270	X-ray, colon; single-contrast study	1.04	24	4	15	5	0.056
74251	X-ray, small intestine; double-contrast study	1.17	32	5	22	5	0.043
74280	X-ray, colon; double-contrast study	1.26	29	4	20	5	0.053

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.

- ☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 74251

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1005

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 74251 is estimated to be provided 1,005 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 948 Percentage 94.32 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 335

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 74251 is estimated to be provided 335 times nationally in a one-year period to Medicare patients.

Specialty Diagnostic Radiology Frequency 316 Percentage 94.32 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Imaging

BETOS Sub-classification:
Standard imaging

BETOS Sub-classification Level II:
Contrast Gastrointestinal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 74251

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 74270 Tracking Number J10

Original Specialty Recommended RVU: **1.04**Presented Recommended RVU: **1.04**Global Period: XXX Current Work RVU: **0.69**RUC Recommended RVU: **1.04**

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 81-year-old male presents to the emergency department with worsening abdominal pain, distension and melena. A single-contrast colon study is requested for evaluation of suspected colonic obstruction.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the reason for the examination and any pertinent clinical history. Confirm that single contrast only examination is appropriate. Determine the type of contrast to use. Review any prior applicable plain film or imaging studies. Provide patient with examination instructions and confirm understanding.

Description of Intra-Service Work: Position the patient. Review the scout abdominal radiograph(s) to ensure the colon is clear of stool. Perform a digital rectal examination to assess for rectal mass or stricture. Insert the rectal tube. With the patient in decubitus position, start the administration of barium under fluoroscopic visualization. Direct the patient to various positions to allow filling to the level of the cecum. Take multiple spot views including a lateral rectosigmoid view, the splenic and hepatic flexures, the cecum, and ileocecal region. Assess for reflux of barium into the terminal ileum. Use paddle palpation to assist visualization of the terminal ileum. Supervise the acquisition of overhead and decubitus films and post evacuation films obtained by the technologist. Compare the current imaging to all pertinent available prior studies. Dictate a report.

Description of Post-Service Work: Review, edit, and sign report for the medical record. Discuss the findings with the patient and referring provider as needed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Kurt Schoppe, MD; Daniel Wessell, MD; Andrew Moriarity, MD				
Specialty(s):	American College of Radiology				
CPT Code:	74270				
Sample Size:	1500	Resp N:	47	Response: 3.1 %	
Description of Sample:	The ACR surveyed a total of 1500 members (a random sample of 750 members and a separate random sample of 750 members who perform x-ray or GI procedures).				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	7.00	20.00	40.00	150.00
Survey RVW:	0.45	1.04	1.22	1.50	3.00
Pre-Service Evaluation Time:			4.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	4.00	11.00	15.00	20.00	30.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	74270	Recommended Physician Work RVU: 1.04		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	4.00	0.00	4.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	15.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	5.00	0.00	5.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74160	XXX	1.27	RUC Time

CPT Descriptor Computed tomography, abdomen; with contrast material(s)**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74170	XXX	1.40	RUC Time

CPT Descriptor Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
76805	XXX	0.99	RUC Time	8,679

CPT Descriptor 1 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

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
70460	XXX	1.13	RUC Time	32,094

CPT Descriptor 2 Computed tomography, head or brain; with contrast material(s)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99213	XXX	0.97	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 16 **% of respondents:** 34.0 %

Number of respondents who choose 2nd Key Reference Code: 13 **% of respondents:** 27.6 %

TIME ESTIMATES (Median)

	CPT Code: <u>74270</u>	Top Key Reference CPT Code: <u>74160</u>	2nd Key Reference CPT Code: <u>74170</u>
Median Pre-Service Time	4.00	3.00	5.00
Median Intra-Service Time	15.00	15.00	18.00
Median Immediate Post-service Time	5.00	5.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	24.00	23.00	28.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	19%	44%	19%	19%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	38%	50%	13%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	13%	19%	69%
Physical effort required	13%	0%	88%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	25%	38%	38%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	15%	8%	54%	23%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	38%	23%	38%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	23%	0%	77%
Physical effort required	8%	8%	85%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	15%	23%	62%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

CPT codes 74250 and 74270 were identified on the screen for CMS/Other codes with utilization over 30,000. The family was expanded to include three other x-ray codes pertaining to the lower gastrointestinal tract, 74251, 74260, and 74280. These codes were referred to the April 2018 CPT meeting. One of the codes, 74260 (*Duodenography, hypotonic*), was deleted, as it is an infrequently performed procedure. The descriptors for the remaining four codes were editorially revised to clarify the procedures, as shown below, and the family was surveyed for the October 2018 RUC.

- **74250** (*Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study*),
- **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*),
- **74270** (*Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study*), and
- **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*).

Survey Process

The ACR surveyed a total of 1500 members (a random sample of 750 members and a separate random sample of 750 members who perform x-ray or gastrointestinal procedures).

Compelling Evidence:

The society is recommending compelling evidence for the entire family of codes to support the proposed wRVUs and times. The two codes identified on the screen, 74250 and 74270, are both CMS/Other, and were valued using flawed methodology. CPT code 74251 was most recently reviewed in July 1993, likely as part of the initial first 5-year review cycle. CPT code 74280 was most recently reviewed in September 2011, and since that time, there have been advances in technology which changed the typical patient. For all four codes in this family, there have been significant changes in the patient population and physician work over the past two decades as detailed below individually.

- **74250** – This is a CMS/Other code, and therefore, the times and values were established using a flawed methodology. Healthy, routine patients are increasingly evaluated with deep endoscopy and/or capsule endoscopy, while patients undergoing radiologic small bowel examinations are increasingly evaluated in the post-operative period to evaluate for both immediate and long-term surgical complications, frequently after multiple operations have been performed. This code is now more typically performed on a complicated patient in the hospital.
- **74251** – This code was most recently reviewed in July 1993, likely as part of the initial first 5-year review cycle. Since that time, healthy, routine patients are increasingly evaluated with deep endoscopy and/or capsule endoscopy, while patients undergoing radiologic small bowel examinations are increasingly evaluated in the post-operative period to evaluate for both immediate and long-term surgical complications, frequently after multiple operations have been performed. This code is now most often used for problem-solving chronic, unexplained symptoms when other investigations have been inconclusive, and is predominately performed in the inpatient setting (69% of claims).
- **74270** – This is a CMS/Other code, and therefore, the times and values were established using a flawed methodology. Many of these patients are now evaluated with CT and managed

accordingly. This code is now most frequently used to evaluate complex pre-operative anatomy, post-operative complications, or indeterminate CT findings.

- **74280** – This code was most recently reviewed in September 2011, and since that time, there have been advances in technology which changed the typical patient. Most patients are typically first evaluated by colonoscopy and, increasingly, CT colonography. 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. While previously used as a screening exam for the colon, that indication is now less than 6% of the claims.

Work RVU Recommendation:

The expert panel recommends a work RVU of 1.04 for CPT code 74270, which is the 25th percentile survey value, and above the current CMS/Other value.

Time Recommendation:

The expert panel recommends the following median survey times: 4 minutes of pre-service time, 15 minutes of intra-service time, and 5 minutes of post-service time. This is a total time of 24 minutes compared to the existing CMS/Other total time of 14 minutes.

Key Reference Services

The most commonly chosen reference codes by survey participants are two CT of the abdomen procedures:

- **74160** (*Computed tomography, abdomen; with contrast material(s)*), chosen by 34% of respondents, and
- **74170** (*Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections*), chosen by 28% of respondents.

The recommended wRVU and survey times are appropriate compared to the most commonly chosen key reference service, 74160 (*Computed tomography, abdomen; with contrast material(s)*), which has 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 wRVU and IWPUT.

The recommended value and service times are also appropriately lower compared to the second key reference service, 74170 (*Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections*), which has 3 minutes more intra-service time. 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.

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWPUT	% chosen
74270	X-ray, colon; single-contrast study	1.04	24	4	15	5	0.056	
74160	CT, abdomen; w/contrast	1.27	23	3	15	5	0.073	34%
74170	CT, abdomen; w/o & w/contrast	1.40	28	5	18	5	0.065	28%

MPC Codes

The surveyed code compares well with three other MPC codes:

- **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*)
- **99213** (*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.*)
- **70460** (*Computed tomography, head or brain; with contrast material(s)*)

Surveyed CPT code 74270 is bracketed by two radiology MPC codes, 76805 and 70460. It has identical intra-service time and similar total time to both CPT codes 76805 and 99213, but the invasive nature of this procedure accounts for the greater intensity and slightly higher wRVU and IWP/UT. CPT code 74270 has slightly more time but is less intense than 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 relationships are summarized in the following table.

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWP/UT
99213	Office or OP visit for E&M of established pt w/MDM of low complexity. Typically, 15 minutes face-to-face with patient.	0.97	23	3	15	5	0.053
76805	US, pregnant uterus, real time w/img doc, fetal & maternal eval after first trimester, transabd. Approach; single gestation	0.99	26	5	15	6	0.050
74270	X-ray, colon; single-contrast study	1.04	24	4	15	5	0.056
70460	CT, head or brain; w/contrast	1.13	22	5	12	5	0.076

Summary

The survey results and comparison with applicable codes support the 25th percentile survey value for 74270 (*Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study*). The recommendation maintains relativity within the lower gastrointestinal tract family and greater RBRVS.

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWP/UT
74250	X-Ray, small intestine; single-contrast study	0.81	23	3	15	5	0.042
74270	X-ray, colon; single-contrast study	1.04	24	4	15	5	0.056
74251	X-ray, small intestine; double-contrast study	1.17	32	5	22	5	0.043
74280	X-ray, colon; double-contrast study	1.26	29	4	20	5	0.053

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 74270

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 102315

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 74270 is estimated to be provided 102,315 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 97371 Percentage 95.16 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 34,105 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 74270 is estimated to be provided 34,105 times nationally in a one-year period to Medicare patients.

Specialty Diagnostic Radiology Frequency 32457 Percentage 95.16 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Imaging

BETOS Sub-classification:

Standard imaging

BETOS Sub-classification Level II:

Contrast Gastrointestinal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 74270

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 74280 Tracking Number J11

Original Specialty Recommended RVU: **1.26**Presented Recommended RVU: **1.26**Global Period: XXX Current Work RVU: **0.99**RUC Recommended RVU: **1.26**

CPT Descriptor: 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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male presents with a history of colon polyps and recent episodes of hematochezia. A double-contrast colon study is ordered following an incomplete colonoscopy.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the reason for the examination and any pertinent clinical history. Confirm that double contrast examination is appropriate. Determine the type of contrast to use and if glucagon is indicated. Review any prior applicable plain film or imaging studies. Provide patient with examination instructions and confirm understanding.

Description of Intra-Service Work: Position the patient. Review the scout abdominal radiograph(s) to ensure the colon is clear of stool. Perform a digital rectal examination to assess for rectal mass or stricture. Insert the rectal tube. With the patient in decubitus position, start the administration of barium and some air under fluoroscopic visualization. Direct the patient to various positions to allow filling to the level of the cecum. Return the patient to the upright position and drain excess barium. Move the patient to the prone and supine positions to distribute air and barium along all mucosal surfaces. Take multiple spot views including a lateral rectosigmoid view, the splenic and hepatic flexures, the cecum, and ileocecal region. Assess for reflux of barium into the terminal ileum. Use paddle palpation to assist visualization of the terminal ileum and any overlapping colonic segments. Supervise the acquisition of overhead and decubitus films and post evacuation films obtained by the technologist. Compare the current imaging to all pertinent available prior studies. Dictate a report.

Description of Post-Service Work: Review, edit, and sign report for the medical record. Discuss the findings with the patient and referring provider as needed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Kurt Schoppe, MD; Daniel Wessell, MD; Andrew Moriarity, MD				
Specialty(s):	American College of Radiology				
CPT Code:	74280				
Sample Size:	1500	Resp N:	47	Response: 3.1 %	
Description of Sample:	The ACR surveyed a total of 1500 members (a random sample of 750 members and a separate random sample of 750 members who perform x-ray or GI procedures).				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	10.00	28.00	200.00
Survey RVW:	0.60	1.26	1.40	1.70	4.05
Pre-Service Evaluation Time:			4.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	6.00	15.00	20.00	25.00	45.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	74280	Recommended Physician Work RVU: 1.26		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	4.00	0.00	4.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	20.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	5.00	0.00	5.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74170	XXX	1.40	RUC Time

CPT Descriptor Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74160	XXX	1.27	RUC Time

CPT Descriptor Computed tomography, abdomen; with contrast material(s)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
70470	XXX	1.27	RUC Time	110,713

CPT Descriptor 1 Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99238	XXX	1.28	RUC Time	3,060,204

CPT Descriptor 2 Hospital discharge day management; 30 minutes or less

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
70460	XXX	1.13	RUC Time

CPT Descriptor Computed tomography, head or brain; with contrast material(s)**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 29 % of respondents: 61.7 %

Number of respondents who choose 2nd Key Reference Code: 11 % of respondents: 23.4 %

TIME ESTIMATES (Median)

	CPT Code: <u>74280</u>	Top Key Reference CPT Code: <u>74170</u>	2nd Key Reference CPT Code: <u>74160</u>
Median Pre-Service Time	4.00	5.00	3.00
Median Intra-Service Time	20.00	18.00	15.00
Median Immediate Post-service Time	5.00	5.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	29.00	28.00	23.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	3%	17%	31%	48%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
24%	41%	34%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	0%	10%	90%
Physical effort required	0%	0%	100%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

10%

14%

76%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More****Overall intensity/complexity**

0%

9%

18%

55%

18%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

27%

36%

36%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

9%

0%

91%

Physical effort required

9%

0%

91%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

18%

45%

36%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

CPT codes 74250 and 74270 were identified on the screen for CMS/Other codes with utilization over 30,000. The family was expanded to include three other x-ray codes pertaining to the lower gastrointestinal tract, 74251, 74260, and 74280. These codes were referred to the April 2018 CPT meeting. One of the codes, 74260

(*Duodenography, hypotonic*), was deleted, as it is an infrequently performed procedure. The descriptors for the remaining four codes were editorially revised to clarify the procedures, as shown below, and the family was surveyed for the October 2018 RUC.

- **74250** (*Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study*),
- **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*),
- **74270** (*Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study*), and
- **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*).

Survey Process

The ACR surveyed a total of 1500 members (a random sample of 750 members and a separate random sample of 750 members who perform x-ray or gastrointestinal procedures).

Compelling Evidence:

The society is recommending compelling evidence for the entire family of codes to support the proposed wRVUs and times. The two codes identified on the screen, 74250 and 74270, are both CMS/Other, and were valued using flawed methodology. CPT code 74251 was most recently reviewed in July 1993, likely as part of the initial first 5-year review cycle. CPT code 74280 was most recently reviewed in September 2011, and since that time, there have been advances in technology which changed the typical patient. For all four codes in this family, there have been significant changes in the patient population and physician work over the past two decades as detailed below individually.

- **74250** – This is a CMS/Other code, and therefore, the times and values were established using a flawed methodology. Healthy, routine patients are increasingly evaluated with deep endoscopy and/or capsule endoscopy, while patients undergoing radiologic small bowel examinations are increasingly evaluated in the post-operative period to evaluate for both immediate and long-term surgical complications, frequently after multiple operations have been performed. This code is now more typically performed on a complicated patient in the hospital.
- **74251** – This code was most recently reviewed in July 1993, likely as part of the initial first 5-year review cycle. Since that time, healthy, routine patients are increasingly evaluated with deep endoscopy and/or capsule endoscopy, while patients undergoing radiologic small bowel examinations are increasingly evaluated in the post-operative period to evaluate for both immediate and long-term surgical complications, frequently after multiple operations have been performed. This code is now most often used for problem-solving chronic, unexplained symptoms when other investigations have been inconclusive, and is predominately performed in the inpatient setting (69% of claims).
- **74270** – This is a CMS/Other code, and therefore, the times and values were established using a flawed methodology. Many of these patients are now evaluated with CT and managed accordingly. This code is now most frequently used to evaluate complex pre-operative anatomy, post-operative complications, or indeterminate CT findings.
- **74280** – This code was most recently reviewed in September 2011, and since that time, there have been advances in technology which changed the typical patient. Most patients are typically first evaluated by colonoscopy and, increasingly, CT colonography. 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. While previously used as a screening exam for the colon, that indication is now less than 6% of the claims.

Work RVU Recommendation:

The expert panel recommends a work RVU of 1.26 for CPT code 74280, which is the 25th percentile survey value, and above the current value.

Time Recommendation:

The expert panel recommends the following median survey times: 4 minutes of pre-service time, 20 minutes of intra-service time, and 5 minutes of post-service time. This is a total time of 29 minutes compared to the existing time of 32 minutes.

Key Reference Services

The most commonly chosen reference codes by survey participants are two CT of the abdomen procedures:

- **74170** (*Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections*), chosen by 62% of respondents, and
- **74160** (*Computed tomography, abdomen; with contrast material(s)*), chosen by 23% of respondents.

While the survey respondents reported a greater intra-service and total time for 74280, there are periods of less intense work compared to the most commonly chosen key reference services, 74170 and 74160, resulting in an appropriately lower wRVU and IWPOT. 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.

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWPOT	% chosen
74280	X-ray, colon; double-contrast study	1.26	29	4	20	5	0.053	
74160	CT, abdomen; w/contrast	1.27	23	3	15	5	0.073	23%
74170	CT, abdomen; w/o & w/contrast	1.40	28	5	18	5	0.065	62%

MPC Codes

The surveyed code compares well with three MPC codes:

- **70460** (*Computed tomography, head or brain; with contrast material(s)*)
- **70470** (*Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections*)
- **99238** (*Hospital discharge day management; 30 minutes or less*)

Surveyed CPT code 74280 is bracketed by two radiology MPC codes, 70460 and 70470. Both MPC codes have appropriately higher IWPOT 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 surveyed 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 relationships are summarized in the following table.

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWPUT
70460	CT, head or brain; w/contrast	1.13	22	5	12	5	0.076
74280	X-ray, colon; double-contrast study	1.26	29	4	20	5	0.053
70470	CT, head or brain; w/o & w/contrast	1.27	25	5	15	5	0.070
99238	Hospital discharge day mngmt; 30 mins or less	1.28	38	8	20	10	0.044

Summary

The survey results and comparison with applicable codes support the 25th percentile survey value for 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 recommendation maintains relativity within the lower gastrointestinal tract family and greater RBRVS.

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWPUT
74250	X-Ray, small intestine; single-contrast study	0.81	23	3	15	5	0.042
74270	X-ray, colon; single-contrast study	1.04	24	4	15	5	0.056
74251	X-ray, small intestine; double-contrast study	1.17	32	5	22	5	0.043
74280	X-ray, colon; double-contrast study	1.26	29	4	20	5	0.053

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 74280

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology	How often? Commonly
--------------------------------	---------------------

Specialty	How often?
-----------	------------

Specialty	How often?
-----------	------------

Estimate the number of times this service might be provided nationally in a one-year period? 36696

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 74280 is estimated to be provided 36,696 times nationally in a one-year period.

Specialty Diagnostic Radiology	Frequency 34988	Percentage 95.34 %
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Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

12,232 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 74280 is estimated to be provided 12,232 times nationally in a one-year period to Medicare patients.

Specialty Diagnostic Radiology	Frequency 11663	Percentage 95.34 %
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Specialty	Frequency	Percentage	%
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Imaging

BETOS Sub-classification:

Standard imaging

BETOS Sub-classification Level II:

Contrast Gastrointestinal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 74280

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR
13	ISSUE: X-Ray Lower GI Tract																							
14	TAB: 11																							
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIE			
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th
17	1st REF	74160	Computed tomography, abdomen; with contrast material(s)	12	0.073			1.27			23	3					15			5				
18	2nd REF	74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	9	0.065			1.40			28	5					18			5				
19	CMS/Other	74250	Radiologic examination, small intestine, including multiple serial images and scout		#DIV/0!			0.47			10													
20	SVY	74250	Radiologic examination, small intestine, including multiple serial images and scout	47	0.061	0.33	0.81	1.09	1.27	3.00	23	3			2	8	15	18	90	5	0	10	20	49
21	ACR - Subset	74250	Radiologic examination, small intestine, including multiple serial images and scout	36	0.061	0.33	0.88	1.09	1.30	3.00	23	3			2	7	15	20	90	5	2	12	20	50
22	ACR - Random	74250	Radiologic examination, small intestine, including multiple serial images and scout	11	0.061	0.40	0.80	1.09	1.20	1.40	23	3			4	9	15	15	15	5	0	5	20	30
23	REC	74250	Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study		0.042	0.81					23	3					15			5				
24																								
25						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIE			
26	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th
27	1st REF	74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	34	0.065			1.40			28	5					18			5	0	80	250	575
28	2nd REF	74160	Computed tomography, abdomen; with contrast material(s)	4	0.073			1.27			23	3					15			5	70	1518	2250	2650
29	Jul-93	74251	Radiologic examination, small intestine, including multiple serial images and scout		0.017			0.69			38	2					32			4				
30	SVY	74251	Radiologic examination, small intestine, including multiple serial images and scout	47	0.056	0.45	1.17	1.45	2.00	4.35	32	5			5	19	22	35	120	5	0	0	0	1
31	SVY - EXP > 0	74251	Radiologic examination, small intestine, including multiple serial images and scout	13	0.051	0.70	1.00	1.25	1.50	3.00	30	5			12	20	20	35	120	5	1	2	3	5
32	SVY - EXP = 0	74251	Radiologic examination, small intestine, including multiple serial images and scout	34	0.051	0.45	1.40	1.50	2.00	4.35	35	5			5	16	25	34	80	5	0	0	0	0
33	ACR - Subset	74251	Radiologic examination, small intestine, including multiple serial images and scout	36	0.046	0.70	1.36	1.50	2.06	4.35	38	5			15	20	28	36	120	5	0	0	0	1
34	ACR - Random	74251	Radiologic examination, small intestine, including multiple serial images and scout	11	0.072	0.45	1.00	1.30	1.48	3.00	25	5			5	14	15	21	35	5	0	0	0	1
35	REC	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		0.043	1.17					32	5					22			5				
36																								

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR
13	ISSUE: X-Ray Lower GI Tract																							
14	TAB: 11																							
37						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIE			
38	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th
39	1st REF	74160	Computed tomography, abdomen; with contrast material(s)	16	0.073			1.27			23	3				15				5				
40	2nd REF	74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	13	0.065			1.40			28	5				18				5				
41	CMS\Other	74270	Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s),		#DIV/0!			0.69			14													
42	SVY	74270	Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s),	47	0.068	0.45	1.04	1.22	1.50	3.00	24	4			4	11	15	20	30	5	0	7	20	40
43	ACR - Subset	74270	Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s),	36	0.069	0.65	1.15	1.24	1.50	3.00	24	4			5	10	15	20	30	5	5	10	24	50
44	ACR - Random	74270	Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s),	11	0.060	0.45	0.90	1.10	1.40	1.80	24	4			4	14	15	20	25	5	0	4	8	15
45	REC	74270	Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study		0.056	1.04					24	4				15				5				
46																								
47						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIE			
48	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th
49	1st REF	74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	29	0.065			1.40			28	5				18				5				
50	2nd REF	74160	Computed tomography, abdomen; with contrast material(s)	11	0.073			1.27			23	3				15				5				
51	Sep-11	74280	Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s),		0.036			0.99			32	5				20				7				
52	SVY	74280	Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s),	47	0.060	0.60	1.26	1.40	1.70	4.05	29	4			6	15	20	25	45	5	0	4	10	28
53	ACR - Subset	74280	Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s),	36	0.060	0.70	1.29	1.40	1.75	4.05	29	4			10	17	20	25	45	5	0	5	13	32
54	ACR - Random	74280	Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s),	11	0.047	0.60	1.00	1.40	1.50	2.50	35	5			6	15	25	25	30	5	0	2	3	7
55	REC	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		0.053	1.26					29	4				20				5				

SS Rec Summary

	AS
13	
14	
15	NCE
16	MAX
17	
18	
19	
20	200
21	200
22	80
23	
24	
25	NCE
26	MAX
27	3000
28	3100
29	
30	20
31	20
32	0
33	20
34	5
35	
36	

SS Rec Summary

	AS
13	
14	
37	NCE
38	MAX
39	
40	
41	
42	150
43	150
44	40
45	
46	
47	NCE
48	MAX
49	
50	
51	
52	200
53	200
54	20
55	

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor:

74250	Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study
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
74270	Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study
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

Global Period: XXX Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

The American College of Radiology (ACR) convened a consensus panel to finalize the practice expense data for the X-Ray Lower GI Tract code family, CPT codes 74250, 74251, 74270, and 74280.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

The society included the existing PE inputs for codes 74250, 74251, 74270 and 74280 on the spreadsheet to serve as a reference.

3. Is this code(s) typically billed with an E/M service?
Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)

No, these codes are not typically billed with an E/M service.

No, these codes are not typically billed with an E/M service in the nonfacility.

4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different then for the global?
(Please see provided data in PE Subcommittee folder)

Diagnostic Radiology is the dominant specialty in the nonfacilityfor CPT codes 74250, 74270, and 74280 (percentages below). No information available for CPT code 74251.

74250	74270	74280
82%	75%	80%

Diagnostic Radiology is the dominant specialty in the global for all four codes.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
N/A
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.
N/A
7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:
N/A
8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code)
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:
N/A
9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

X-ray small intestine, single-contrast (74250)

Bring patient into x-ray room and have patient stand or lay on x-ray table as appropriate. Position patient for the first view at the direction of the physician. Step behind shielding to control panel. Set appropriate exposure parameters. Instruct patient to hold still. Take exposure for first view. Step from behind shielding. Review the image with the supervising physician and adjust patient positioning and parameters as needed. The above steps are repeated for all subsequent views to be obtained under supervision by the physician performing the procedure as needed to demonstrate the relevant anatomy and any pertinent pathology. For each image after the initial image, assist the supervising physician in administering oral contrast as needed to demonstrate pertinent anatomy and findings. All cassettes are taken to the image reader and run through reader. Check all images for adequate exposure, positioning, coverage, etc. Discuss with the radiologist and repeat any views as needed.

X-ray small intestine, double-contrast (74251)

Bring patient into x-ray room and have patient stand or lay on x-ray table as appropriate. Place the enteroclysis tube if indicated. Position patient for the first view at the direction of the physician. Step behind shielding to control panel. Set appropriate exposure parameters. Instruct patient to hold still. Take exposure for first view. Step from behind shielding. Review the image with the supervising physician and adjust patient positioning and parameters as needed. The above steps are repeated for all subsequent views to be obtained under supervision by the physician performing the procedure as needed to demonstrate the relevant anatomy and any pertinent pathology. For each image after the initial image, assist the supervising physician in administering oral contrast as needed to demonstrate pertinent anatomy and findings. All cassettes are taken to the image reader and run through reader. Check all

images for adequate exposure, positioning, coverage, etc. Discuss with the radiologist and repeat any views as needed.

X-ray colon, single-contrast (74270)

Bring patient into x-ray room and have patient stand or lay on x-ray table as appropriate. Place the rectal tube. Position patient for the first view at the direction of the physician. Step behind shielding to control panel. Set appropriate exposure parameters. Instruct patient to hold still. Take exposure for first view. Step from behind shielding. Review the image with the supervising physician and adjust patient positioning and parameters as needed. The above steps are repeated for all subsequent views to be obtained under supervision by the physician performing the procedure as needed to demonstrate the relevant anatomy and any pertinent pathology. For each image after the initial image, assist the supervising physician in administering rectal contrast as needed to demonstrate pertinent anatomy and findings. All cassettes are taken to the image reader and run through reader. Check all images for adequate exposure, positioning, coverage, etc. Discuss with the radiologist and repeat any views as needed.

X-ray colon, double contrast (74280)

Bring patient into x-ray room and have patient stand or lay on x-ray table as appropriate. Place the rectal tube and connect the tubing to air insufflation device. Position patient for the first view at the direction of the physician. Step behind shielding to control panel. Set appropriate exposure parameters. Instruct patient to hold still. Take exposure for first view. Step from behind shielding. Review the image with the supervising physician and adjust patient positioning and parameters as needed. The above steps are repeated for all subsequent views to be obtained under supervision by the physician performing the procedure as needed to demonstrate the relevant anatomy and any pertinent pathology. For each image after the initial image, assist the supervising physician in administering rectal contrast and insufflation as needed to demonstrate pertinent anatomy and findings. All cassettes are taken to the image reader and run through reader. Check all images for adequate exposure, positioning, coverage, etc. Discuss with the radiologist and repeat any views as needed.

10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
N/A
11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:
N/A
12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.
N/A
13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:
N/A
14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:
N/A

15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:

- **Technologist PACS Workstation Proxy (ED050)** –PACS formula; Equals total service period time
- **Professional PACS Workstation (ED053)** – Equals physician work intra time + 1/2 physician work pre-time
- **Room, basic radiology (EL012)** – Highly technical formula

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:

N/A

17. If there is any other item on your spreadsheet that needs further explanation please include here:

We have included two additional supply items not currently in the existing codes:

- **Gloves, non-sterile (SB022)** – 2 pairs, one for the tech and one for the radiologist
- **Underpad 2ft x 3ft (Chux) (SB044)** – included only for CPT codes 74270 and 74280. Used as a barrier between the patient and the table.

18. Please include an explanation of each line item:

N/A

	A	B	D	E	F	I	K	O	Q	U	W	AA	AC
1	RUC Practice Expense Spreadsheet REVISED AT RUC					CURRENT	RECOMMENDED	CURRENT	RECOMMENDED	CURRENT	RECOMMENDED	CURRENT	RECOMMENDED
2		column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.				74250	74250	74251	74251	74270	74270	74280	74280
3		RUC Collaboration Website				Radiologic examination, small intestine, includes multiple serial images; (Jan. 2004)	Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study (Oct. 2018)	Radiologic examination, small intestine, includes multiple serial images; via enteroclysis tube (Jan. 2004)	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 (Oct. 2018)	Radiologic examination, colon; contrast (eg, barium) enema, with or without KUB (Jan. 2004)	Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study (Oct. 2018)	Radiologic examination, colon; air contrast with specific high density barium, with or without glucagon (Jan. 2004)	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 (Oct. 2018)
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 11- X-Ray Lower GI Tract Specialty: ACR	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute								
5		LOCATION				Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac
6		GLOBAL PERIOD											
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				\$ 68.65	\$ 60.46	\$ 335.75	\$ 289.60	\$ 98.51	\$ 73.74	\$ 141.21	\$ 117.63
8		TOTAL CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	35.0	34.0	64.0	47.0	48.0	42.0	58.0	53.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L041B	Technologist	0.41	0.0	0.0	0.0	2.0	0.0	2.0	0.0	2.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	35.0	34.0	64.0	45.0	48.0	40.0	58.0	51.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE				\$ 14.35	\$ 13.94	\$ 26.24	\$ 18.45	\$ 19.68	\$ 16.40	\$ 23.78	\$ 20.91
13		PRE-SERVICE PERIOD											
14		Start: Following visit when decision for surgery or procedure made											
15	CA001	Complete pre-service diagnostic and referral forms											
16	CA002	Coordinate pre-surgery services (including test results)											
17	CA003	Schedule space and equipment in facility											
18	CA004	Provide pre-service education/obtain consent											
19	CA005	Complete pre-procedure phone calls and prescription											
20	CA006	Confirm availability of prior images/studies							2		2		2
21	CA007	Review patient clinical extant information and questionnaire											
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)											
29		End: When patient enters office/facility for surgery/procedure											
30		SERVICE PERIOD											
31		Start: When patient enters office/facility for surgery/procedure:											
32		Pre-Service (of service period)											
33	CA009	Obtain patient, provide gowning, ensure appropriate medical records are available	L041B	Radiologic Technologist	0.41	3	3	3	3	3	3	3	3
34	CA010	Obtain vital signs											
35	CA011	Provide education/obtain consent											
36	CA012	Review requisition, assess for special needs											
37	CA013	Prepare room, equipment and supplies	L041B	Radiologic Technologist	0.41	2	2	2	2	2	2	2	2
38	CA014	Confirm order, protocol exam											
39	CA015	Setup scope (nonfacility setting only)											
40	CA016	Prepare, set up and start IV, initial positioning and monitoring of patient	L041B	Radiologic Technologist	0.41	1	2	1	2	1	2	1	2
41	CA017	Sedate/apply anesthesia											
48		Intra-service (of service period)											
49	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time											
50	CA019	Assist physician or other qualified healthcare professional---directly related to physician work time											
51	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time											
52	CA021	Perform procedure/service---NOT directly related to physician work time	L041B	Radiologic Technologist	0.41	15	19	15	30	18	25	24	36
53													
54													
55													
56		Assist physician in performing fluoroscopy and spot film acquisition	L041B	Radiologic Technologist	0.41	4		30		10		12	
57		Other activity: please include short clinical description here and											
58		Other activity: please include short clinical description here and											
59		Post-Service (of service period)											
60	CA022	Monitor patient following procedure/service, multitasking 1:4											
61	CA023	Monitor patient following procedure/service, no multitasking											
62	CA024	Clean room/equipment by clinical staff	L041B	Radiologic Technologist	0.41	3	3	3	3	3	3	3	3
63	CA025	Clean scope											
64	CA026	Clean surgical instrument package											
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions											
66	CA028	Review/read post-procedure x-ray, lab and pathology reports											
67	CA029	Check dressings, catheters, wounds											
68	CA030	Technologist QC's images in PACS, checking for all images, reformat, and deep save	L041B	Radiologic Technologist	0.41		2		2		2		2
69	CA031	Review examination with interpreting MD/DO	L041B	Radiologic Technologist	0.41	7	2	10	2	11	2	13	2
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue	L041B	Radiologic Technologist	0.41		1		1		1		1

[illegible]

[illegible]

AMA/Specialty Society RVS Update Committee Summary of Recommendations
High Volume Growth

October 2018

Myocardial PET

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.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Radiology Nuclear Medicine Cardiovascular System Myocardial perfusion (<u>SPECT and PET</u>) and cardiac blood pool imaging studies may be performed at rest and/or during stress. When performed during exercise and/or pharmacologic stress, the appropriate stress testing code from the 93015-93018 series should be reported in addition to 78451-78454, 78472-, 78491, 78430, 78492, 78431, 78432, 78433. PET can be performed on either a dedicated PET machine (<u>which uses a PET source for attenuation correction</u>) or a combination PET/CT camera (78429, 78430, 78431, 78433). A cardiac PET study performed on a PET/CT camera includes examination of the CT transmission images for review of anatomy in the field of view.				
▲ 78459	K1	Myocardial imaging, positron emission tomography (PET), metabolic evaluation <u>study (including ventricular wall motion(s), and/or ejection fraction(s), when performed); single study;</u> (For myocardial perfusion study, see 78491-78492) (78460-78465 have been deleted. To report, see 78451-78454)	XXX	Resurvey for January 2019
● 78429	K2	with concurrently acquired computed tomography transmission scan (For CT coronary calcium scoring, use 75571) (CT performed for other than attenuation correction and anatomical localization is reported using the appropriate site specific CT code with modifier 59)	XXX	Resurvey for January 2019
▲ 78491	K3	Myocardial imaging, positron emission tomography, perfusion; <u>study (including ventricular wall motion(s), and/or ejection fractions(s), when performed); single study, at rest or stress (exercise or pharmacologic)</u>	XXX	Resurvey for January 2019
● 78430	K4	single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	XXX	Resurvey for January 2019
▲ 78492	K5	multiple studies at rest and/or stress (<u>exercise or pharmacologic</u>)	XXX	Resurvey for January 2019

●78431	K6	multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	XXX	Resurvey for January 2019
●78432	K7	Myocardial imaging, positron emission tomography, combined perfusion with metabolic evaluation study (including ventricular wall motion(s), and/or ejection fraction(s), when performed), dual radiotracer (eg, myocardial viability);	XXX	Resurvey for January 2019
●78433	K8	with concurrently acquired computed tomography transmission scan (CT performed for other than attenuation correction and anatomical localization is reported using the appropriate site specific CT code with modifier 59)	XXX	Resurvey for January 2019
+ ●78434	K9	Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography, rest and pharmacologic stress (List separately in addition to code for primary procedure) (Use 78434 in conjunction with 78492, 78431) (For myocardial imaging by planar or SPECT, see 78451, 78452, 78453, 78454) (For CT coronary calcium scoring, use 75571)	ZZZ	Resurvey for January 2019
Category III Codes				
D 0482T	-	Absolute quantitation of myocardial blood flow, positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure) (0482T has been deleted) (For absolute quantitation myocardial blood flow for cardiac PET, use 78434) (Use 0482T in conjunction with 78491, 78492) (For myocardial imaging metabolic evaluation, use 78459) (For positron emission tomography [PET] myocardial perfusion study, see 78491, 78492)	ZZZ	N/A (2018 work RVU = 0.00)

AMA/Specialty Society RVS Update Committee Summary of Recommendations
High Volume Growth

October 2018

Long-Term EEG Monitoring

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 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 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.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery Nervous System Skull, Meninges, and Brain Craniectomy or Craniotomy 61533 <i>Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long-term seizure monitoring</i> (For continuous EEG monitoring, see 95950-95954 <u>95700-95726</u>) Medicine Neurology and Neuromuscular Procedures <i>Neurologic services are...</i>				
<i>In addition, services...</i> The <u>electroencephalogram (EEG)</u> , <u>video-electroencephalogram (VEEG)</u> , autonomic function, evoked potential, reflex tests, <u>electromyography (EMG)</u> , <u>nerve conduction velocity (NCV)</u> , and <u>magnetoencephalography (MEG)</u> services (95812-95829, 95700-95726 , and 95860-95967) include recording, interpretation, and report by a physician or other qualified health care professional. For interpretation only, use modifier 26 <u>with codes 95812-95829, 95860-95967</u> . For interpretation only for long-term EEG services, report codes <u>95717, 95718, 95719, 95720, 95721, 95722, 95723, 95724, 95725, 95726</u> . For EMG guidance, see 95873, 95874. Codes 95812-95822 95950-95953 and 95956 and <u>95700-95726</u> use EEG/VEEG recording time as a basis for code use. Recording time is when the recording is underway and <u>diagnostic EEG</u> data is being collected. Recording time excludes set up and take down time. <u>If diagnostic EEG recording is disrupted, recording time stops until diagnostic EEG recording is resumed.</u> Codes 95961-95962 use physician or other qualified health care professional attendance time as a basis for code use. (Do not report codes 95860-95875 in addition to 96000-96004) Routine Electroencephalography (EEG) <i>EEG codes 95812-95822...</i>				

(f)95812	M1	<i>Electroencephalogram (EEG) extended monitoring; 41-60 minutes</i> <u>(Do not report 95812 in conjunction with 95700-95726)</u>	XXX	1.08 Affirmed January 2016 RUC Recommendation
▲95813	M2	greater than 1 hour <u>61-119 minutes</u> <u>(Do not report 95813 in conjunction with 95700-95726)</u> <u>(For long-term EEG services [2 hours or more], see 95700-95726)</u>	XXX	1.63 Affirmed January 2016 RUC Recommendation
95816	<i>Electroencephalogram (EEG); including recording awake and drowsy</i> <u>(Do not report 95816 in conjunction with 95700-95726)</u>			
95819	<i>including recording awake and asleep</i> <u>(Do not report 95819 in conjunction with 95700-95726)</u>			
95822	<i>recording in coma or sleep only</i> <u>(Do not report 95822 in conjunction with 95700-95726)</u>			
95824	<i>cerebral death evaluation only</i>			
95827	-	all night recording <u>(95827 has been deleted. To report all night EEG recording, see 95705, 95706, 95707, 95711, 95712, 95713, 95717, 95718)</u> <u>(For 24-hour long-term EEG monitoring, see 95700-95726 95950-95953 or 95956)</u> <i>(For EEG during nonintracranial surgery, use 95955)</i> <i>(For Wada test, use 95958)</i> (For digital analysis of EEG, use 95957)	XXX	N/A (2018 Work RVU = 1.08)

Special EEG Tests

Codes 95950-95953 and 95956 are used per 24 hours of recording. For recording more than 12 hours, do not use modifier 52. For recording 12 hours or less, use modifier 52. Codes 95951 and 95956 are used for recordings in which interpretations can be made throughout the recording time, with interventions to alter or end the recording or to alter the patient care during the recordings as needed.

Codes 95961 and 95962 use physician or other qualified health care professional time as a basis for unit of service. Report 95961 for the first hour of attendance. Use modifier 52 with 95961 for 30 minutes or less. Report 95962 for each additional hour of attendance. Codes 95961, 95962 may be reported with 95700-95726 when functional cortical or subcortical mapping is performed with long-term EEG monitoring.

Codes 95700-95726 are long-term continuous recording services for electroencephalography (EEG), which are performed to differentiate seizures from other abnormalities, determine type or location of seizures, monitor treatment of seizures and status epilepticus, establish if the patient is a candidate for epilepsy surgery and/or screen for adverse change in critically ill patients.

The set of codes that describe long-term continuous recording EEG services (95700-95726) is divided into two major groups: (1) technical services; and (2) professional services. Codes 95700-95726 may be reported for any site of service. The technical component of the services is reported with 95700-95716. The professional component of the services is reported with 95717-95726. Diagnostic EEG recording time of less than two hours (ie, one minute, up to one hour and 59 minutes) is not separately reported as a long-term EEG service.

Long-term continuous recording EEG services (95700-95726) are different than routine EEGs (95812, 95813, 95816, 95819, 95822). Routine EEGs capture brain wave activity within a short duration of testing, defined as less than two hours. Long-term continuous recording EEGs capture brain wave activity for durations of time equal to or greater than two hours. The length of recording is based on a number of factors including the clinical indication for the test and the frequency of seizures.

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.

Definitions

EEG technologist: An individual who is qualified by education, training, licensure/certification/regulation (when applicable) in seizure recognition. An EEG technologist(s) performs EEG set-up, take down when performed, patient education, technical description, maintenance and seizure recognition when within his or her scope of practice and is allowed by law, regulation, and facility policy (when applicable).

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 of the studies are reported as unmonitored.

Continuous real-time monitoring (may be provided remotely): 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 recording, the study is an intermittent study.

Technical description: The EEG technologist(s)'s written documentation of the reviewed EEG/VEEG data including technical interventions. The technical description is based on the EEG technologist(s)'s review of data and includes the following required elements: uploading and/or transferring EEG/VEEG data from EEG equipment to a server or storage device; reviewing raw EEG/VEEG data and events and automated detection as well as patient activations; and annotating, editing, and archiving EEG/VEEG data for review by the physician or other qualified health care professional. For unmonitored services, the EEG technologist(s) annotates the recording for review by the physician or other qualified health care professional and creates a single summary.

Maintenance of long-term EEG equipment: Performed by the EEG technologist(s) and involves ensuring the integrity and quality of the recording(s) (eg, camera position, electrode placement, and impedances).

Set-up: Performed in person by the EEG technologist(s) and includes preparing supplies and equipment; and securing electrodes using the 10/20 system. Code 95700 is reported only once per recording period on the date set-up was performed. 'In person', means that the EEG technologist(s) must be physically present with the patient.

Technical Component Services: Code 95700 describes any long-term continuous EEG/VEEG recording, set-up, take down when performed, and patient/caregiver education by the EEG technologist(s). To report 95700, the set-up must include a minimum of eight channels of EEG. Services with fewer than eight channels may be reported using 95999. Channels of 8-15 are typically used for neonates and when electrodes cannot be placed on certain regions of the scalp that are sterile. Twenty or more channels are typically used for children and adults. If set-up is performed by someone who does not meet the definition of an EEG technologist(s), report 95999.

Codes 95705-95716 describe monitoring, maintenance, review of data, and creating a summary technical description. These codes are divided into four groups based on duration and whether video is utilized. Key elements in determining the appropriate technical code (95705-95716) for long-term EEG continuous recording are: (1) whether diagnostic video recording is captured in conjunction and simultaneously with the EEG service, which is referred to as video-EEG (VEEG); and (2) the level of technician monitoring for the study (ie unmonitored, intermittently monitored or continuously monitored). Codes 95711, 95712, 95713, 95714, 95715, 95716 are reported if diagnostic video of the patient is recorded at a minimum of 80% of the time of the entire long-term VEEG service, concurrent with diagnostic EEG recording (ie, the entire study is reported as an EEG without video if concurrent diagnostic video occurs less than 80% of the entire study). Diagnostic EEG recording is an essential component of all long-term EEG services. If diagnostic EEG recording stops, timing stops until diagnostic EEG is resumed.

Codes 95705, 95706, 95707, 95711, 95712, 95713 are reported when total diagnostic recording time is between two and 12 hours, or to capture the final increment of a multi-day service when the final increment extends 2-12 hours beyond time reported by the appropriate greater than 12 hours up to 26 hour code(s) (95708, 95709, 95710, 95714, 95715, 95716). A maximum of one 2-12 hour code may be reported for an entire long-term EEG service. For example, if the testing lasts 48 hours, but diagnostic recording occurs only the initial 11 hours and the final 11 hours of the

testing period, a single greater than 12 hours up to 26 hours technical service is reported rather than two 2-12 hour services for the 48 hour service. (See the Long-Term EEG Monitoring table).

Professional Component Services: Codes 95717-95726 describe the professional services performed by a physician or other qualified health care professional for reviewing, analyzing, interpreting, and reporting the results of the continuous recording EEG/VEEG with recommendations based on the findings of the studies. These codes do not include any E/M services, which may be separately reported.

Codes 95719, 95720 are used for greater than 12 hours (ie, 12 hours and 1 minute) up to 26 hours of recording. Code selection for professional interpretation for long-term EEG is based on: (1) length of the recording being interpreted; and (2) when the physician or other qualified healthcare professional reports are generated (ie, whether diagnostic interpretations and reports are made daily during the study, or whether the entire professional interpretation is performed after the entire study is completed). Codes 95717, 95718, 95719, 95720 are reported when: (1) daily professional reports are generated during the long-term recording, even if the entire study extends over multiple days; or (2) the time of recording for the entire study is between 2 hours and 36 hours. Codes 95717, 95718 are reported once for each 2-12 hour recording, and are reported a maximum of one time for an entire long-term EEG service. Codes 95719, 95720 are reported once for each greater than 12 hours up to 26-hour recording period. Studies lasting 26-36 hours or longer are reported using building blocks, and are reported using one or more of the greater than 12 hours up to 26-hour code with one 2-12 hour code. The recorded data is reviewed, interpreted, and reported daily by the physician or other qualified health care professional, and summary reports are made for the entire multiple-day study. The summary reports are included in each code (95717-95726) and are not separately reported (See the Long-term EEG Monitoring table).

For codes 95721-95726, the entire professional interpretation (including retrospective daily reports and a summary report) is made after the entire study is recorded and downloaded at the completion of the study. When the entire professional interpretation is provided for a multiple-day study that is greater than 36 hours, codes 95721-95726 are used to report the entire professional service, with the appropriate code determined by the span of diagnostic recording time as defined by the codes. A single code (95721-95726) is reported for the multiple day study. For example, a long-term EEG recording that spans three days with a total of 50 hours of VEEG recording would be reported with 95722. Sixty hours and one minute of diagnostic VEEG recording is reported with 95724. (See the Long-Term EEG Monitoring table).

<u>Long-Term EEG Monitoring Table</u>					
Duration of Long-Term EEG/VEEG Recording	Professional		Technical		
	<i>With report each 24 hours</i>	<i>With report at conclusion of entire recording period)</i>	<i>Unmonitored</i>	<i>Intermittent</i>	<i>Continuous</i>
Less than 120 minutes (with video or w/out video)	Not reported separately	Not reported separately	Not reported separately	Not reported separately	Not reported separately

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

2 to 12 hours (w/out video)	95717 x 1	95717 x 1	95705 x 1	95706 x 1	95707 x 1
2 to 12 hours (with video)	95718 x 1	95718 x 1	95711 x 1	95712 x 1	95713 x 1
12 hours and 1 minute to 26 hours (w/out video)	96X16 x 1		95708 x 1	95709 x 1	95710 x 1
12 hours and 1 minute to 26 hours (with video)	95720 x 1		95714 x 1	95715 x 1	95716 x 1
26 hours and 1 minute to 36 hours (w/out video)	95719 x 1 and 95717 x 1		95708 x 1 and 95705 x 1	95709 x 1 and 95706 x 1	95710 x 1 and 95707 x 1
26 hours and 1 minute to 36 hours (with video)	95720 x 1 and 95718 x 1		95714 x 1 and 95711 x 1	95715 x 1 and 95712 x 1	95716 x 1 and 95713 x 1
36 hours and 1 minute to 50 hours (w/out video)	95719 x 2	95721 x 1	95708 x 2	95709 x 2	95710 x 2
36 hours and 1 minute to 50 hours (with video)	95720 x 2	95722 x 1	95714 x 2	95715 x 2	95716 x 2
50 hours and 1 minute to 60 hours (w/out video)	95719 x 2 and 95717 x 1	95721 x 1	95708 x 1 and 95705 x 1	95709 x 2 and 95706 x 1	95710 x 2 and 95707 x 1
50 hours and 1 minute to 60 hours (with video)	95720 x 2 and 95718 x 1	95722 x 1	95714 x 2 and 95711 x 1	95715 x 2 and 95712 x 1	95716 x 2 and 95713 x 1
60 hours and 1 minute to 74 hours (w/out video)	95719 x 3	95723 x 1	95708 x 3	95709 x 3	95710 x 3
60 hours and 1 minute to 74 hours (with video)	95720 x 3	95724 x 1	95714 x 3	95715 x 3	95716 x 3

CPT five-digit codes, two-digit modifiers, and descriptions only are copyright by the American Medical Association.

74 hours and 1 minute to 84 hours (w/out video)	95719 x 3 and 95717 x 1	95723 x 1	95708 x 3 and 95705 x 1	95709 x 3 and 95706 x 1	95710 x 3 and 95707 x 1
74 hours and 1 minute to 84 hours (with video)	95720 x 3 and 95718 x 1	95724 x 1	95714 x 3 and 95711 x 1	95715 x 3 and 95712 x 1	95716 x 3 and 95713 x 1
84 hours and 1 minute to 98 hours (w/out video)	95719 x 4	95725 x 1	95708 x 4	95709 x 4	95710 x 4
84 hours and 1 minute to 98 hours (with video)	95720 x 4	95726 x 1	95714 x 4	95715 x 4	95716 x 4

D95950	-	Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours	XXX	N/A (2018 Work RVU = 1.51)
D95951	-	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	XXX	N/A (2018 Work RVU = 5.99)
Illustration Electroencephalographic (EEG) Monitoring and Video Recording 95951				
D95953	-	Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended <u>(95950, 95951, 95953 have been deleted. To report, see 95700-95726 and the Long-Term EEG Monitoring table)</u>	XXX	N/A (2018 Work RVU = 3.08)

95954	Pharmacological or physical activation requiring physician or other qualified health care professional attendance during EEG recording of activation phase (eg, thiopental activation test)			
95955	Electroencephalogram (EEG) during nonintracranial surgery (eg, carotid surgery)			
D 95956	-	Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours, attended by a technologist or nurse (95956 has been deleted. To report, see 95700-95726 and the Long-Term EEG Monitoring table)	XXX	N/A (2018 Work RVU = 3.61)
95957	Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis) (Do not report 95957 for use of automated software. For use of automated spike and seizure detection and trending software when performed with long-term EEG, see 95700-95726)			
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)			
95966	for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)			
+95967	for evoked magnetic fields, each additional modality (eg, sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure) (Use 95967 in conjunction with 95966) (For electroencephalography performed in addition to magnetoencephalography, see 95812-95824-95827)			
<u>Long-Term EEG Set-up</u>				
●95700	M3	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 (95700 should be reported once per recording period) (For electroencephalogram [EEG] using patient-placed electrode sets, use 95999) (For set-up performed by non-EEG technologist or remotely supervised by an EEG technologist, use 95999)	XXX	0.00 (PE Only)

<u>Monitoring</u>				
●95705	M4	Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored	XXX	0.00 (PE Only)
●95706	M5	with intermittent monitoring and maintenance	XXX	0.00 (PE Only)
●95707	M6	with continuous, real-time monitoring and maintenance	XXX	0.00 (PE Only)
●95708	M7	Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	XXX	0.00 (PE Only)
●95709	M8	with intermittent monitoring and maintenance	XXX	0.00 (PE Only)
●95710	M9	with continuous, real-time monitoring and maintenance	XXX	0.00 (PE Only)
●95711	M10	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored	XXX	0.00 (PE Only)
●95712	M11	with intermittent monitoring, and maintenance	XXX	0.00 (PE Only)
●95713	M12	with continuous, real-time monitoring and maintenance	XXX	0.00 (PE Only)

●95714	M13	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	XXX	0.00 (PE Only)
●95715	M14	with intermittent monitoring and maintenance	XXX	0.00 (PE Only)
●95716	M15	with continuous, real-time monitoring and maintenance <u>(95705, 95706, 95707, 95711, 95712, 95713 may be reported a maximum of once for an entire longer-term EEG service to capture either the entire time of service or the final 2-12 hour increment of a service extending beyond 26 hours)</u>	XXX	0.00 (PE Only)
●95717	M16	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	XXX	2.00
●95718	M17	with video (VEEG) (For recording greater than 12 hours, see 95719, 95720, 95721, 95722, 95723, 95724, 95725, 95726) (95717, 95718 may be reported a maximum of once for the an entire long-term EEG service to capture either the entire time of service or the or final 2-12 hour increment of a service extending beyond 24 hours)	XXX	2.50
●95719	M18	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	XXX	3.00

●95720	M19	<p>with video (VEEG)</p> <p>(95719, 95720 may be reported only once for a recording period greater than 12 hours up to 26 hours. For multiple-day studies, 95719, 95720 may be reported after each 24-hour period during the extended recording period. 95719, 95720 include a single report and may include multiple reports completed within a 26-hour recording period, when performed)</p> <p>(95717, 95718 may be reported with 95719, 95720 for studies lasting greater than 26 hours, up to 36 hours)</p> <p>(Do not report 95717, 95718, 95719, 95720 for professional interpretation of long-term EEG studies when the recording is greater than 36 hours and the entire professional report is retroactively generated, even if separate daily reports are rendered after the completion of recording)</p> <p>(When the entire study includes recording greater than 36 hours, and the professional interpretation is performed after the entire recording is completed, see 95721, 95722, 95723, 95724, 95725, 95726)</p>	XXX	3.86
●95721	M20	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	XXX	3.86
●95722	M21	greater than 36 hours, up to 60 hours of EEG recording, with video (VEEG)	XXX	4.70
●95723	M22	greater than 60 hours, up to 84 hours of EEG recording, without video	XXX	4.75
●95724	M23	greater than 60 hours, up to 84 hours of EEG recording, with video (VEEG)	XXX	6.00

●95725	M24	greater than 84 hours of EEG recording, without video	XXX	5.40
●95726	M25	<p>greater than 84 hours of EEG recording, with video (VEEG)</p> <p>(When the entire study includes recording greater than 24 hours, and the professional interpretation is performed after the entire recording is completed, report 95721, 95722, 95723, 95724, 95725, 95726)</p> <p>(Do not report 95721, 95722, 95723, 95724, 95725, 95726 in conjunction with 95717, 95718, 95719, 95720)</p>	XXX	7.58

Table of Key Code Elements – Practice Expense

Handout A

9-25-2018

Long-Term EEG (LTEEG) Technical Services		Key Elements Table		
Duration of LTEEG	EEG/VEEG Recording Type	95700 (1) Set Up Code billed – <i>Set Up Includes Take Down</i>		
		Unmonitored Or 13+ patients monitored	Intermittent Up to 12 pts monitored	Continuous Up to 4 pts monitored
2 to 12 hours recording <i>Typical service is 8 hours</i>	EEG alone	95705	95706	95707
	EEG w/ VIDEO	95708	95709	95710
12 to 26 hours recording <i>Typical service is 24 hours</i>	EEG alone	95711	95712	95713
	EEG w/ VIDEO	95714	95715	95716

Table of Key Elements for RUC – 9-25-2018

Long-Term EEG (LTEEG) Professional Services					
Duration of LTEEG Professional Service	2 to 12 hours recording <i>Typical 8 hours</i>	12 to 26 hours recording <i>Typical 24 hours</i>	36 to 60 hours recording <i>Typical 2 Days</i>	60 to 84 hours recording <i>Typical 3 Days</i>	Greater than 84 hours recording <i>Typical 4 Days</i>
Recording Type	Reports are Generated Daily (physician access to data throughout recording)		Entire LTEEG Report is Retroactively Generated (physician access to data at end of recording)		
EEG alone	95X14	95X16*	95X18	95X20	95X22
EEG w/ VIDEO	95X15	95X17*	95X19	95X21	95X23

*95X16 and 95X17 are reported for each 24-hour recording period. Additional units are reported for each 24-hour period

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 95717 Tracking Number M16

Original Specialty Recommended RVU: **2.00**Presented Recommended RVU: **2.00**

Global Period: XXX Current Work RVU:

RUC Recommended RVU: **2.00**

CPT Descriptor: 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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 8-year-old male with a history of absence seizures reports seizure freedom for the past year. A 24-hour EEG without video is ordered to confirm seizure freedom and assist physician to determine if medications can be reduced or withdrawn. The patient removes the electrode wires after 10 hours.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews indication for continuous EEG recording and results of prior EEGs if available, communicates with referring physician to clarify the reason for referral and EEG technologist to determine the appropriate activation techniques (hyperventilation, photic stimulation).

Description of Intra-Service Work: The physician or other qualified health care professional reviews patient log of previous seizures, EEG technologist log that includes clinical history, medication history, brain imaging findings if applicable, patient alertness and orientation during awake state and other EEG technologist notes/observations. In addition, seizure detection software is reviewed to identify time of possible seizures or events. The EEG recording is reviewed for artifacts, background activity, normal variants, sleep stages, interictal epileptiform abnormalities and/or ictal patterns suggestive of clinical or subclinical seizures. The field potential of each type of epileptiform activity is analyzed to determine localization. For each seizure or event, acquired EEG data is reviewed and the EEG recording before, during, and after the event is annotated, describing EEG findings for each recorded event. ECG is reviewed and interpretation is made. Relevant sections of EEG are annotated to be archived by EEG technologists. A report is prepared that contains interpretation of EEG background activity, interictal/ ictal abnormalities, localization of the seizures or events, and clinical correlation of findings.

Description of Post-Service Work: EEG report is finalized and uploaded into the EMR, EEG findings are discussed with patient's family and communicated to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Marianna V. Spanaki, MD, PhD; Marc Nuwer, MD, PhD				
Specialty Society(ies):	American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS)				
CPT Code:	95717				
Sample Size:	2239	Resp N:	133	Response: 5.9 %	
Description of Sample:	AAN: a sample of members from the Epilepsy and Clinical Neurophysiology Sections (current US members); ACNS: a sample of current US members; National Association of Epilepsy Centers (NAEC): a sample of current US members				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	20.00	50.00	373.00
Survey RVW:	1.05	2.00	2.50	3.20	8.00
Pre-Service Evaluation Time:			8.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	0.00	20.00	28.00	37.00	300.00
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	95717	Recommended Physician Work RVU: 2.00		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	8.00	0.00	8.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	28.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	10.00	0.00	10.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95811	XXX	2.60	RUC Time

CPT Descriptor Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95957	XXX	1.98	RUC Time

CPT Descriptor Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95805	XXX	1.20	RUC Time	3,624

CPT Descriptor 1 Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99204	XXX	2.43	RUC Time	10,292,014

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 20 % of respondents: 15.0 %

Number of respondents who choose 2nd Key Reference Code: 18 % of respondents: 13.5 %

TIME ESTIMATES (Median)

	CPT Code: <u>95717</u>	Top Key Reference CPT Code: <u>95811</u>	2nd Key Reference CPT Code: <u>95957</u>
Median Pre-Service Time	8.00	15.00	15.00
Median Intra-Service Time	28.00	35.00	30.00
Median Immediate Post-service Time	10.00	15.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	46.00	65.00	55.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	5%	65%	30%	0%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
10%	55%	35%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	5%	55%	40%
Physical effort required	10%	80%	10%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	5%	40%	55%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	42%	37%	21%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	0%	37%	63%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	5%	37%	58%
Physical effort required	11%	63%	26%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	0%	53%	47%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2016, 95951 was identified under the CMS High Volume screen, as services with total Medicare utilization of 10,000 or more that has increased by at least 100% from 2009 through 2014. As a result, the specialty societies (AAN, ACNS, NAEC) presented an Action Plan to the RAW at the January 2017 *recommending that 95951 and the family of long term monitoring codes (95950, 95951, 95953, 95956) 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.* The medical specialties societies assert the 95951 utilization increase was partially due to incorrect coding, as the existing CPT code language for the long term monitoring family of codes is unclear (as it relates to the use of video and attended vs. unattended requirements.) The specialty societies also acknowledge that since the last review of 95951 was in August 1995 the family of codes should be revised to more accurately capture the services provided.

The specialty societies presented code change applications at the following CPT meetings: June 2017, September 2017, February 2018, and May 2018 when the Panel accepted the addition of 13 new codes for reporting the Technical Component of long-term EEG services (95700 – 95716) and 10 new codes for reporting the Professional Component of long-term EEG services (95717 – 95726.)

The physician services fall into 2 categories:

- 1.) Services where 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 such as 2-12 or 12 to 24 hours. These services are reported with 95717 – 95720.
- 2.) Services where the physician does not have access to EEG and video (when recorded) data during the recording period and the review and analysis occurs at the conclusion of the multiple day study. These services are reported with 95X18 – 95726.

Survey Sample and Process

A survey of physicians from the membership rosters of the American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), and the National Association of Epilepsy Centers (NAEC) was conducted (2239 total members). There were 133 respondents for 95717, 81% of whom found the vignette to be typical and who performed a median of 20 services in the last year. An expert consensus panel (“panel”) composed of members of the participating societies familiar with the code in question and the RUC process reviewed the results. The panel confirmed the reliability of the survey.

Rationale for 95717:

The expert panel reviewed the entire new code family (95717 – 95726) of physician work services and kept the rank order of the family in mind when developing their recommendations. Factors that were taken into consideration were the inclusion or exclusion of video with the EEG recording, the typical vignette for each service, duration of the recording, and timing of report generation by the physician. The length of recording is based on a number of factors including the clinical indication for the test and the frequency of seizures. The expert panel believes that the 25th percentile work RVU and median physician time are an accurate representation of the intra service time and physician work associated with 95717.

Codes 95717 – 95720 involve physician review, with daily report generation even if the entire study extends over multiple days. 95717 is reported for a 2-12-hour EEG recoding *without* video. The 25th percentile RVU of 2.00 puts 95717 in the appropriate rank order within the code family as the panel is recommending 3.00 for 95X16, which is the physician service (and daily report generation) for a 24-hour recording without video. The 25th percentile is further supported given its relation to 95720 (recommended RVU of 4.50), the physician service for a 24-hour recoding *with* video, with daily report generation. The difference in patient vignette also supports the rank order of the family of codes.

Pre-service time: The expert panel agrees that the pre-service activities are consistent regardless of the duration of the long-term EEG recording period and the pre-service time should be the same for each code in the family 95717 – 95726. Upon reviewing the time survey data, the panel agrees the survey pre-service median time of 10 minute is an accurate reflection of those activities which includes review or prior EEG results and relevant patient notes to understand reason for EEG referral to identify the appropriate activation techniques. We are therefore recommending an increase from 8 minutes (survey median) to 10 minutes for the pre-service time to be consistent across the family.

Post service time: Similarly, the post service activities are consistent regardless of the duration of the long-term EEG recording period and the post-service time should be the same for each code in the family. The expert panel asserts the survey post-service median time of 10 minutes is an accurate reflection of those activities.

The panel further compared the survey 25th percentile wRVU and median times to the key reference services and other comparison codes to support the recommendations:

Key Reference Codes

15% of respondents chose 95811, wRVU of 2.60 and times of 15/35/15/65

14% of respondents chose 95957, wRVU of 1.98 and times 15/30/10/55

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
95717	EEG, physician interpretation and report after each 2-12-hour period; without video	2.00	0.055	60	10	28	10
95811	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist	2.60	0.0551	65	15	35	15
95957	Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)	1.98	0.0957	55	15	30	10

MPC Comparison

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
95805	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness	1.20	0.0264	50	15	20	15
95717	EEG, physician interpretation and report after each 2-12-hour period; without video	2.00	0.055	48	10	28	10
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	2.43	0.0698	45	5	30	10

Other Comparison Codes

The table below provides other comparison codes as support.

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
95812	Electroencephalogram (EEG) extended monitoring; 41-60 minutes	1.08	0.0571	25	5	15	5
95957	Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)	1.98	0.0473	55	15	30	10
95717	EEG, physician interpretation and report after each 2-12-hour period; without video	2.00	0.055	48	10	28	10

95812: Electroencephalogram (EEG) extended monitoring; 41-60 minutes. 95812 has a work RVU of 1.08 and work times of 5/15/5/25. 95812 is reported for a routine outpatient EEG with a short duration of testing (between 41 and 60 minutes) and was reviewed by the RUC in January 2016. The survey 25th percentile RVU of 2.00 and survey median time of 28 minutes places 95717 in proper rank order with the comparison code as the work involved in reviewing the

24-hour EEG recording is much greater than that of a 41-60-minute recording (also supported by the consistent ratio of both time and RVU between 95717 and the comparison code.)

95957: Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis). 95957 has a work RVU of 1.98 and work times of 15/30/10/55. 95957 is reported in addition to a long-term EEG monitoring code to capture the additional work associated with detailed analysis of spikes detected on the EEG recording. The code was reviewed by the RUC in January 2016. The survey 25th percentile RVU of 2.00 and survey median time of 28 minutes puts places 95717 in proper rank order when comparing the amount of data involved in the review of the 2-12-hour EEG recording and the sub-set of data reviewed with 95957.

Recommendations:

For 95717 the expert panel recommends a work RVU of 2.00; and a total time of 48 minutes (10 minutes pre /28 minutes intra /10 minutes post).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95956-52, 95953-52

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 6369

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the national utilization will be 3 times that of the Medicare utilization.

Specialty Neurology Frequency 6369 Percentage 100.00 %

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,123
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the specialty utilization based upon existing specialty break out in the RUC database.

Specialty Neurology	Frequency 2123	Percentage 100.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Tests

BETOS Sub-classification:

Other tests

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95953

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 95718 Tracking Number M17

Original Specialty Recommended RVU: **3.00**Presented Recommended RVU: **2.50**

Global Period: XXX Current Work RVU:

RUC Recommended RVU: **2.50**

CPT Descriptor: 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)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 8-year-old male with a history of absence seizures reports seizure freedom for the past year. A 24-hour video EEG video is ordered to confirm seizure freedom and assist physician to determine if medications can be reduced or withdrawn. The study is concluded after 10 hours after sufficient data has been recorded.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews indication for continuous EEG recording and results of prior EEGs if available, communicates with referring physician to clarify the reason for referral and EEG technologist to determine the appropriate activation techniques (hyperventilation, photic stimulation).

Description of Intra-Service Work: The physician or other qualified health care professional reviews patient log of previous seizures, EEG technologist log that includes clinical history, medication history, brain imaging findings if applicable, patient alertness and orientation during awake state and other EEG technologist notes/observations. In addition, seizure detection software is reviewed to identify time of possible seizures or events. The EEG recording is reviewed for artifacts, background activity, normal variants, sleep stages, interictal epileptiform abnormalities and/or ictal patterns suggestive of clinical or subclinical seizures. The field potential of each type of epileptiform activity is analyzed to determine localization. For each seizure or event, acquired EEG and Video data is reviewed and the EEG recording and Video before, during, and after the event is annotated, describing EEG/Video findings for each recorded event. ECG is reviewed and interpretation is made. Relevant sections of EEG along with Video are annotated to be archived by EEG technologists. A report is prepared that contains interpretation of pertinent Video findings along with EEG background activity, interictal/ ictal abnormalities, localization of the seizures or events, and clinical correlation of findings.

Description of Post-Service Work: EEG report is finalized and uploaded into the EMR, Video-EEG findings are discussed with patient's family and with the referring physician in order to further determine the length of stay and/or medication adjustment/withdrawal.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Marianna V. Spanaki, MD, PhD; Marc Nuwer, MD, PhD				
Specialty Society(ies):	American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS)				
CPT Code:	95718				
Sample Size:	2239	Resp N:	149	Response: 6.6 %	
Description of Sample:	AAN: a sample of members from the Epilepsy and Clinical Neurophysiology Sections (current US members); ACNS: a sample of current US members; National Association of Epilepsy Centers (NAEC): a sample of current US members.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	50.00	110.00	415.00
Survey RVW:	0.97	2.50	3.00	4.00	8.50
Pre-Service Evaluation Time:			10.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	0.00	25.00	35.00	50.00	300.00
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	95718	Recommended Physician Work RVU: 2.50		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	10.00	0.00	10.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	35.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	10.00	0.00	10.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99205	XXX	3.17	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99223	XXX	3.86	RUC Time

CPT Descriptor Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99204	XXX	2.43	RUC Time	10,292,014

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99223	XXX	3.86	RUC Time	10,830,157

CPT Descriptor 2 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95957	XXX	1.98	RUC Time

CPT Descriptor Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 27 % of respondents: 18.1 %

Number of respondents who choose 2nd Key Reference Code: 22 % of respondents: 14.7 %

TIME ESTIMATES (Median)

	CPT Code: 95718	Top Key Reference CPT Code: 99205	2nd Key Reference CPT Code: 99223
Median Pre-Service Time	10.00	7.00	15.00
Median Intra-Service Time	35.00	45.00	55.00
Median Immediate Post-service Time	10.00	15.00	20.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	55.00	67.00	90.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	4%	33%	41%	22%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

15%

44%

41%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

0%

7%

93%

Physical effort required

33%

48%

19%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

26%

33%

41%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

14%

36%

36%

14%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

14%

54%

32%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

0%

18%

82%

Physical effort required

46%

27%

27%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

14%

54%

32%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

In October 2016, 95951 was identified under the CMS High Volume screen, as services with total Medicare utilization of 10,000 or more that has increased by at least 100% from 2009 through 2014. As a result, the specialty societies (AAN, ACNS, NAEC) presented an Action Plan to the RAW at the January 2017 recommending that 95951 and the family of long term monitoring codes (95950, 95951, 95953, 95956) 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. The medical specialties societies assert the 95951 utilization increase was partially due to incorrect coding, as the existing CPT code language for the long term monitoring family of codes is unclear (as it relates to the use of video and attended vs. unattended requirements.) The specialty societies also acknowledge that since the last review of 95951 was in August 1995 the family of codes should be revised to more accurately capture the services provided.

The specialty societies presented code change applications at the following CPT meetings: June 2017, September 2017, February 2018, and May 2018 when the Panel accepted the addition of 13 new codes for reporting the Technical Component of long-term EEG services (95700 – 95716) and 10 new codes for reporting the Professional Component of long-term EEG services (95717 – 95726.)

The physician services fall into 2 categories:

- 1.) Services where 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 such as 2-12 or 12 to 24 hours. These services are reported with 95717 – 95720.
- 2.) Services where the physician does not have access to EEG and video (when recorded) data during the recording period and the review and analysis occurs at the conclusion of the multiple day study. These services are reported with 95721 – 95726.

Survey Sample and Process

A survey of physicians from the membership rosters of the American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), and the National Association of Epilepsy Centers (NAEC) was conducted (2239 total members). There were 149 respondents for 95718, 79% of whom found the vignette to be typical and who performed a median of 50 services in the last year. An expert consensus panel (“panel”) composed of members of the participating societies familiar with the code in question and the RUC process reviewed the results. The panel confirmed the reliability of the survey.

Rationale for 95718:

The expert panel reviewed the entire new code family (95717 – 95726) of physician work services and kept the rank order of the family in mind when developing their recommendations. Factors that were taken into consideration were the inclusion or exclusion of video with the EEG recording, the typical vignette for each service, duration of the recording, and timing of report generation by the physician. The length of recording is based on a number of factors including the clinical indication for the test and the frequency of seizures. The expert panel believes that the median percentile work RVU and median physician time are an accurate representation of the intra service time and physician work associated with 95718.

Codes 95717 – 95720 involve physician review, with daily report generation even if the entire study extends over multiple days. 95718 is reported for a 2-12-hour EEG recording *with* video. The panel asserts that the 25th percentile RVU of 2.50 would create a rank order anomaly and instead is recommending the survey median of 3.00. The analysis of video time synced with the EEG recording requires additional work that is more accurately reflected in the IWP/UT with the median RVU. The median percentile is further supported when comparing it to 95719 (the physician service (and daily report generation) for a 24-hour recording without video, which we are also recommending 3.00 for. The expert panel asserts that a similar RVU for 95718 and 95719 is appropriate when considering the time and intensity of the two services in relation to each other.

Pre-service time: The expert panel agrees that the pre-service activities are consistent regardless of the duration of the long-term EEG recording period and the pre-service time should be the same for each code in the family 95717 – 95726. Upon reviewing the time survey data, the panel agrees the survey pre-service median time of 10 minute is an accurate reflection of those activities.

Post service time: Similarly, the post service activities are consistent regardless of the duration of the long-term EEG recording period and the post-service time should be the same for each code in the family. The expert panel asserts the survey post-service median time of 10 minutes is an accurate reflection of those activities.

The panel further compared the survey median percentile wRVU and median times to the key reference services and other comparison codes to support the recommendations:

Key Reference Codes

18% of respondents chose 99205, wRVU of 3.17 and times of 7/45/15/67

15% of respondents chose 99223, wRVU of 3.86 and times of 15/55/20/90

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
95718	EEG, physician interpretation and report after each 2-12-hour period; with video	3.00	0.073	55	10	35	10
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	3.17	0.0595	67	7	45	15
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	3.86	0.0559	90	15	55	20

MPC Comparison

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	2.43	0.0698	45	5	30	10
95718	EEG, physician interpretation and report after each 2-12-hour period; with video	3.00	0.073	55	10	35	10

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	3.86	0.0559	90	15	55	20

Other Comparison Codes

The table below provides other comparison codes as support.

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
95812	Electroencephalogram (EEG) extended monitoring; 41-60 minutes	1.08	0.0571	25	5	15	5
95957	Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)	1.98	0.0473	55	15	30	10
95718	EEG, physician interpretation and report after each 2-12-hour period; with video	3.00	0.073	55	10	35	10

95812: Electroencephalogram (EEG) extended monitoring; 41-60 minutes. 95812 has a work RVU of 1.08 and work times of 5/15/5/25. 95812 is reported for a routine outpatient EEG with a short duration of testing (between 41 and 60 minutes) and was reviewed by the RUC in January 2016. The survey 25th percentile RVU of 3.00 and survey median time of 40 minutes places 95719 in proper rank order with the comparison code as the work involved in reviewing the 24-hour EEG recording is much greater than that of a 41-61-minute recording (also supported by the consistent ratio of both time and RVU between 95719 and the comparison code.)

95957: Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis). 95957 has a work RVU of 1.98 and work times of 15/30/10/55. 95957 is reported in addition to a long-term EEG monitoring code to capture the additional work associated with detailed analysis of spikes detected on the EEG recording. The code was reviewed by the RUC in January 2016. The survey 25th percentile RVU and survey median time of 40 minutes puts places 95719 in proper rank order with the comparison code as the amount of data involved in the review of the 24-hour EEG recording is greater than that identified for additional spike detection (sub-set of data.)

Recommendations:

For 95718 the expert panel recommends a work RVU of 3.00; and a total time of 55 minutes (10 minutes pre /35 minutes intra /10 minutes post).

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.

- ☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95951-52

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 72747

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the national utilization will be 3 times that of the Medicare utilization.

Specialty Neurology Frequency 72747 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

24,249 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the specialty utilization based upon existing specialty break out in the RUC database.

Specialty Neurology Frequency 24249 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Tests

BETOS Sub-classification:

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95953

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 95719 Tracking Number M18

Original Specialty Recommended RVU: **3.00**Presented Recommended RVU: **3.00**

Global Period: XXX Current Work RVU:

RUC Recommended RVU: **3.00**

CPT Descriptor: 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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A critically ill 56-year-old female with intracerebral hemorrhage has fluctuating mental status, with periods of unresponsiveness several times per day. A 24-hour EEG without video is ordered to determine if these episodes are epileptic seizures.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews indication for continuous EEG recording and results of prior EEGs if available, communicates with referring physician to clarify the reason for referral and EEG technologist to determine the appropriate activation techniques (photoc stimulation).

Description of Intra-Service Work: The physician or other qualified health care professional reviews EEG technologist log that includes clinical history, medication history including sedatives, brain imaging findings, patient alertness and orientation during awake state and other EEG technologist notes/observations. In addition, seizure detection software is reviewed to identify time of possible seizures or events. The EEG recording is reviewed for artifacts, background activity, normal variants, sleep stages, interictal epileptiform abnormalities and/or ictal patterns suggestive of clinical or subclinical seizures. The field potential of each type of epileptiform activity is analyzed to determine localization. For each seizure or event, acquired EEG is reviewed and the EEG recording before, during, and after the event is annotated, describing EEG findings for each recorded event. ECG is reviewed and interpretation is made. Relevant sections of EEG are annotated to be archived by EEG technologists. Each 24 hours the physician or QHP prepares a report that contains interpretation of EEG background activity, interictal/ ictal abnormalities, localization of the seizures or events, and clinical correlation of findings.

Description of Post-Service Work: EEG report is finalized and uploaded into the EMR, EEG findings are discussed with patient's family and communicated to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Marianna V. Spanaki, MD, PhD; Marc Nuwer, MD, PhD				
Specialty Society(ies):	American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS)				
CPT Code:	95719				
Sample Size:	2239	Resp N:	133	Response: 5.9 %	
Description of Sample:	AAN: a sample of members from the Epilepsy and Clinical Neurophysiology Sections (current US members); ACNS: a sample of current US members; National Association of Epilepsy Centers (NAEC): a sample of current US members.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	7.00	24.00	50.00	300.00
Survey RVW:	1.20	3.00	3.95	4.80	10.00
Pre-Service Evaluation Time:			10.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	0.00	30.00	40.00	60.00	450.00
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	95719	Recommended Physician Work RVU: 3.00		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	10.00	0.00	10.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	40.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	10.00	0.00	10.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99223	XXX	3.86	RUC Time

CPT Descriptor Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99291	XXX	4.50	RUC Time

CPT Descriptor Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99204	XXX	2.43	RUC Time	10,292,014

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99223	XXX	3.86	RUC Time	10,830,157

CPT Descriptor 2 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity.

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95957	XXX	1.98	RUC Time

CPT Descriptor Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 26 % of respondents: 19.5 %

Number of respondents who choose 2nd Key Reference Code: 25 % of respondents: 18.7 %

TIME ESTIMATES (Median)

	CPT Code: <u>95719</u>	Top Key Reference CPT Code: <u>99223</u>	2nd Key Reference CPT Code: <u>99291</u>
Median Pre-Service Time	10.00	15.00	15.00
Median Intra-Service Time	40.00	55.00	40.00
Median Immediate Post-service Time	10.00	29.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	60.00	99.00	70.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	42%	50%	8%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

19%

54%

27%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

0%

19%

81%

Physical effort required

46%

27%

27%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

15%

46%

38%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

4%

24%

24%

36%

12%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

24%

40%

36%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

20%

28%

52%

Physical effort required

32%

32%

36%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

32%

36%

32%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2016, 95951 was identified under the CMS High Volume screen, as services with total Medicare utilization of 10,000 or more that has increased by at least 100% from 2009 through 2014. As a result, the specialty societies (AAN, ACNS, NAEC) presented an Action Plan to the RAW at the January 2017 recommending that 95951 and the family of long term monitoring codes (95950, 95951, 95953, 95956) 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. The medical specialties societies assert the 95951 utilization increase was partially due to incorrect coding, as the existing CPT code language for the long term monitoring family of codes is unclear (as it relates to the use of video and attended vs. unattended requirements.) The specialty societies also acknowledge that since the last review of 95951 was in August 1995 the family of codes should be revised to more accurately capture the services provided.

The specialty societies presented code change applications at the following CPT meetings: June 2017, September 2017, February 2018, and May 2018 when the Panel accepted the addition of 13 new codes for reporting the Technical Component of long-term EEG services (95700 – 95716) and 10 new codes for reporting the Professional Component of long-term EEG services (95717 – 95726.)

The physician services fall into 2 categories:

- 1.) Services where 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 such as 2-12 or 12 to 24 hours. These services are reported with 95717 – 95720.
- 2.) Services where the physician does not have access to EEG and video (when recorded) data during the recording period and the review and analysis occurs at the conclusion of the multiple day study. These services are reported with 95721 – 95726.

Survey Sample and Process

A survey of physicians from the membership rosters of the American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), and the National Association of Epilepsy Centers (NAEC) was conducted (2239 total members). There were 133 respondents for 95719, 79% of whom found the vignette to be typical and who performed a median of 24 services in the last year. An expert consensus panel (“panel”) composed of members of the participating societies familiar with the code in question and the RUC process reviewed the results. The panel confirmed the reliability of the survey.

Rationale for 95719:

The expert panel reviewed the entire new code family (95717 – 95726) of physician work services and kept the rank order of the family in mind when developing their recommendations. Factors that were taken into consideration were the inclusion or exclusion of video with the EEG recording, the typical vignette for each service, duration of the recording, and timing of report generation by the physician. The length of recording is based on a number of factors including the clinical indication for the test and the frequency of seizures. The expert panel believes that the 25th percentile work RVU and median physician time are an accurate representation of the intra service time and physician work associated with 95719.

The code involves the physician review of a 24-hour EEG recoding *without* video, with daily report generation even if the entire study extends over multiple days. The 25th percentile RVU of 3.00 puts 95719 in the appropriate rank order within the code family as the panel is recommending 2.00 for 95717, which is the physician service for a 2-12 hour recording without video. The 25th percentile is further supported given its relation to 95720 (recommended RVU of 4.50), the physician service for a 24-hour recoding *with* video, with daily report generation.

Pre-service time: The expert panel agrees that the pre-service activities are consistent regardless of the duration of the long-term EEG recording period and the pre-service time should be the same for each code in the family 95717 –

95726. Upon reviewing the time survey data, the panel agrees the survey pre-service median time of 10 minute is an accurate reflection of those activities.

Post service time: Similarly, the post service activities are consistent regardless of the duration of the long term EEG recording period and the post-service time should be the same for each code in the family. The expert panel asserts the survey post-service median time of 10 minutes is an accurate reflection of those activities.

The panel further compared the survey 25th percentile wRVU and median times to the key reference services and other comparison codes to support the recommendations:

Key Reference Codes

20% of respondents chose 99223, wRVU 3.86 and times of 15/55/20/90

19% of respondents chose 99291, wRVU of 4.50 and times 15/40/15/70

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
95719	EEG, physician interpretation and report after each 24-hour period; without video	3.00	0.064	60	10	40	10
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	3.86	0.0559	90	15	55	20
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	4.50	0.0957	70	15	40	15

MPC Comparison

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	2.43	0.0698	45	5	30	10
95719	EEG, physician interpretation and report after each 24-hour period; without video	3.00	0.064	60	10	40	10
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	3.86	0.0559	90	15	55	20

Other Comparison Codes

The table below provides other comparison codes as support.

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
95812	Electroencephalogram (EEG) extended monitoring; 41-60 minutes	1.08	0.0571	25	5	15	5
95957	Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)	1.98	0.0473	55	15	30	10
95719	EEG, physician interpretation and report after each 24-hour period; without video	3.00	0.0640	60	10	40	10

95812: Electroencephalogram (EEG) extended monitoring; 41-60 minutes. 95812 has a work RVU of 1.08 and work times of 5/15/5/25. 95812 is reported for a routine outpatient EEG with a short duration of testing (between 41 and 60 minutes) and was reviewed by the RUC in January 2016. The survey 25th percentile RVU of 3.00 and survey median time of 40 minutes places 95719 in proper rank order with the comparison code as the work involved in reviewing the 24-hour EEG recording is much greater than that of a 41-61-minute recording (also supported by the consistent ratio of both time and RVU between 95719 and the comparison code.)

95957: Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis). 95957 has a work RVU of 1.98 and work times of 15/30/10/55. 95957 is reported in addition to a long-term EEG monitoring code to capture the additional work associated with detailed analysis of spikes detected on the EEG recording. The code was reviewed by the RUC in January 2016. The survey 25th percentile RVU and survey median time of 40 minutes puts places 95719 in proper rank order with the comparison code as the amount of data involved in the review of the 24-hour EEG recording is greater than that identified for additional spike detection (sub-set of data.)

Recommendations:

For 95719 the expert panel recommends a work RVU of 3.00; and a total time of 60 minutes (10 minutes pre /40 minutes intra /10 minutes post).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95950, 95953, 95956

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 13236

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the national utilization will be 3 times that of the Medicare utilization.

Specialty Neurology Frequency 13236 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,412

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the specialty utilization based upon existing specialty break out in the RUC database.

Specialty Neurology Frequency 4412 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Tests

BETOS Sub-classification:

Other tests

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95953

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 95720 Tracking Number M19

Original Specialty Recommended RVU: **4.50**Presented Recommended RVU: **4.50**

Global Period: XXX Current Work RVU:

RUC Recommended RVU: **3.86**

CPT Descriptor: 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)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old female with intractable epilepsy is admitted to the epilepsy monitoring unit for seizure characterization and pre-surgical evaluation. Anti-epileptic medications are withdrawn. Continuous video EEG recording is ordered to localize site of seizure onset.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews indication for continuous Video-EEG recording and results of prior EEGs if available, communicates with referring physician to clarify the indications for referral, and communicates with the EEG technologist to determine the appropriate routine activation techniques (photic stimulation, hyperventilation), the frequency at which they are performed (upon admission and/or daily) including and other activation techniques (sleep deprivation).

Description of Intra-Service Work: The physician or other qualified health care professional reviews patient log, EEG technologist log, EEG technologist technical description summary, nurses' notes and other medical team notes if appropriate. Seizure detection software is reviewed to identify possible seizures and/or spells. The EEG recording is reviewed for artifacts, background activity, sleep stages, and interictal epileptiform abnormalities. The field potential of each type of epileptiform activity is analyzed to determine localization. For each seizure or event, the video and EEG data is reviewed during the entire event to make correlations of changes in video and EEG to localize the site of seizure onset. Nursing or EEG technologist interaction with the patient during the seizure (nursing ictal and postictal assessment) is reviewed for language, motor and memory assessment, including vital signs. The recording before, during, and after each event, is annotated describing clinical and EEG findings and their relative timing. Clinical and EEG findings are correlated to determine localization of each seizure. Seizure features are compared to determine if seizures arise from multiple locations. Relevant sections of EEG and video are annotated to be archived by EEG technologists. Any electrode or recording issues, and any required modification to recording (eg, additional electrodes, or changes to seizure or spike detection parameters), are communicated to the EEG technologist when necessary. Each 24 hours the physician or QHP prepares a written report that contains interpretation of EEG background activity, interictal abnormalities, detailed description of electrographic seizure onset, evolution and offset in relation to detailed description of clinical manifestations based on Video data interpretation. Based on these data, localization of the seizures or events, and clinical correlation of findings are reported.

Description of Post-Service Work: EEG report is finalized and uploaded into the EMR. Video-EEG findings are discussed with the referring physician in order to further determine the length of stay and/or medication adjustment/withdrawal. A compilation of the video-EEG recording results from seizures recorded over days is compared to history, examination, imaging, and neuropsychological findings, and the compilation of these video-EEG results is used to write a report recommending to the neurosurgeon the specific region of cerebral cortex to resect as a treatment for medically intractable seizures.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Marianna V. Spanaki, MD, PhD; Marc Nuwer, MD, PhD				
Specialty Society(ies):	American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS)				
CPT Code:	95720				
Sample Size:	2239	Resp N:	152	Response: 6.7 %	
Description of Sample:	AAN: a sample of members from the Epilepsy and Clinical Neurophysiology Sections (current US members); ACNS: a sample of current US members; National Association of Epilepsy Centers (NAEC): a sample of current US members.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	50.00	100.00	200.00	1500.00
Survey RVW:	1.00	3.50	5.00	6.26	12.00
Pre-Service Evaluation Time:			10.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	12.00	40.00	55.00	75.00	450.00
Immediate Post Service-Time:	15.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	95720	Recommended Physician Work RVU: 3.86		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	10.00	0.00	10.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	55.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	10.00	0.00	10.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99476	XXX	6.75	RUC Time

CPT Descriptor Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99291	XXX	4.50	RUC Time

CPT Descriptor Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99223	XXX	3.86	RUC Time	10,830,157

CPT Descriptor 1 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99291	XXX	4.50	RUC Time	5,721,334

CPT Descriptor 2 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99184	XXX	4.50	RUC Time

CPT Descriptor Initiation of selective head or total body hypothermia in the critically ill neonate, includes appropriate patient selection by review of clinical, imaging and laboratory data, confirmation of esophageal temperature probe location, evaluation of amplitude EEG, supervision of controlled hypothermia, and assessment of patient tolerance of cooling.

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 33 % of respondents: 21.7 %

Number of respondents who choose 2nd Key Reference Code: 24 % of respondents: 15.7 %

TIME ESTIMATES (Median)

	CPT Code: 95720	Top Key Reference CPT Code: 99476	2nd Key Reference CPT Code: 99291
Median Pre-Service Time	10.00	20.00	15.00
Median Intra-Service Time	55.00	65.00	40.00
Median Immediate Post-service Time	10.00	20.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	75.00	105.00	70.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	3%	15%	55%	6%	21%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	24%	52%	24%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	6%	40%	54%
Physical effort required	46%	33%	21%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	27%	46%	27%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	17%	29%	33%	21%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	13%	50%	37%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	8%	25%	67%
Physical effort required	42%	29%	29%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	33%	33%	34%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUP analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2016, 95951 was identified under the CMS High Volume screen, as services with total Medicare utilization of 10,000 or more that has increased by at least 100% from 2009 through 2014. As a result, the specialty societies (AAN, ACNS, NAEC) presented an Action Plan to the RAW at the January 2017 *recommending that 95951 and the family of long term monitoring codes (95950, 95951, 95953, 95956) 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.* The medical specialties societies assert the 95951 utilization increase was partially due to incorrect coding, as the existing CPT code language for the long term monitoring family of codes is unclear (as it relates to the use of video and attended vs. unattended requirements.) The specialty societies also acknowledge that since the last review of 95951 was in August 1995 the family of codes should be revised to more accurately capture the services provided.

The specialty societies presented code change applications at the following CPT meetings: June 2017, September 2017, February 2018, and May 2018 when the Panel accepted the addition of 13 new codes for reporting the Technical Component of long-term EEG services (95700 – 95716) and 10 new codes for reporting the Professional Component of long-term EEG services (95717 – 95726.)

The physician services fall into 2 categories:

- 1.) Services where 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 such as 2-12 or 12 to 24 hours. These services are reported with 95717 – 95720.
- 2.) Services where the physician does not have access to EEG and video (when recorded) data during the recording period and the review and analysis occurs at the conclusion of the multiple day study. These services are reported with 95721 – 95726.

Survey Sample and Process

A survey of physicians from the membership rosters of the American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), and the National Association of Epilepsy Centers (NAEC) was conducted (2239 total members). There were 152 respondents for 95720, 88% of whom found the vignette to be typical and who performed a median of 100 services in the last year. An expert consensus panel (“panel”) composed of members of the participating societies familiar with the code in question and the RUC process reviewed the results. The panel confirmed the reliability of the survey.

Rationale for 95720:

The expert panel reviewed the entire new code family (95717 – 95726) of physician work services and kept the rank order of the family in mind when developing their recommendations. Factors that were taken into consideration were the inclusion or exclusion of video with the EEG recording, the typical vignette for each service, duration of the recording, and timing of report generation by the physician. The length of recording is based on a number of factors including the clinical indication for the test and the frequency of seizures. The expert panel believes that the median percentile work RVU and median physician time are an accurate representation of the intra service time and physician work associated with 95720.

Codes 95717 – 95720 involve physician review, with daily report generation even if the entire study extends over multiple days. 95720 is reported for a 24-hour EEG recording *with* video. The panel asserts that the 25th percentile RVU would create a rank order anomaly and instead is recommending a work RVU of 4.50 using a crosswalk code to support that recommendation. The 25th percentile RVU does not accurately reflect the work associated with reviewing the 24-hour recording (with video) given the acuity of the typical patient and the additional work involved when video is correlated with the EEG. The vignette for 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.) The simultaneous review of video (with the EEG recording) and increased frequency of events given the typical patient, further supports the RVU recommendation, and fits the rank order of the family. An RVU of 4.50 is supported by crosswalk code 99184 (work RVU of 4.50 and times of 30/60/20/110) given the nearly identical intra-service times and IWP/UTs of 95720 and comparison code 99184.

Pre-service time: The expert panel agrees that the pre-service activities are consistent regardless of the duration of the long-term EEG recording period and the pre-service time should be the same for each code in the family 95717 –

95726. Upon reviewing the time survey data, the panel agrees the survey pre-service median time of 10 minute is an accurate reflection of those activities.

Post service time: Similarly, the post service activities are consistent regardless of the duration of the long-term EEG recording period and the post-service time should be the same for each code in the family. The expert panel asserts the survey post-service median time of 10 minutes is an accurate reflection of those activities.

The panel further compared the recommended RVU of 4.50 and median times to the key reference services and other comparison codes to support the recommendations:

Key Reference Codes

22% of respondents chose 99476, wRVU of 6.75 and times of 20/65/20/105

16% of respondents chose 99291, wRVU of 4.50 and times of 15/40/15/70

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
95720	EEG, physician interpretation and report after each 24-hour period; with video	4.50	0.055	75	10	55	10
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	4.50	0.0957	70	15	40	15
99476	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	6.75	0.0901	105	20	65	20

MPC Comparison

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	3.86	0.0559	90	15	55	20
95720	EEG, physician interpretation and report after each 24-hour period; with video	4.50	0.055	75	10	55	10
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	4.50	0.0957	70	15	40	15

Other Comparison Codes

The table below provides other comparison codes as support.

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
95957	Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)	1.98	0.0473	55	15	30	10
95720	EEG, physician interpretation and report after each 24-hour period; with video	4.50	0.055	75	10	55	10

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
99184	Initiation of selective head or total body hypothermia in the critically ill neonate, includes appropriate patient selection by review of clinical, imaging and laboratory data, confirmation of esophageal temperature probe location, evaluation of amplitude EEG, supervision of controlled hypothermia, and assessment of patient tolerance of cooling	4.50	0.0563	110	30	60	20

95957: Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis). 95957 has a work RVU of 1.98 and work times of 15/30/10/55. 95957 is reported in addition to a long-term EEG monitoring code to capture the additional work associated with detailed analysis of spikes detected on the EEG recording during a pre-surgical evaluation. The code was reviewed by the RUC in January 2016. The recommended RVU of 4.50 survey median time of 55 minutes puts places 95720 in proper rank order with the comparison code and is supported by the consistent ratio of both time and RVU between 95720 and 95957.)

99184: Initiation of selective head or total body hypothermia in the critically ill neonate, includes appropriate patient selection by review of clinical, imaging and laboratory data, confirmation of esophageal temperature probe location, evaluation of amplitude EEG, supervision of controlled hypothermia, and assessment of patient tolerance of cooling. 99184 has a work RVU of 4.50 and times of 30/50/20/110. The code was reviewed by the RUC in January 2014. The panel asserts crosswalk code strongly 99184 supports the recommended RVU of 4.50 given the nearly identical intra-service times and IWPUTs of 95720 and 99184.

Recommendations:

For 95720 the expert panel recommends a work RVU of 4.50; and a total time of 75 minutes (10 minutes pre /55 minutes intra /10 minutes post).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95950, 95951

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 290985

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the national utilization will be 3 times that of the Medicare utilization.

Specialty Neurology Frequency 290985 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

96,995 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the specialty utilization based upon existing specialty break out in the RUC database.

Specialty Neurology Frequency 96995 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Tests

BETOS Sub-classification:

Other tests

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95953

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 95721 Tracking Number M20

Original Specialty Recommended RVU: **3.86**Presented Recommended RVU: **3.86**

Global Period: XXX Current Work RVU:

RUC Recommended RVU: **3.86**

CPT Descriptor: 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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 14-year-old male with a history of absence seizures experiences staring spells nearly daily. 48-hour EEG without video recordings is ordered to determine if the patients staring spells are seizures.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews indication for continuous EEG recording and results of prior EEGs if available, communicates with referring physician to clarify the indications for referral and EEG technologist to determine the appropriate activation techniques (photoc stimulation, hyperventilation).

Description of Intra-Service Work: The physician or other qualified health care professional reviews patient log, EEG technologist log, EEG technologist technical description summary, including medication history. Seizure detection software is reviewed to identify possible seizures and/or spells. The EEG recording is reviewed for artifacts, background activity, sleep stages and interictal epileptiform abnormalities. The field potential of each type of epileptiform activity is analyzed to determine localization. For each seizure or event EEG data is reviewed during the entire event to make correlations of changes and EEG to localize the site of seizure onset. The recording before, during, and after each event, is annotated describing EEG findings. Clinical and EEG findings are correlated to determine localization of each seizure. Seizure features are compared to determine if seizures arise from multiple locations. ECG is reviewed and interpretation is made. Relevant sections of EEG are annotated to be archived by EEG technologists. At the end of 48 hours of testing, the physician or QHP prepares a written report that contains interpretation of EEG background activity, interictal abnormalities, detailed description of electrographic seizure onset, evolution and offset and clinical correlation of findings for each 24 hours of recording.

Description of Post-Service Work: EEG report is finalized and uploaded into the EMR. EEG findings are discussed with the referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Marianna V. Spanaki, MD, PhD; Marc Nuwer, MD, PhD				
Specialty Society(ies):	American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS)				
CPT Code:	95721				
Sample Size:	2239	Resp N:	133	Response: 5.9 %	
Description of Sample:	AAN: a sample of members from the Epilepsy and Clinical Neurophysiology Sections (current US members); ACNS: a sample of current US members; National Association of Epilepsy Centers (NAEC): a sample of current US members.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	15.00	40.00	300.00
Survey RVW:	1.08	3.86	5.50	7.50	12.47
Pre-Service Evaluation Time:			10.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	0.00	45.00	65.00	90.00	480.00
Immediate Post Service-Time:	15.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	95721	Recommended Physician Work RVU: 3.86		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	10.00	0.00	10.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	65.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	10.00	0.00	10.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99291	XXX	4.50	RUC Time

CPT Descriptor Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99476	XXX	6.75	RUC Time

CPT Descriptor Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95810	XXX	2.50	RUC Time	299,765

CPT Descriptor 1 Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99223	XXX	3.86	RUC Time	10,830,157

CPT Descriptor 2 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 29 % of respondents: 21.8 %

Number of respondents who choose 2nd Key Reference Code: 24 % of respondents: 18.0 %

TIME ESTIMATES (Median)

	CPT Code: 95721	Top Key Reference CPT Code: 99291	2nd Key Reference CPT Code: 99476
Median Pre-Service Time	10.00	15.00	20.00
Median Intra-Service Time	65.00	40.00	65.00
Median Immediate Post-service Time	10.00	15.00	20.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	85.00	70.00	105.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	17%	42%	24%	17%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
28%	38%	34%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	7%	34%	59%
Physical effort required	41%	38%	21%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	48%	31%	21%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	4%	4%	38%	50%	4%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	29%	46%	25%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	13%	25%	62%
Physical effort required	33%	38%	29%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	25%	46%	29%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2016, 95951 was identified under the CMS High Volume screen, as services with total Medicare utilization of 10,000 or more that has increased by at least 100% from 2009 through 2014. As a result, the specialty societies (AAN, ACNS, NAEC) presented an Action Plan to the RAW at the January 2017 *recommending that 95951 and the family of long term monitoring codes (95950, 95951, 95953, 95956) 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.* The medical specialties societies assert the 95951 utilization increase was partially due to incorrect coding, as the existing CPT code language for the long term monitoring family of codes is unclear (as it relates to the use of video and attended vs. unattended requirements.) The specialty societies also acknowledge that since the last review of 95951 was in August 1995 the family of codes should be revised to more accurately capture the services provided.

The specialty societies presented code change applications at the following CPT meetings: June 2017, September 2017, February 2018, and May 2018 when the Panel accepted the addition of 13 new codes for reporting the Technical Component of long-term EEG services (95700 – 95716) and 10 new codes for reporting the Professional Component of long-term EEG services (95717 – 95726.)

The physician services fall into 2 categories:

- 1.) Services where 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 such as 2-12 or 12 to 24 hours. These services are reported with 95717 – 95720.
- 2.) Services where the physician does not have access to EEG and video (when recorded) data during the recording period and the review and analysis occurs at the conclusion of the multiple day study. These services are reported with 95721 – 95726.

Survey Sample and Process

A survey of physicians from the membership rosters of the American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), and the National Association of Epilepsy Centers (NAEC) was conducted (2239 total members). There were 133 respondents for 95721, 82% of whom found the vignette to be typical and who performed a median of 15 services in the last year. An expert consensus panel (“panel”) composed of members of the participating societies familiar with the code in question and the RUC process reviewed the results. The panel confirmed the reliability of the survey.

Rationale for 95721:

The expert panel reviewed the entire new code family (95717 – 95726) of physician work services and kept the rank order of the family in mind when developing their recommendations. Factors that were taken into consideration were the inclusion or exclusion of video with the EEG recording, the typical vignette for each service, duration of the recording, and timing of report generation by the physician. The length of recording is based on a number of factors including the clinical indication for the test and the frequency of seizures. The expert panel believes that the 25th percentile work RVU and median physician time are an accurate representation of the intra service time and physician work associated with 95721.

When reviewing the survey data for services with a single review and report generation at the conclusion of the recording period (95721 – 95726) the expert panel looked to 24-hour recoding with daily review codes (95719-without video and 95720-with video) to establish rank order. **The panel noted that the IWPUT from the 25% percentile RVU of 3.86 and median time of 65 minutes supports the assertion that the physician work of codes 95721 – 95726 (review and report generation at the conclusion of the study) is typically less intense than the work of codes 95717 – 95720 (daily review and report generation). The survey patient vignettes also support this assertion.**

95721 involves a *single physician review and report generation at the conclusion* of a 36-60-hour EEG recoding *without* video. The 25 percentile RVU of 3.86 puts 95721 in the appropriate rank order within the code family as the panel is recommending 3.00 for 95719, which is the physician service for a 24-hour recording without video. The 25th percentile is further supported when comparing to MPC code 99223 which has the same work RVU and nearly identical IWPUTs.

Pre-service time: The expert panel agrees that the pre-service activities are consistent regardless of the duration of the long-term EEG recording period and the pre-service time should be the same for each code in the family 95717 –

95726. Upon reviewing the time survey data, the panel agrees the survey pre-service median time of 10 minute is an accurate reflection of those activities.

Post service time: Similarly, the post service activities are consistent regardless of the duration of the long-term EEG recording period and the post-service time should be the same for each code in the family. The expert panel asserts the survey post-service median time of 15 minutes is not an accurate reflection of time required for those activities. We are therefore recommending a decrease from 15 minutes (survey median) to 10 minutes for the post-service time to be consistent across the family.

The panel further compared the survey 25th percentile wRVU, and median intra times to the key reference services and MPC codes to support the recommendations:

Key Reference Codes

21% of respondents chose 99291, wRVU of 4.50 and times 15/40/15/70

18% of respondents chose 99476, wRVU of 6.75 and times 20/65/10/105

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
95721	EEG, physician interpretation and report at conclusion of recording, 36-60 hours, without video	3.86	0.052	90	10	65	10
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	4.50	0.0957	70	15	40	15
99476	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	6.75	0.0901	105	20	65	20

MPC Comparison

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
95810	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	2.50	0.050	66.5	15	36.5	15
95721	EEG, physician interpretation and report at conclusion of recording, 36-60 hours, without video	3.86	0.052	90	10	65	10
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	3.86	0.0559	90	15	55	20

Recommendations:

For 95721 the expert panel recommends a work RVU of 3.86; and a total time of 85 minutes (10 minutes pre /65 minutes intra /10 minutes post).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95953

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 17889

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the national utilization will be 3 times that of the Medicare utilization.

Specialty Neurology Frequency 17889 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,963

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the specialty utilization based upon existing specialty break out in the RUC database.

Specialty Neurology Frequency 5963 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Tests

BETOS Sub-classification:

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95953

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 95722 Tracking Number M21

Original Specialty Recommended RVU: **4.70**Presented Recommended RVU: **4.70**

Global Period: XXX Current Work RVU:

RUC Recommended RVU: **4.70**

CPT Descriptor: 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)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old male with a history of focal epilepsy has episodes of amnesia nearly daily. 48-hour EEG with video recordings is ordered to determine if the patient's amnesic episodes are seizures and to determine the clinical manifestations of the seizures.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews indication for continuous Video-EEG recording and results of prior EEGs if available, communicates with referring physician to clarify the indications for referral and EEG technologist to determine the appropriate activation techniques (photic stimulation, hyperventilation).

Description of Intra-Service Work: The physician or other qualified health care professional reviews patient log, EEG technologist log, EEG technologist technical description summary, including medication history. Seizure detection software is reviewed to identify possible seizures and/or spells. The EEG recording is reviewed for artifacts, background activity, sleep stages and interictal epileptiform abnormalities. The field potential of each type of epileptiform activity is analyzed to determine localization. For each seizure or event Video and EEG data is reviewed during the entire event to make correlations of changes and EEG to localize the site of seizure onset. The recording before, during, and after each event, is annotated describing EEG findings. Clinical and EEG findings are correlated to determine localization of each seizure. Seizure features are compared to determine if seizures arise from multiple locations. Relevant sections of EEG and Video are annotated to be archived by EEG technologists. At the end of the 48 hours of testing the physician or QHP prepares a written report that contains interpretation of pertinent Video findings along with EEG background activity, interictal abnormalities, detailed description of electrographic seizure onset, evolution and offset and clinical correlation of findings for each 24 hours of recording.

Description of Post-Service Work: EEG report is finalized and uploaded into the EMR. Video EEG findings are discussed with the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Marianna V. Spanaki, MD, PhD; Marc Nuwer, MD, PhD				
Specialty Society(ies):	American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS)				
CPT Code:	95722				
Sample Size:	2239	Resp N:	145	Response: 6.4 %	
Description of Sample:	AAN: a sample of members from the Epilepsy and Clinical Neurophysiology Sections (current US members); ACNS: a sample of current US members; National Association of Epilepsy Centers (NAEC): a sample of current US members.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	14.00	50.00	100.00	400.00
Survey RVW:	1.08	4.70	7.15	10.00	18.24
Pre-Service Evaluation Time:			12.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	0.00	60.00	80.00	120.00	480.00
Immediate Post Service-Time:	15.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	95722	Recommended Physician Work RVU: 4.70		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	10.00	0.00	10.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	80.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	10.00	0.00	10.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95965	XXX	7.99	RUC Time

CPT Descriptor Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99291	XXX	4.50	RUC Time

CPT Descriptor Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99223	XXX	3.86	RUC Time	10,830,157

CPT Descriptor 1 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99291	XXX	4.50	RUC Time	5,721,334

CPT Descriptor 2 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 51 % of respondents: 35.1 %

Number of respondents who choose 2nd Key Reference Code: 28 % of respondents: 19.3 %

TIME ESTIMATES (Median)

	CPT Code: <u>95722</u>	Top Key Reference CPT Code: <u>95965</u>	2nd Key Reference CPT Code: <u>99291</u>
Median Pre-Service Time	10.00	20.00	15.00
Median Intra-Service Time	80.00	180.00	40.00
Median Immediate Post-service Time	10.00	30.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	100.00	230.00	70.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	2%	23%	43%	32%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
2%	41%	57%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	8%	43%	49%
Physical effort required	6%	51%	43%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	0%	42%	58%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	7%	39%	32%	22%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	36%	25%	39%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	7%	22%	71%
Physical effort required	29%	32%	39%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	39%	36%	25%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2016, 95951 was identified under the CMS High Volume screen, as services with total Medicare utilization of 10,000 or more that has increased by at least 100% from 2009 through 2014. As a result, the specialty societies (AAN, ACNS, NAEC) presented an Action Plan to the RAW at the January 2017 *recommending that 95951 and the family of long term monitoring codes (95950, 95951, 95953, 95956) 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.* The medical specialties societies assert the 95951 utilization increase was partially due to incorrect coding, as the existing CPT code language for the long term monitoring family of codes is unclear (as it relates to the use of video and attended vs. unattended requirements.) The specialty societies also acknowledge that since the last review of 95951 was in August 1995 the family of codes should be revised to more accurately capture the services provided.

The specialty societies presented code change applications at the following CPT meetings: June 2017, September 2017, February 2018, and May 2018 when the Panel accepted the addition of 13 new codes for reporting the Technical Component of long-term EEG services (95700 – 95716) and 10 new codes for reporting the Professional Component of long-term EEG services (95717 – 95726.)

The physician services fall into 2 categories:

- 1.) Services where 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 such as 2-12 or 12 to 24 hours. These services are reported with 95717 – 95720.
- 2.) Services where the physician does not have access to EEG and video (when recorded) data during the recording period and the review and analysis occurs at the conclusion of the multiple day study. These services are reported with 95721 – 95726.

Survey Sample and Process

A survey of physicians from the membership rosters of the American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), and the National Association of Epilepsy Centers (NAEC) was conducted (2239 total members). There were 145 respondents for 95722, 93% of whom found the vignette to be typical and who performed a median of 50 services in the last year. An expert consensus panel (“panel”) composed of members of the participating societies familiar with the code in question and the RUC process reviewed the results. The panel confirmed the reliability of the survey.

Rationale for 95722

The expert panel reviewed the entire new code family (95717 – 95726) of physician work services and kept the rank order of the family in mind when developing their recommendations. Factors that were taken into consideration were the inclusion or exclusion of video with the EEG recording, the typical vignette for each service, duration of the recording, and timing of report generation by the physician. The length of recording is based on a number of factors including the clinical indication for the test and the frequency of seizures. The expert panel believes that the 25th percentile work RVU and median physician time are an accurate representation of the intra service time and physician work associated with 95722.

When reviewing the survey data for services with a single review and report generation at the conclusion of the recording period (95721 – 95726) the expert panel looked to 24-hour recoding with daily review codes (95719-without video and 95720-with video) to establish rank order. **The panel noted that the IWPUR from the 25% percentile RVU of 4.70 and median time of 80 minutes supports the assertion that the physician work of codes 95721 – 95726 (review and report generation at the conclusion of the study) is typically less intense than the work of codes 95717 – 95720 (daily review and report generation). The survey patient vignettes also support this assertion.**

95722 involves a *single physician review and report generation at the conclusion* of 36-60-hour EEG recoding, *with* video. The 25 percentile RVU of 4.70 puts 95722 in the appropriate rank order within the code family as the panel is recommending 4.50 for 95720, which is the physician service for a 24-hour recording with video. The recommendation also maintains a consistent IWPUR for those codes with the physician review and report at the conclusion of the recording. The 25th percentile is further supported when comparing the intra service time and IWPUR of 95X22 to key reference service 99291 (also an MPC code) in relation to each other.

Pre-service time: The expert panel agrees that the pre-service activities are consistent regardless of the duration of the long-term EEG recording period and the pre-service time should be the same for each code in the family 95717 –

95726. Upon reviewing the time survey data, the panel agrees the survey pre-service median time of 12 minute is not an accurate reflection of those activities. We are therefore recommending a decrease from 12 minutes (survey median) to 10 minutes for the pre-service time to be consistent across the family.

Post service time: Similarly, the post service activities are consistent regardless of the duration of the long-term EEG recording period and the post-service time should be the same for each code in the family. The expert panel asserts the survey post-service median time of 15 minutes is not an accurate reflection of time required for those activities. We are therefore recommending a decrease from 15 minutes (survey median) to 10 minutes for the post-service time to be consistent across the family.

The panel further compared the survey 25th percentile wRVU and median intra times to the key reference services and MPC codes to support the recommendations:

Key Reference Codes

36% of respondents chose 95965, wRVU of 7.99 and times 20/180/30/230

19% of respondents chose 99291, wRVU of 4.50 and times 15/40/15/70

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	4.50	0.0957	70	15	40	15
95722	EEG, physician interpretation and report at conclusion of recording, 36-60 hours, with video	4.70	0.053	100	10	80	10
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)	7.99	0.0382	230	20	180	30

MPC Comparison

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	3.86	0.0559	90	15	55	20
95722	EEG, physician interpretation and report at conclusion of recording, 36-60 hours, with video	4.70	0.053	100	10	80	10
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	4.50	0.0957	70	15	40	15

Recommendations:

For 95722 the expert panel recommends a work RVU of 4.70; and a total time of 100 minutes (10 minutes pre /80 minutes intra /10 minutes post).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95951, 95953

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 27738

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the national utilization will be 3 times that of the Medicare utilization.

Specialty Neurology Frequency 27738 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 9,246

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the specialty utilization based upon existing specialty break out in the RUC database.

Specialty Neurology Frequency 9246 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Tests

BETOS Sub-classification:

Other tests

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95953

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 95723 Tracking Number M22

Original Specialty Recommended RVU: **4.75**Presented Recommended RVU: **4.75**

Global Period: XXX Current Work RVU:

RUC Recommended RVU: **4.75**

CPT Descriptor: 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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 14-year-old male with a history of absence seizures experiences staring spells 2-3 times per week. 72-hour EEG without video recordings is ordered to determine if the patients staring spells are seizures.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews indication for continuous EEG recording and results of prior EEGs if available, communicates with referring physician to clarify the indications for referral and EEG technologist to determine the appropriate activation techniques (photoc stimulation, hyperventilation).

Description of Intra-Service Work: The physician or other qualified health care professional reviews patient log, EEG technologist log, EEG technologist technical description summary, including medication history. Seizure detection software is reviewed to identify possible seizures and/or spells. The EEG recording is reviewed for artifacts, background activity, sleep stages and interictal epileptiform abnormalities. The field potential of each type of epileptiform activity is analyzed to determine localization. For each seizure or event the EEG data is reviewed during the entire event to make correlations of changes and EEG to localize the site of seizure onset. The recording before, during, and after each event, is annotated describing EEG findings. Clinical and EEG findings are correlated to determine localization of each seizure. Seizure features are compared to determine if seizures arise from multiple locations. ECG is reviewed and interpretation is made. Relevant sections of EEG are annotated to be archived by EEG technologists. At the end of 72 hours of testing, the physician or QHP prepares a written report that contains interpretation of EEG background activity, interictal abnormalities, detailed description of electrographic seizure onset, evolution and offset and clinical correlation of findings for each 24 hours of recording.

Description of Post-Service Work: EEG report is finalized and uploaded into the EMR. EEG findings are discussed with the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Marianna V. Spanaki, MD, PhD; Marc Nuwer, MD, PhD				
Specialty Society(ies):	American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS)				
CPT Code:	95723				
Sample Size:	2239	Resp N:	132	Response: 5.8 %	
Description of Sample:	AAN: a sample of members from the Epilepsy and Clinical Neurophysiology Sections (current US members); ACNS: a sample of current US members; National Association of Epilepsy Centers (NAEC): a sample of current US members.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	10.00	31.00	300.00
Survey RVW:	1.08	4.75	7.08	10.00	20.00
Pre-Service Evaluation Time:			12.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	0.00	60.00	90.00	121.00	726.00
Immediate Post Service-Time:	15.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	95723	Recommended Physician Work RVU: 4.75		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	10.00	0.00	10.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	90.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	10.00	0.00	10.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95965	XXX	7.99	RUC Time

CPT Descriptor Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99476	XXX	6.75	RUC Time

CPT Descriptor Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99291	XXX	4.50	RUC Time	5,721,334

CPT Descriptor 1 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36475	000	5.30	RUC Time	127,660

CPT Descriptor 2 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 39 % of respondents: 29.5 %

Number of respondents who choose 2nd Key Reference Code: 28 % of respondents: 21.2 %

TIME ESTIMATES (Median)

	CPT Code: 95723	Top Key Reference CPT Code: 95965	2nd Key Reference CPT Code: 99476
Median Pre-Service Time	10.00	20.00	20.00
Median Intra-Service Time	90.00	180.00	65.00
Median Immediate Post-service Time	10.00	30.00	20.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	110.00	230.00	105.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	8%	30%	25%	37%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
3%	70%	27%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	10%	40%	50%

Physical effort required	5%	43%	32%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

3%	37%	60%
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2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	11%	21%	50%	18%
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Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

25%	29%	46%
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Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	4%	32%	64%
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Physical effort required	29%	46%	25%
--------------------------	-----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

21%	43%	36%
-----	-----	-----

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2016, 95951 was identified under the CMS High Volume screen, as services with total Medicare utilization of 10,000 or more that has increased by at least 100% from 2009 through 2014. As a result, the specialty societies (AAN, ACNS, NAEC) presented an Action Plan to the RAW at the January 2017 recommending that 95951 and the

family of long term monitoring codes (95950, 95951, 95953, 95956) 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. The medical specialties societies assert the 95951 utilization increase was partially due to incorrect coding, as the existing CPT code language for the long term monitoring family of codes is unclear (as it relates to the use of video and attended vs. unattended requirements.) The specialty societies also acknowledge that since the last review of 95951 was in August 1995 the family of codes should be revised to more accurately capture the services provided.

The specialty societies presented code change applications at the following CPT meetings: June 2017, September 2017, February 2018, and May 2018 when the Panel accepted the addition of 13 new codes for reporting the Technical Component of long-term EEG services (95700 – 95716) and 10 new codes for reporting the Professional Component of long-term EEG services (95717 – 95726.)

The physician services fall into 2 categories:

- 1.) Services where 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 such as 2-12 or 12 to 24 hours. These services are reported with 95717 – 95720.
- 2.) Services where the physician does not have access to EEG and video (when recorded) data during the recording period and the review and analysis occurs at the conclusion of the multiple day study. These services are reported with 95721 – 95726.

Survey Sample and Process

A survey of physicians from the membership rosters of the American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), and the National Association of Epilepsy Centers (NAEC) was conducted (2239 total members). There were 132 respondents for 95723, 84% of whom found the vignette to be typical and who performed a median of 10 services in the last year. An expert consensus panel (“panel”) composed of members of the participating societies familiar with the code in question and the RUC process reviewed the results. The panel confirmed the reliability of the survey.

Rationale for 95723

The expert panel reviewed the entire new code family (95717 – 95726) of physician work services and kept the rank order of the family in mind when developing their recommendations. Factors that were taken into consideration were the inclusion or exclusion of video with the EEG recording, the typical vignette for each service, duration of the recording, and timing of report generation by the physician. The length of recording is based on a number of factors including the clinical indication for the test and the frequency of seizures. The expert panel believes that the 25th percentile work RVU and median physician time are an accurate representation of the intra service time and physician work associated with 95723.

When reviewing the survey data for services with a single review and report generation at the conclusion of the recording period (95721 – 95726) the expert panel looked to 24-hour recoding with daily review codes (95X16-without video and 95720-with video) to establish rank order. **The panel noted that the IWPOT from the 25% percentile RVU of 4.75 and median time of 90 minutes supports the assertion that the physician work of codes 95721 – 95726 (review and report generation at the conclusion of the study) is typically less intense than the work of codes 95717 – 95720 (daily review and report generation). The survey patient vignettes also support this assertion.**

95723 involves a *single physician review and report generation at the conclusion* of a 60-84-hour EEG recoding *without* video. The 25th percentile RVU of 4.75 puts 95723 in the appropriate rank order within the code family and maintains a consistent IWPOT for those codes with the physician review and report at the conclusion of the recording. The 25th percentile is further supported when comparing the intra service time and IWPOT of 95723 to MPC code 99291 in relation to each other.

Pre-service time: The expert panel agrees that the pre-service activities are consistent regardless of the duration of the long-term EEG recording period and the pre-service time should be the same for each code in the family 95717 – 95726. Upon reviewing the time survey data, the panel agrees the survey pre-service median time of 12 minute is not an accurate reflection of those activities. We are therefore recommending a decrease from 12 minutes (survey median) to 10 minutes for the pre-service time to be consistent across the family.

Post service time: Similarly, the post service activities are consistent regardless of the duration of the long-term EEG recording period and the post-service time should be the same for each code in the family. The expert panel asserts the survey post-service median time of 15.5 minutes is not an accurate reflection of time required for those activities. We

are therefore recommending a decrease from 15.5 minutes (survey median) to 10 minutes for the post-service time to be consistent across the family.

The panel further compared the survey 25th percentile wRVU and median intra times to the key reference services and MPC codes to support the recommendations:

Key Reference Codes

30% of respondents chose 95965, wRVU of 7.99 and times 20/180/30/230

21% of respondents chose 99476, wRVU of 6.75 and times 20/65/10/105

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
95723	EEG, physician interpretation and report at conclusion of recording, 60-84 hours, without video	4.75	0.048	110	10	90	10
99476	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	6.75	0.0901	105	20	65	20
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)	7.99	0.0382	230	20	180	30

MPC Comparison

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	4.50	0.0957	70	15	40	15
95723	EEG, physician interpretation and report at conclusion of recording, 60-84 hours, without video	4.75	0.048	110	10	90	10
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	5.30	0.096	94	34	45	15

Recommendations:

For 95723 the expert panel recommends a work RVU of 4.75; and a total time of 110 minutes (10 minutes pre /90 minutes intra /10 minutes post).

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is

involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95953

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 17889

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the national utilization will be 3 times that of the Medicare utilization.

Specialty Neurology Frequency 17889 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,963

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the specialty utilization based upon existing specialty break out in the RUC database.

Specialty Neurology Frequency 5963 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Tests

BETOS Sub-classification:

Other tests

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95953

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 95724 Tracking Number M23

Original Specialty Recommended RVU: **6.00**Presented Recommended RVU: **6.00**

Global Period: XXX Current Work RVU:

RUC Recommended RVU: **6.00**

CPT Descriptor: 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)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old male with a history of focal epilepsy has episodes of amnesia 2-3 times per week. 72-hour EEG with video recordings is ordered to determine if the patient's amnesic episodes are seizures and to determine the clinical manifestations of the seizures.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews indication for continuous Video-EEG recording and results of prior EEGs if available, communicates with referring physician to clarify the indications for referral and EEG technologist to determine the appropriate activation techniques (photic stimulation, hyperventilation).

Description of Intra-Service Work: The physician or other qualified health care professional reviews patient log, EEG technologist log, EEG technologist technical description summary, including medication history. Seizure detection software is reviewed to identify possible seizures and/or spells. The EEG recording is reviewed for artifacts, background activity, sleep stages and interictal epileptiform abnormalities. The field potential of each type of epileptiform activity is analyzed to determine localization. For each seizure or event Video and EEG data is reviewed during the entire event to make correlations of changes and EEG to localize the site of seizure onset. The recording before, during, and after each event, is annotated describing EEG findings. Clinical and EEG findings are correlated to determine localization of each seizure. Seizure features are compared to determine if seizures arise from multiple locations. Relevant sections of EEG and Video are annotated to be archived by EEG technologists. At the end of the 72 hours of testing the physician or QHP prepares a written report that contains interpretation of pertinent Video findings along with EEG background activity, interictal abnormalities, detailed description of electrographic seizure onset, evolution and offset and clinical correlation of findings for each 24 hours of recording.

Description of Post-Service Work: EEG report is finalized and uploaded into the EMR. Video EEG findings are discussed with the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Marianna V. Spanaki, MD, PhD; Marc Nuwer, MD, PhD				
Specialty Society(ies):	American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS)				
CPT Code:	95724				
Sample Size:	2239	Resp N:	147	Response: 6.5 %	
Description of Sample:	AAN: a sample of members from the Epilepsy and Clinical Neurophysiology Sections (current US members); ACNS: a sample of current US members; National Association of Epilepsy Centers (NAEC): a sample of current US members.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	8.00	30.00	80.00	588.00
Survey RVW:	1.08	6.00	8.30	15.00	28.00
Pre-Service Evaluation Time:			15.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	0.00	75.00	110.00	177.00	726.00
Immediate Post Service-Time:	20.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	95724	Recommended Physician Work RVU: 6.00		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	10.00	0.00	10.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	110.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	10.00	0.00	10.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95965	XXX	7.99	RUC Time

CPT Descriptor Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99476	XXX	6.75	RUC Time

CPT Descriptor Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99223	XXX	3.86	RUC Time	10,830,157

CPT Descriptor 1 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99291	XXX	4.50	RUC Time	5,721,334

CPT Descriptor 2 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 68 % of respondents: 46.2 %

Number of respondents who choose 2nd Key Reference Code: 30 % of respondents: 20.4 %

TIME ESTIMATES (Median)

	CPT Code: <u>95724</u>	Top Key Reference CPT Code: <u>95965</u>	2nd Key Reference CPT Code: <u>99476</u>
Median Pre-Service Time	10.00	20.00	20.00
Median Intra-Service Time	110.00	180.00	65.00
Median Immediate Post-service Time	10.00	30.00	20.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	130.00	230.00	105.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	1%	19%	39%	41%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
3%	22%	75%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	6%	42%	52%
Physical effort required	4%	39%	57%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	4%	42%	54%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	13%	33%	27%	27%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	20%	37%	43%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	7%	33%	60%
Physical effort required	44%	23%	33%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	47%	30%	23%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2016, 95951 was identified under the CMS High Volume screen, as services with total Medicare utilization of 10,000 or more that has increased by at least 100% from 2009 through 2014. As a result, the specialty societies (AAN, ACNS, NAEC) presented an Action Plan to the RAW at the January 2017 *recommending that 95951 and the family of long term monitoring codes (95950, 95951, 95953, 95956) 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.* The medical specialties societies assert the 95951 utilization increase was partially due to incorrect coding, as the existing CPT code language for the long term monitoring family of codes is unclear (as it relates to the use of video and attended vs. unattended requirements.) The specialty societies also acknowledge that since the last review of 95951 was in August 1995 the family of codes should be revised to more accurately capture the services provided.

The specialty societies presented code change applications at the following CPT meetings: June 2017, September 2017, February 2018, and May 2018 when the Panel accepted the addition of 13 new codes for reporting the Technical Component of long-term EEG services (95700 – 95716) and 10 new codes for reporting the Professional Component of long-term EEG services (95717 – 95726.)

The physician services fall into 2 categories:

- 1.) Services where 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 such as 2-12 or 12 to 24 hours. These services are reported with 95717 – 95720.
- 2.) Services where the physician does not have access to EEG and video (when recorded) data during the recording period and the review and analysis occurs at the conclusion of the multiple day study. These services are reported with 95721 – 95726.

Survey Sample and Process

A survey of physicians from the membership rosters of the American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), and the National Association of Epilepsy Centers (NAEC) was conducted (2239 total members). There were 147 respondents for 95724, 93% of whom found the vignette to be typical and who performed a median of 30 services in the last year. An expert consensus panel (“panel”) composed of members of the participating societies familiar with the code in question and the RUC process reviewed the results. The panel confirmed the reliability of the survey.

Rationale for 95724

The expert panel reviewed the entire new code family (95717 – 95726) of physician work services and kept the rank order of the family in mind when developing their recommendations. Factors that were taken into consideration were the inclusion or exclusion of video with the EEG recording, the typical vignette for each service, duration of the recording, and timing of report generation by the physician. The length of recording is based on a number of factors including the clinical indication for the test and the frequency of seizures. The expert panel believes that the 25th percentile work RVU and median physician time are an accurate representation of the intra service time and physician work associated with 95724.

When reviewing the survey data for services with a single review and report generation at the conclusion of the recording period (95721 – 95726) the expert panel looked to 24-hour recoding with daily review codes (95X16-without video and 95720-with video) to establish rank order. **The panel noted that the IWPOT from the 25% percentile RVU of 6.00 and median time of 110 minutes supports the assertion that the physician work of codes 95721 – 95726 (review and report generation at the conclusion of the study) is typically less intense than the work of codes 95717 – 95720 (daily review and report generation). The survey patient vignettes also support this assertion.**

95724 involves a *single physician review and report generation at the conclusion* of 60-84-hour EEG recoding, *with* video. The 25 percentile RVU of 6.00 puts 95724 in the appropriate rank order within the code family and maintains a consistent IWPOT for those codes with the physician review and report at the conclusion of the recording. The 25th percentile is further supported when comparing the intra service time, RVU and IWPOT of 95724 to MPC code 99223 in relation to each other.

Pre-service time: The expert panel agrees that the pre-service activities are consistent regardless of the duration of the long-term EEG recording period and the pre-service time should be the same for each code in the family 95717 – 95726. Upon reviewing the time survey data, the panel agrees the survey pre-service median time of 15 minute is not an

accurate reflection of those activities. We are therefore recommending a decrease from 15 minutes (survey median) to 10 minutes for the pre-service time to be consistent across the family.

Post service time: Similarly, the post service activities are consistent regardless of the duration of the long-term EEG recording period and the post-service time should be the same for each code in the family. The expert panel asserts the survey post-service median time of 20 minutes is not an accurate reflection of time required for those activities. We are therefore recommending a decrease from 20 minutes (survey median) to 10 minutes for the post-service time to be consistent across the family.

The panel further compared the survey 25th percentile wRVU and median intra times to the key reference services and MPC codes to support the recommendations:

Key Reference Codes

46% of respondents chose 95965, wRVU of 7.99 and times 20/180/30/230

20% of respondents chose 99476, wRVU of 6.75 and times 20/65/20/105

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
95724	EEG, physician interpretation and report at conclusion of recording, 60-84 hours, with video	6.00	0.050	130	10	110	10
99476	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	6.75	0.0901	105	20	65	20
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)	7.99	0.0382	230	20	180	30

MPC Comparison

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	3.86	0.0559	90	15	55	20
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	4.50	0.0957	70	15	40	15
95724	EEG, physician interpretation and report at conclusion of recording, 60-84 hours, with video	6.00	0.050	130	10	110	10

Recommendations:

For 95724 the expert panel recommends a work RVU of 6.00; and a total time of 130 minutes (10 minutes pre /110 minutes intra /10 minutes post).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95953, 95951

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 76236

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the national utilization will be 3 times that of the Medicare utilization.

Specialty Neurology Frequency 76236 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 25,412 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the specialty utilization based upon existing specialty break out in the RUC database.

Specialty Neurology Frequency 25412 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Tests

BETOS Sub-classification:

Other tests

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95953

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 95725 Tracking Number M24

Original Specialty Recommended RVU: **6.50**Presented Recommended RVU: **6.50**

Global Period: XXX Current Work RVU:

RUC Recommended RVU: **5.40**

CPT Descriptor: 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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 14-year-old male with a history of absence seizures experiences staring spells approximately once a week. 96-hour EEG without video recordings is ordered to determine if the patient's staring spells are seizures.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews indication for continuous EEG recording and results of prior EEGs if available, communicates with referring physician to clarify the indications for referral and EEG technologist to determine the appropriate activation techniques (photoc stimulation, hyperventilation).

Description of Intra-Service Work: The physician or other qualified health care professional reviews patient log, EEG technologist log, EEG technologist technical description summary, including medication history. Seizure detection software is reviewed to identify possible seizures and/or spells. The EEG recording is reviewed for artifacts, background activity, sleep stages and interictal epileptiform abnormalities. The field potential of each type of epileptiform activity is analyzed to determine localization. For each seizure or event EEG data is reviewed during the entire event to make correlations of changes and EEG to localize the site of seizure onset. The recording before, during, and after each event, is annotated describing EEG findings. Clinical and EEG findings are correlated to determine localization of each seizure. Seizure features are compared to determine if seizures arise from multiple locations. ECG is reviewed and interpretation is made. Relevant sections of EEG are annotated to be archived by EEG technologists. At the end of 96 hours of testing, the physician or QHP prepares a written report that contains interpretation of EEG background activity, interictal abnormalities, detailed description of electrographic seizure onset, evolution and offset and clinical correlation of findings for each 24 hours of recording.

Description of Post-Service Work: EEG report is finalized and uploaded into the EMR. EEG findings are discussed with the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Marianna V. Spanaki, MD, PhD; Marc Nuwer, MD, PhD				
Specialty Society(ies):	American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS)				
CPT Code:	95725				
Sample Size:	2239	Resp N:	124	Response: 5.5 %	
Description of Sample:	AAN: a sample of members from the Epilepsy and Clinical Neurophysiology Sections (current US members); ACNS: a sample of current US members; National Association of Epilepsy Centers (NAEC): a sample of current US members.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	1.00	13.00	300.00
Survey RVW:	1.08	6.50	8.13	13.40	26.00
Pre-Service Evaluation Time:			15.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	0.00	80.00	110.00	164.00	726.00
Immediate Post Service-Time:	20.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	95725	Recommended Physician Work RVU: 5.40		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	10.00	0.00	10.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	110.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	10.00	0.00	10.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95965	XXX	7.99	RUC Time

CPT Descriptor Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99476	XXX	4.50	RUC Time

CPT Descriptor Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99291	XXX	4.50	RUC Time	5,721,334
<u>CPT Descriptor 1</u> Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
90960	XXX	5.18	RUC Time	2,268,319

CPT Descriptor 2 End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 56 % of respondents: 45.1 %

Number of respondents who choose 2nd Key Reference Code: 31 % of respondents: 25.0 %

TIME ESTIMATES (Median)

	CPT Code: <u>95725</u>	Top Key Reference CPT Code: <u>95965</u>	2nd Key Reference CPT Code: <u>99476</u>
Median Pre-Service Time	10.00	20.00	20.00
Median Intra-Service Time	110.00	180.00	65.00
Median Immediate Post-service Time	10.00	30.00	20.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	130.00	230.00	105.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	3%	14%	37%	46%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
7%	23%	70%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	9%	44%	47%

Physical effort required	7%	44%	49%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

2%	40%	58%
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2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	10%	22%	42%	26%
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Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

26%	35%	39%
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Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	6%	32%	62%
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Physical effort required	36%	29%	35%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

26%	29%	45%
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Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2016, 95951 was identified under the CMS High Volume screen, as services with total Medicare utilization of 10,000 or more that has increased by at least 100% from 2009 through 2014. As a result, the specialty societies (AAN, ACNS, NAEC) presented an Action Plan to the RAW at the January 2017 recommending that 95951 and the

family of long term monitoring codes (95950, 95951, 95953, 95956) 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. The medical specialties societies assert the 95951 utilization increase was partially due to incorrect coding, as the existing CPT code language for the long term monitoring family of codes is unclear (as it relates to the use of video and attended vs. unattended requirements.) The specialty societies also acknowledge that since the last review of 95951 was in August 1995 the family of codes should be revised to more accurately capture the services provided.

The specialty societies presented code change applications at the following CPT meetings: June 2017, September 2017, February 2018, and May 2018 when the Panel accepted the addition of 13 new codes for reporting the Technical Component of long-term EEG services (95700 – 95716) and 10 new codes for reporting the Professional Component of long-term EEG services (95717 – 95726.)

The physician services fall into 2 categories:

- 1.) Services where 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 such as 2-12 or 12 to 24 hours. These services are reported with 95717 – 95720.
- 2.) Services where the physician does not have access to EEG and video (when recorded) data during the recording period and the review and analysis occurs at the conclusion of the multiple day study. These services are reported with 95721 – 95726.

Survey Sample and Process

A survey of physicians from the membership rosters of the American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), and the National Association of Epilepsy Centers (NAEC) was conducted (2239 total members). There were 124 respondents for 95725, 79% of whom found the vignette to be typical and who performed a median of 1 service in the last year. An expert consensus panel (“panel”) composed of members of the participating societies familiar with the code in question and the RUC process reviewed the results. The panel confirmed the reliability of the survey.

Rationale for 95725

The expert panel reviewed the entire new code family (95717 – 95726) of physician work services and kept the rank order of the family in mind when developing their recommendations. Factors that were taken into consideration were the inclusion or exclusion of video with the EEG recording, the typical vignette for each service, duration of the recording, and timing of report generation by the physician. The length of recording is based on a number of factors including the clinical indication for the test and the frequency of seizures. The expert panel believes that the 25th percentile work RVU and median physician time are an accurate representation of the intra service time and physician work associated with 95725.

When reviewing the survey data for services with a single review and report generation at the conclusion of the recording period (95721 – 95726) the expert panel looked to 24-hour recoding with daily review codes (95719-without video and 95720-with video) to establish rank order. **The panel noted that the IWPOT from the 25% percentile RVU of 6.50 and median time of 110 minutes supports the assertion that the physician work of codes 95721 – 95726 (review and report generation at the conclusion of the study) is typically less intense than the work of codes 95717 – 95720 (daily review and report generation). The survey patient vignettes also support this assertion.**

95725 involves a *single physician review and report generation at the conclusion* of EEG recording greater than 84 hours, *without* video. The 25 percentile RVU of 6.50 puts 95725 in the appropriate rank order within the code family and maintains a consistent IWPOT for those codes with the physician review and report at the conclusion of the recording. The 25th percentile is further supported when comparing the intra service time and IWPOT of 95725 to MPC code 99476 in relation to each other.

Pre-service time: The expert panel agrees that the pre-service activities are consistent regardless of the duration of the long-term EEG recording period and the pre-service time should be the same for each code in the family 95717 – 95726. Upon reviewing the time survey data, the panel agrees the survey pre-service median time of 15 minute is not an accurate reflection of those activities. We are therefore recommending a decrease from 15 minutes (survey median) to 10 minutes for the pre-service time to be consistent across the family.

Post service time: Similarly, the post service activities are consistent regardless of the duration of the long-term EEG recording period and the post-service time should be the same for each code in the family. The expert panel asserts the survey post-service median time of 20 minutes is not an accurate reflection of time required for those activities. We are

therefore recommending a decrease from 20 minutes (survey median) to 10 minutes for the post-service time to be consistent across the family.

The panel further compared the survey 25th percentile wRVU and median intra times to the key reference services and MPC codes to support the recommendations:

Key Reference Codes

45% of respondents chose 95965, wRVU of 7.99 and times 20/180/30/230

25% of respondents chose 99476, wRVU of 6.75 and times 20/65/10/105

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
95725	EEG, physician interpretation and report at conclusion of recording, > 84 hours, without video	6.50	0.055	130	10	110	10
99476	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	6.75	0.0901	105	20	65	20
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)	7.99	0.0382	230	20	180	30

MPC Comparison

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	4.50	0.0957	70	15	40	15
90960	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month	5.18	0.0405	128		128	
95725	EEG, physician interpretation and report at conclusion of recording, > 84 hours, without video	6.50	0.055	130	10	110	10

Recommendations:

For **95725** the expert panel recommends a work RVU of 6.50; and a total time of 130 minutes (10 minutes pre /110 minutes intra /10 minutes post).

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is

involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95953

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 17667

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the national utilization will be 3 times that of the Medicare utilization.

Specialty Neurology Frequency 17667 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,889

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the specialty utilization based upon existing specialty break out in the RUC database.

Specialty Neurology Frequency 5889 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Tests

BETOS Sub-classification:

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95953

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 95726 Tracking Number M25

Original Specialty Recommended RVU: **7.58**Presented Recommended RVU: **7.58**

Global Period: XXX Current Work RVU:

RUC Recommended RVU: **7.58**

CPT Descriptor: 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)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old male with a history of focal epilepsy has episodes of amnesia approximately once per week. A 96-hour EEG with video recordings is ordered to determine if the patient's amnestic episodes are seizures and to determine the clinical manifestations of the seizures.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The physician or other qualified health care professional reviews indication for continuous Video-EEG recording and results of prior EEGs if available, communicates with referring physician to clarify the indications for referral and EEG technologist to determine the appropriate activation techniques (photic stimulation, hyperventilation).

Description of Intra-Service Work: The physician or other qualified health care professional reviews patient log, EEG technologist log, EEG technologist technical description summary, including medication history. Seizure detection software is reviewed to identify possible seizures and/or spells. The EEG recording is reviewed for artifacts, background activity, sleep stages and interictal epileptiform abnormalities. The field potential of each type of epileptiform activity is analyzed to determine localization. For each seizure or event Video and EEG data is reviewed during the entire event to make correlations of changes and EEG to localize the site of seizure onset. The recording before, during, and after each event, is annotated describing EEG findings. Clinical and EEG findings are correlated to determine localization of each seizure. Seizure features are compared to determine if seizures arise from multiple locations. Relevant sections of EEG and Video are annotated to be archived by EEG technologists. At the end of the 96-hour period of testing, the physician or QHP prepares a written report that contains interpretation of pertinent Video findings along with EEG background activity, interictal abnormalities, detailed description of electrographic seizure onset, evolution and offset and clinical correlation of findings for each 24 hours of recording.

Description of Post-Service Work: EEG report is finalized and uploaded into the EMR. EEG findings are discussed with the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Marianna V. Spanaki, MD, PhD; Marc Nuwer, MD, PhD				
Specialty Society(ies):	American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS)				
CPT Code:	95726				
Sample Size:	2239	Resp N:	142	Response: 6.3 %	
Description of Sample:	AAN: a sample of members from the Epilepsy and Clinical Neurophysiology Sections (current US members); ACNS: a sample of current US members; National Association of Epilepsy Centers (NAEC): a sample of current US members.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	21.00	60.00	400.00
Survey RVW:	1.08	7.58	9.25	20.00	36.48
Pre-Service Evaluation Time:			15.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	0.00	91.00	140.00	223.00	800.00
Immediate Post Service-Time:	25.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	95726	Recommended Physician Work RVU: 7.58		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	10.00	0.00	10.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	140.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	10.00	0.00	10.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95965	XXX	7.99	RUC Time

CPT Descriptor Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99476	XXX	6.75	RUC Time

CPT Descriptor Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99223	XXX	3.86	RUC Time	10,830,157

CPT Descriptor 1 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99291	XXX	4.50	RUC Time	5,721,334

CPT Descriptor 2 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 97 **% of respondents:** 68.3 %

Number of respondents who choose 2nd Key Reference Code: 15 **% of respondents:** 10.5 %

TIME ESTIMATES (Median)

	CPT Code: <u>95726</u>	Top Key Reference CPT Code: <u>95965</u>	2nd Key Reference CPT Code: <u>99476</u>
Median Pre-Service Time	10.00	20.00	20.00
Median Intra-Service Time	140.00	180.00	65.00
Median Immediate Post-service Time	10.00	30.00	20.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	160.00	230.00	105.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	2%	16%	27%	55%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
4%	24%	52%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	7%	44%	49%
Physical effort required	6%	38%	56%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	3%	36%	61%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	53%	20%	27%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	7%	47%	46%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	7%	33%	60%
Physical effort required	47%	27%	26%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	13%	60%	27%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background:

In October 2016, 95951 was identified under the CMS High Volume screen, as services with total Medicare utilization of 10,000 or more that has increased by at least 100% from 2009 through 2014. As a result, the specialty societies (AAN, ACNS, NAEC) presented an Action Plan to the RAW at the January 2017 *recommending that 95951 and the family of long term monitoring codes (95950, 95951, 95953, 95956) 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.* The medical specialties societies assert the 95951 utilization increase was partially due to incorrect coding, as the existing CPT code language for the long term monitoring family of codes is unclear (as it relates to the use of video and attended vs. unattended requirements.) The specialty societies also acknowledge that since the last review of 95951 was in August 1995 the family of codes should be revised to more accurately capture the services provided.

The specialty societies presented code change applications at the following CPT meetings: June 2017, September 2017, February 2018, and May 2018 when the Panel accepted the addition of 13 new codes for reporting the Technical Component of long-term EEG services (95700 – 95716) and 10 new codes for reporting the Professional Component of long-term EEG services (95717 – 95726.)

The physician services fall into 2 categories:

- 1.) Services where 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 such as 2-12 or 12 to 24 hours. These services are reported with 95717 – 95720.
- 2.) Services where the physician does not have access to EEG and video (when recorded) data during the recording period and the review and analysis occurs at the conclusion of the multiple day study. These services are reported with 95721 – 95726.

Survey Sample and Process

A survey of physicians from the membership rosters of the American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), and the National Association of Epilepsy Centers (NAEC) was conducted (2239 total members). There were 142 respondents for 95726, 92% of whom found the vignette to be typical and who performed a median of 21 services in the last year. An expert consensus panel (“panel”) composed of members of the participating societies familiar with the code in question and the RUC process reviewed the results. The panel confirmed the reliability of the survey.

Rationale for 95726

The expert panel reviewed the entire new code family (95717 – 95726) of physician work services and kept the rank order of the family in mind when developing their recommendations. Factors that were taken into consideration were the inclusion or exclusion of video with the EEG recording, the typical vignette for each service, duration of the recording, and timing of report generation by the physician. The length of recording is based on a number of factors including the clinical indication for the test and the frequency of seizures. The expert panel believes that the 25th percentile work RVU and median physician time are an accurate representation of the intra service time and physician work associated with 95726.

When reviewing the survey data for services with a single review and report generation at the conclusion of the recording period (95721 – 95726) the expert panel looked to 24-hour recoding with daily review codes (95719-without video and 95720-with video) to establish rank order. **The panel noted that the IWPUT from the 25% percentile RVU of 7.58 and median time of 140 minutes supports the assertion that the physician work of codes 95721 – 95726 (review and report generation at the conclusion of the study) is typically less intense than the work of codes 95717 – 95720 (daily review and report generation). The survey patient vignettes also support this assertion.**

95726 involves a *single physician review and report generation at the conclusion* of an EEG recording greater than 84 hours, *with* video. The 25 percentile RVU of 7.58 puts 95726 in the appropriate rank order within the code family and maintains a consistent IWPUT for those codes with the physician review and report at the conclusion of the recording. The 25th percentile is further supported when comparing the intra service time and IWPUT of 95726 to key reference service 99476 in relation to each other.

Pre-service time: The expert panel agrees that the pre-service activities are consistent regardless of the duration of the long-term EEG recording period and the pre-service time should be the same for each code in the family 95717 – 95726. Upon reviewing the time survey data, the panel agrees the survey pre-service median time of 15 minute is not an

accurate reflection of those activities. We are therefore recommending a decrease from 15 minutes (survey median) to 10 minutes for the pre-service time to be consistent across the family.

Post service time: Similarly, the post service activities are consistent regardless of the duration of the long-term EEG recording period and the post-service time should be the same for each code in the family. The expert panel asserts the survey post-service median time of 25 minutes is not an accurate reflection of time required for those activities. We are therefore recommending a decrease from 25 minutes (survey median) to 10 minutes for the post-service time to be consistent across the family.

The panel further compared the survey 25th percentile wRVU and median intra times to the key reference services and MPC codes to support the recommendations:

Key Reference Codes

68% of respondents chose 95965, wRVU of 7.99 and times 20/180/30/230

10% of respondents chose 99476, wRVU of 6.75 and times 20/65/20/105

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
99476	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	6.75	0.0901	105	20	65	20
95726	EEG, physician interpretation and report at conclusion of recording, > 84 hours, with video	7.58	0.051	160	10	140	10
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)	7.99	0.0382	230	20	180	30

MPC Comparison

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	3.86	0.0559	90	15	55	20
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	4.50	0.0957	70	15	40	15
95726	EEG, physician interpretation and report at conclusion of recording, > 84 hours, with video	7.58	0.051	160	10	140	10

Recommendations:

For 95726 the expert panel recommends a work RVU of 7.58; and a total time of 160 minutes (10 minutes pre /140 minutes intra /10 minutes post).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95951, 95953

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 27738

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the national utilization will be 3 times that of the Medicare utilization.

Specialty Neurology Frequency 27738 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 9,246

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate the specialty utilization based upon existing specialty break out in the RUC database.

Specialty Neurology Frequency 9246 Percentage 100.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Tests

BETOS Sub-classification:

Other tests

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95953

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR	AS
5	ISSUE: Long-Term EEG Monitoring																								
6	TAB: 13 Revised																								
7																									
8	Tracking #	M16				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
9	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
10	1st REF	95811	Polysomnography; age 6 years c	20	0.055			2.60			65	15					35			15					
11	2nd REF	95957	Digital analysis of electroenceph	18	0.047			1.98			55	15					30			10					
12	CURRENT				#DIV/0!						0														
13	SVY	95717	EEG physician review, 2-12, without video	133	0.075	1.05	2.00	2.50	3.20	8.00	46	8			0	20	28	37	300	10	0	5	20	50	373
14	REC	95717			0.057	2.00					46	8					28			10					
15																									
16	Tracking #	M17				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
17	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
18	1st REF	99205	Office or other outpatient visit fo	27	0.059			3.17			67	7					45			15					
19	2nd REF	99223	Initial hospital care, per day, for	22	0.056			3.86			90	15					55			20					
20	CURRENT				#DIV/0!						0														
21	SVY	95718	VEEG physician review, 2-12	149	0.073	0.97	2.50	3.00	4.00	8.50	55	10			0	25	35	50	300	10	0	20	50	110	415
22	REC	95718			0.059	2.50					55	10					35			10					
23																									
24	Tracking #	M18				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
25	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
26	1st REF	99223	Initial hospital care, per day, for	26	0.056			3.86			90	15					55			20					
27	2nd REF	99291	Critical care, evaluation and mar	25	0.096			4.50			70	15					40			15					
28	CURRENT				#DIV/0!						0														
29	SVY	95719	EEG physician review, report each 24 hr. without video	133	0.088	1.20	3.00	3.95	4.80	10.00	60	10			0	30	40	60	450	10	0	7	24	50	300
30	REC	95719			0.064	3.00					60	10					40			10					
31																									
32	Tracking #	M19				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
33	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
34	1st REF	99476	Subsequent inpatient pediatric c	33	0.090			6.75			105	20					65			20					
35	2nd REF	99291	Critical care, evaluation and mar	24	0.096			4.50			70	15					40			15					

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR	AS
36	CURRENT				#DIV/0!						0														
37	SVY	95720	VEEG physician review, report each 24 hour	152	0.081	1.00	3.50	5.00	6.26	12.00	80	10			12	40	55	75	450	15	0	50	100	200	1500
38	Xwalk	99223	Initial hospital care, per day, for the eva		0.056			3.86			90	15					55			20					
39	REC	95720	VEEG physician review, report each 24 hour		0.062			3.86			75	10					55			10					
40																									
41																									
42	Tracking #	M20				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
43	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
44	1st REF	99291	Critical care, evaluation and mar	29	0.096			4.50			70	15					40			15					
45	2nd REF	99476	Subsequent inpatient pediatric c	24	0.090			6.75			105	20					65			20					
46	CURRENT				#DIV/0!						0														
47	SVY	95721	EEG physician review, 36-60 hours, without video	133	0.076	1.08	3.86	5.50	7.50	12.47	90	10			0	45	65	90	480	15	0	5	15	40	300
48	REC	95721			0.052			3.86			85	10					65			10					
49																									
50	Tracking #	M21				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
51	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
52	1st REF	95965	Magnetoencephalography (MEG)	51	0.038			7.99			230	20					180			30					
53	2nd REF	99291	Critical care, evaluation and mar	28	0.096			4.50			70	15					40			15					
54	CURRENT				#DIV/0!						0														
55	SVY	95722	VEEG physician review, 36-60 hours	145	0.082	1.08	4.70	7.15	10.00	18.24	107	12			0	60	80	120	480	15	0	14	50	100	400
56	REC	95722			0.053			4.70			100	10					80			10					
57																									
58	Tracking #	M22				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
59	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
60	1st REF	95965	Magnetoencephalography (MEG)	39	0.038			7.99			230	20					180			30					
61	2nd REF	99476	Subsequent inpatient pediatric c	28	0.090			6.75			105	20					65			20					
62	CURRENT				#DIV/0!						0														
63	SVY	95723	EEG physician review, 60-84 hours, without video	132	0.072	1.08	4.75	7.08	10.00	20.00	118	12			0	60	90	121	726	15.5	0	0	10	31	300
64	REC	95723			0.048			4.75			110	10					90			10					

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR	AS
65																									
66	Tracking #	M23				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
67	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
68	1st REF	95965	Magnetoencephalography (MEG)	68	0.038			7.99			230	20					180			30					
69	2nd REF	99476	Subsequent inpatient pediatric c	30	0.090			6.75			105	20					65			20					
70	CURRENT				#DIV/0!						0														
71	SVY	92X21	VEEG physician review, 60-84 hours	147	0.068	1.08	6.00	8.30	15.00	28.00	145	15			0	75	110	177	726	20	0	8	30	80	588
72	REC	95724			0.050	6.00					130	10					110			10					
73																									
74	Tracking #	M24				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
75	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
76	1st REF	95965	Magnetoencephalography (MEG)	56	0.038			7.99			230	20					180			30					
77	2nd REF	99476	Subsequent inpatient pediatric c	31	0.090			6.75			105	20					65			20					
78	CURRENT				#DIV/0!						0														
79	SVY	92X22	EEG physician review, >84 hours, without video	124	0.067	1.08	6.50	8.13	13.40	26.00	145	15			0	80	110	164	726	20	0	0	1	13	300
80	Xwalk	77772	Remote afterloading high dose rate rad		0.049	5.40					124	6					100			18					
81	REC	95725			0.045	5.40					130	10					110			10					
82																									
83	Tracking #	M25				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
84	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
85	1st REF	95965	Magnetoencephalography (MEG)	97	0.038			7.99			230	20					180			30					
86	2nd REF	99476	Subsequent inpatient pediatric c	15	0.090			6.75			105	20					65			20					
87	CURRENT				#DIV/0!						0														
88	SVY	95726	VEEG physician review, >84 hours	142	0.060	1.08	7.58	9.25	20.00	36.48	180	15			0	91	140	223	800	25	0	5	21	60	400
89	REC	95726			0.051	7.58					160	10					140			10					

	A	B	C	D	E	F	G	H	I	J	K	L
1	CA021	CPT Code	95X01		95X04		95X07		95X10		95X13	
2		Short Description	EEG Set Up		EEG, NO video, 2-12 hrs, continuous monitoring		EEG, NO Video, 12-26 hrs, continuous monitoring		Video-EEG, 2-12 hrs, continuous monitoring		Video-EEG, 12-26 hrs, continuous monitoring	
3		Global Period	XXX		XXX		XXX		XXX		XXX	
4		CPT Descriptor	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		Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance		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		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance		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	
5		Vignette Used In Survey	A 44-year-old male with a history of tonic-clonic seizures reports seizure freedom for the past year. A 72-hour EEG with 20 channels is ordered to confirm seizure freedom and assist physician to determine if medications can be reduced or withdrawn entirely.		A 36-year-old female with a known seizure disorder reports feeling dizzy and disoriented. A 10-hour EEG without video and with continuous monitoring is ordered to evaluate effect of recent medication changes.		A 65-year-old female post cardiac arrest was placed in a medically induced coma. A 48-hour continuously monitored EEG without video is ordered to evaluate level of medication induced coma.		A newborn female has atypical movements. A continuously monitored 8-hour video EEG is ordered to evaluate for seizures.		A 5-year-old autistic male is having sudden head drops and is unresponsive for a few seconds after the event. The events occur several times per week. A 72-hour video EEG with continuous monitoring to capture the event(s) is ordered.	
6		Total: Typical patient question	139		102		101		114		113	
7		Percentage of Survey Respondents who found Vignette to be typical	83%		66%		64%		84%		88%	
8			25th Percentile	Median	25th Percentile	Median	25th Percentile	Median	25th Percentile	Median	25th Percentile	Median
9		Total: Performance Rate Completed on survey	51		20		23		31		33	
10		Performance Rate	3	30	0	4	0	5	1	7	3	10
11		what percent were performed in physician office	60%	100%		80%		50%		68%		75%
12		what percent were performed in patient home	40%	0%		20%		50%		33%		25%
29		Start: Patient EEG and/or VEEG monitoring begins										
30		In office or remote, real-time EEG monitoring with or without video May include: Review patient clinical history, current medications, and prior monitoring notes (follow up on notes from previous sessions) Confirm camera is displaying live view, when used Review any patient events from prior monitoring Review EEG recording for quality Look for events that might require physician notification Check electrode impedances for quality Document findings and notes for current session Ensure patient is still in camera view, when used			17	30	21	40	21	38	20	44
31		Per expert panel row 31 times are for monitoring. Row 30 times represent the technologist that checks electrodes and camera positioning and does not include the actual monitoring time. We have added the times for monitoring based on the survey results of how many patients were monitored for each code and based on the CPT code time. For 2-12 hour codes, the assumption is the study is typically 8 hours. For the 12 to 26 hour code, the assumption is the study is typically 24 hours.			160	160	480	480	240	240	480	480
32		Maintenance during patient session (do not include initial set-up) May include: Contact/initiate on-call maintenance support, if needed Repair electrodes, video, laptop, or other faulty equipment, if needed Validate repairs are complete, if needed • New electrode placement, if needed Check electrode impedances for quality of each new EEG electrode, if needed Reposition/reactivate/reset video equipment, when used Reposition/reactivate/reset laptop/computer and internet connections, when used			10	20	14	26	15	28	14	30
33		May include: Continued education/instruction/counseling if electrodes stop recording or patient event occurs. Continued education/instruction/counseling if video stop recording or patient event occurs			5	10	5	10	7	10	7	10
34		May include: Communicate with physician/QHP for events or triggers identified by physician/QHP for MD intervention or notification			5	10	5	10	9	10	5	13
35		May include: Review and prepare data for physician Annotate EEG and/or VEEG Note spike generator location Document technologist initial notes Send all data to physician for reading			18	30	20	40	20	34	30	55
36		CA021 Total			215	260	545	606	312	360	556	632
37		Other Clinical Activity not listed above			0	2	0	5	0	4	0	5
38		End: Patient EEG and/or VEEG monitoring ends										

	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB
1	95X03		95X06		95X09		95X12		95X02		95X05		95X08		95X11	
2	EEG, NO video, 2-12 hrs, intermittent monitoring		EEG, NO Video, 12-26 hrs, intermittentmonitoring		Video-EEG, 2-12 hrs, intermittent monitoring		Video-EEG, 12-26 hrs, intermittent monitoring		EEG, NO video, 2-12 hrs, unmonitored		EEG, NO Video, 12-26 hrs, unmonitored		Video-EEG, 2-12 hrs, unmonitored		Video-EEG, 12-26 hrs, unmonitored	
3	XXX		XXX		XXX		XXX		XXX		XXX		XXX		XXX	
4	Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance		Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring, and maintenance		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance		Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored		Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	
5	A 48-year-old male has daily intermittent mental status changes. An 8-hour intermittently monitored EEG without video is ordered to evaluate for subclinical seizures.		A 54-year-old male previously presented in non-convulsive status epilepticus. A 48-hour EEG intermittently monitored, without video, is ordered to evaluate that non-convulsive seizures have resolved.		A 13-year-old autistic male has frequent episodes of eyelid flutter. An 8-hour video EEG with intermittent monitoring is ordered to evaluate for absence seizures.		A 15-year-old female is experiencing episodes described as collapsing with convulsions. Episodes have occurred during school where she reports feeling stressed. A 72-hour video EEG with intermittent monitoring is ordered to determine if the patient is having non-epileptic or epileptic seizures.		An 8-year-old male with a history of absence seizures reports seizure freedom for the past year. A 24-hour unmonitored EEG without video is ordered to confirm seizure freedom and assist physician to determine if medications can be reduced or withdrawn. The patient removes the electrode wires after 10 hours.		A 25-year-old male in a motorcycle accident two years ago was placed on anticonvulsant medication prophylactically. An unmonitored 24-hour EEG without video is ordered to evaluate prior to medication ween.		A 15-year-old female has frequent jerking movements in the morning. An 8-hour video EEG, unmonitored, is ordered to evaluate for juvenile myoclonic epilepsy.		A 30-year-old male presents with known seizure disorder. A 24-hour EEG, unmonitored, is ordered to evaluate break through seizures.	
6	93		91		95		99		89		95		93		99	
7	55%		56%		78%		90%		74%		84%		73%		81%	
8	25th Percentile	Median	25th Percentile	Median	25th Percentile	Median	25th Percentile	Median	25th Percentile	Median	25th Percentile	Median	25th Percentile	Median	25th Percentile	Median
9	26		26		25		27									
10	0	1	0	3	0	7	2	10								
11		75%		5%		70%		50%								
12		25%		95%		30%		50%								
29																
30	14	23	15	24	14	20	15	30								
31	137	137	40	40	120	120										
32	13	20	15	29	12	21	13	30								
33	5	13	5	12	5	15	6	15								
34	5	10	5	10	5	10	5	11								
35	20	27	26	40	13	30	30	60	19	30	30	34	18	30	29	35
36	194	230	106	155	169	216	69	146	19	30	30	34	18	30	29	35
37	0	1	0	3	0	1	0	1	0	0	0	0	0	2	0	1
38																

		B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y
1		95X04		95X07		95X10		95X13		95X03		95X06		95X09		95X12		95X02		95X05		95X08		95X11	
2		EEG, NO video, 2-12 hrs, continuous monitoring		EEG, NO Video, 12-26 hrs, continuous monitoring		Video-EEG, 2-12 hrs, continuous monitoring		Video-EEG, 12-26 hrs, continuous monitoring		EEG, NO video, 2-12 hrs, intermittent monitoring		EEG, NO Video, 12-26 hrs, intermittent monitoring		Video-EEG, 2-12 hrs, intermittent monitoring		Video-EEG, 12-26 hrs, intermittent monitoring		EEG, NO video, 2-12 hrs, unmonitored		EEG, NO Video, 12-26 hrs, unmonitored		Video-EEG, 2-12 hrs, unmonitored		Video-EEG, 12-26 hrs, unmonitored	
3		How many patients do you personally monitor continuously at one time, please tell us the typical or most common situation								How many patients do you personally monitor intermittently at one time, please tell us the typical or most common situation								On a typical day, how many unmonitored patients does your practice have recording their EEG							
4	Min	0		0		0		0		0		0		0		0		0		0		0		0	
5	25th	0		0		0		0		0		0		0		1.5		0		0		0		0	
6	Median	0		1		0		1		1		3		7		10		0		1		0		1	
7	75th	1		3		2		3		7		19		75		125		1		3		2		3	
8	Max	5		5		6		13		100		100		200		850		5		5		6		13	
9	Mode	0		0		0		0		0		0		0		0		0		0		0		0	
10	Total Count	27		30		25		28		26		26		25		27		27		30		25		28	
11	Below Data -Performs These Services removed all responses with 0 and made them blank																								
12		95X04		95X07		95X10		95X13		95X03		95X06		95X09		95X12		95X02		95X05		95X08		95X11	
13	CPT Guidance	EEG, NO video, 2-12 hrs, continuous monitoring		EEG, NO Video, 12-26 hrs, continuous monitoring		Video-EEG, 2-12 hrs, continuous monitoring		Video-EEG, 12-26 hrs, continuous monitoring		EEG, NO video, 2-12 hrs, intermittent monitoring		EEG, NO Video, 12-26 hrs, intermittent monitoring		Video-EEG, 2-12 hrs, intermittent monitoring		Video-EEG, 12-26 hrs, intermittent monitoring		EEG, NO video, 2-12 hrs, unmonitored		EEG, NO Video, 12-26 hrs, unmonitored		Video-EEG, 2-12 hrs, unmonitored		Video-EEG, 12-26 hrs, unmonitored	
14	Assumptions for calculations of monitoring time	12 hour period typical is 8 hours of recording		24 hour period is typical		12 hour period typical is 8 hours of recording		24 hour period is typical		12 hour period typical is 8 hours of recording		24 hour period is typical		12 hour period typical is 8 hours of recording		24 hour period is typical		No Monitoring therefore time not calculated							
15		# of Pts	Minutes	# of Pts	Minutes	# of Pts	Minutes	# of Pts	Minutes	# of Pts	Minutes	# of Pts	Minutes	# of Pts	Minutes	# of Pts	Minutes								
16	Minimum	1	720	1	1440	1	720	1	1440	1	720	1	1440	1	720	1	1440								
17	8 hour period	3	160			3	160			6	80			12	40										
18	Median	3	240	3	480	3	240	3	480	6	120	11	137	18	41	20	74								
19	Maximum	4	180	4	360	4	180	4	360	12	60	12	120	12	60	12	120	>12		>12		>12		>12	
20	Min	1		1		1		1		1		2		1		1		1		1		1		1	
21	25th	1		2		2		1		4		6		5		6		1		2		2		2	
22	Median	3		3		3		3		6		11		18		20		1		2		2		3	
23	75th	4		6		6		6		18		23		136		89		3		4		5		5	
24	Max	360		840		386		1601		360		840		450		1601		5		5		6		13	
25	Mode	1		2		2		1		4		6		5		6		1		2		1		1	
26	Total Count	20		20		23		27		20		20		24		26		12		19		11		15	

	A	Tab 13 Longterm_EEG_Direct_PE_summary data revised 9-25-2018 v1c1	D	
1		CPT Code	95X01	
2		Short Description	EEG Set Up	
3		Global Period	XXX	
4		CPT Descriptor	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	
5		Vignette Used In Survey	A 44-year-old male with a history of tonic-clonic seizures reports seizure freedom for the past year. A 72-hour EEG with 20 channels is ordered to confirm seizure freedom and assist physician to determine if medications can be reduced or withdrawn entirely.	
6		Total: Typical patient question	139	
7		Percentage of Survey Respondents who found Vignette to be typical	83%	
8			25th Percentile	Median
9		Total: Performance Rate Completed on survey	51	
10		Performance Rate	3	30
11		what percent were performed in physician office	60%	100%
12		what percent were performed in patient home	40%	0%
13	CMS	Start: When appointment for procedure is made		
14	CA005	Call patient to confirm they have completed all pre-procedure activities Sanitize & prepare any equipment that needs to be sanitized prior to each procedure. Collect supplies to complete setup (paste, gauze, solvent, electrodes, etc.), Test equipment Load equipment and supplies into vehicle	3	10
15	CA013 in pre service	Equipment and supplies preparation	6	15
16		Other Clinical Activity not listed above	0	0
17		End: Patient arrives at office, IDTF or clinical staff arrives at patient home to set-up for procedure		
18		Start: Patient arrives at office, IDTF or clinical staff arrives at patient home to set-up for procedure		
19	CA011	Patient/family education - Explain service and set-up process Ensure consent signed Answer patient and family questions regarding the procedure, logs, operation of equipment and how to get technical assistance	7	13
20	CA010	Patient Preparation May include: Blood Pressure was reply to detail in survey Obtain Vital Signs	0	2
21	CA013 in pre service	Room, equipment and supplies set-up - Scout living area(s) to locate optimal placement of cameras Set-up room Set-up equipment and supplies Set-up video equipment, tripod, laptop/computer and internet connections, when used Check/test and/or reposition/reactivate/reset video equipment, laptop/computer and internet connections, when used	5	10
22	CA016	Prepare and position patient - Clean skin/scalp Measure and mark head for EEG electrodes Apply and secure EEG electrodes with protective material for long term use Position patient • Position EEG wires, EEG monitor and belt Check/test and/or reposition/reattach EEG monitor, wires and belt Check impedances of each EEG electrode	22	45
23		Other Clinical Activity not listed above	0	0
24		Start: Patient EEG monitoring ends or clinical staff arrives at patient home for take down activities.		
25	CA011 place in post service	Patient/family education - Review documented events with patient to gather additional context and/or notes Explain how the electrodes will be removed Answer patient and family questions on use of EEG and video data, explain what will happen next regarding physician review and interpretation	7	10
26	CA034	Room, equipment and supplies take down - Take down equipment Collodion, electrode and wire removal and clean patient Disconnect cameras, when used Clean room Disinfect equipment and supplies	13	22
27		Other Clinical Activity not listed above	0	2
28		End: Patient leaves the office, IDTF or clinical staff leaves patient home after take down activities complete		
29		Page 4 of 6		

Medical Supplies -Equipment

	A	B	C	D	E	F
1	CMS #	Medical Supplies	UNIT of measure, (e.g., each, per roll, per box, per pack, per inch etc.)	Medical supplies that you typically use to provide 24-hour monitoring with video	Medical supplies that you typically use to provide 24-hour monitoring with video	# completed Survey
2				Survey Median	Survey Average	Count
3	SD053	EEG Electrode (ECG) single or each	each	20	15	21
4	SJ014	Collodion (2oz uou)	2 oz	1	1	21
5	SD265	EEG Electrode (ECG) single or each, MRI compatible	each	2	11	18
6	SL001	Acetone per ml	per ml	2	19	19
7	SG051	Gauze	each	1	9	21
8	SJ022	electrode skin prep gel (NuPrep)	oz or ml	1	2	21
9	SC034	Blunted tips	each	0	2	17
10	SJ061	Tongue depressors	each	1	2	20
11	SJ053	Alcohol wipes	each	2	5	20
12	SK048	Measuring Tape	per inch	1	1	20
13	SK075	Marking pencils	each	1	1	21
14	SC051	Syringes 10 cc	each	1	1	18
15	SG030	Cotton balls	each	4	7	19
16	SG079	tape, surgical paper 1in (Micropore)	inch	1	3	21
17	SG017	Kerlix gauge		1	3	18
18	SB022	Gloves		2	3	21
19	SL020	Clorox Bleach		1	4	20
20	SK057	Paper for report		3	6	20
21	SK057	Patient Diary		1	2	21
22		EEG wires (disposable)		1	11	17
23	SK075	Skin marking pencil, sterile,		0	0	17
24	SG017	bandage, Kling, non-sterile 2in		1	1	19
25	SC034	needle, blunt tip		0	1	17
26	SB036	paper, exam table		0	2	17
27	SJ041	povidone soln (Betadine)		0	1	16
28	SK048	measuring tape, paper		1	1	19
29	SG077	tape, porous-hypoallergenic 2in (Scanpore)		0	1	17
30	SK011	Batteries		3	3	21
31		Other supplies not listed (provide details)		0	0	9
32						
33		Medical Supplies				
34		Bedroom furniture (hospital bed, table reclining chair)		1	3	
35		Air compressor, safety		1	2	
36		Crash cart, EMG and/or cardiac monitor		1	1	
37		EEG, digital, prolonged testing system (w/computer)		1	2	
38		EEG, digital, prolonged testing system (w/computer and video equipment)		1	4	
39		EEG, review station, ambulatory		1	2	
40		EEG analysis software		1	2	
41		2n Video camera with mobile cart		1	2	
42		EEG, encryption software		1	2	

Medical Supplies -Equipment

	A	B	C	D	E	F
1	CMS #	Medical Supplies	UNIT of measure, (e.g., each, per roll, per box, per pack, per inch etc.)	Medical supplies that you typically use to provide 24-hour monitoring with video	Medical supplies that you typically use to provide 24-hour monitoring with video	# completed Survey
2				Survey Median	Survey Average	Count
43		Archiving workstation (for data archive, storage and review)		1	1	
44		Audio devices, microphones		1	3	
45		Patient monitoring status		1	1	
46	Other equipment not listed (provide details)					
47	HOT SPOT INTERNET DEVICE, EMERGENCY EEG RESTART KITS (INCLUDING SD CARDS, HEX DRIVERS, BATTERIES), CAR KITS (INCLUDING SNOW SHOVELS, WARNING TRIANGLES, TIRE CHAINS), GPS, COMPANY WORK VEHICLE, COMPANY CELL PHONE, MATS TO PROTECT WORK AREAS, SHOE COVERS, PERSONAL PROTECTIVE EQUIPMENT (FULL GOWNS, FACE MASKS, SAFETY GOGGLES)				1	
48	2 iterations of video equipment needed - video recorded from 2 vantage points, and 2nd set of equipment as backup of this very necessary component. EEG analysis equipment is considered routine state of the art at this point; mathematic computer support adds additional precision to EEG evaluation, and can speed up review of a 24 hour monitoring.				1	
49	Our equipment in addition to listed above also has blue tooth and hot spot to provide internet, several power cords				1	
50						

Specialties: American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN)

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

Meeting Date: October 2018 Revised 10-4-18

CPT code	CPT Long Descriptor	Global Period
95X01 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	XXX

- Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel: The joint societies including the American Academy of Neurology (AAN), the American Clinical Neurophysiology Society (ACNS), the American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN) surveyed members totaling 5532. We received responses from 139 to 33 completing various aspects of the detailed PE survey tool that was approved by research. Additionally, the AMA staff performed a webinar for any available and interested members of the EEG technologist community, the webinar was recorded and made available for anyone taking the PE survey.

We have included the results of the survey in a separate file attached. The consensus panel reviewed the median and 25th percentile times and the median ~~or average results~~ of the survey for supplies and equipment.

A consensus panel consisting of EEG technologists, and physicians reviewed the survey data and reference code comparisons noted below to come up with the final recommendations presented in the PE worksheet. In some instances, we accepted the survey median ~~or average supply~~ and when survey results did not agree with the consensus panels expert opinion, we used ~~the existing inputs~~ the consensus panel.

- You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here: CPT 95950 and 95953, 95956 (presented February 2010) as references plus survey data, reviewed by consensus of experts.
- Is this code(s) typically billed with an E/M service? No
Is this code(s) typically billed with the E/M service in the nonfacility? No
(Please see provided data in PE Subcommittee folder)
- What specialty is the dominant provider in the nonfacility? Neurology
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different then for the global? No
(Please see provided data in PE Subcommittee folder)
95950 – Neurology – 74%
95951 – IDTF – 51%
95953 – Neurology – 91%
95956 – Neurology – 51%

Specialties: American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: [N/A](#)
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time. [N/A](#)
7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: [N/A](#)
8. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

Equipment and supplies preparation:

- Sanitize & prepare equipment
- Collect supplies to complete setup (paste, gauze, solvent, electrodes, etc.)
- Test equipment

Patient/family education:

- Explain service and set-up process
- Ensure consent signed
- Answer patient and family questions regarding the procedure, logs, operation of equipment and how to get technical assistance

Patient Preparation

- Obtain Vital Signs, blood pressure, 2 minutes.

Room, equipment and supplies set-up:

- Set-up room, set-up equipment and supplies, set-up video equipment, tripod, laptop/computer and internet connections (when used), check/test and/or reposition/reactivate/reset video equipment (when used), laptop/computer and internet connections (when used)

Prepare and position patient

- Clean skin/scalp
- Measure and mark head for EEG electrodes
- Apply and secure EEG electrodes with protective material for long term use
- Position patient
- position EEG wires, EEG monitor and belt,
- Check/test and/or reposition/reattach EEG monitor, wires and belt, check impedances of each EEG electrode

Patient/family education (after set-up):

- Review documented events with patient to gather additional context and/or note
- Explain how the electrodes will be removed
- Answer patient and family questions on use of EEG and video data
- Explain what will happen next regarding physician review and interpretation
- Remove electrodes: remove collodion, electrodes and wires, clean patient

Data retrieval and management:

Specialties: American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN)

- Merge EEG and Video files by automated program, confirm transfer of data, delete from laptop/computer if necessary

Room, equipment and supplies take down:

- Take down equipment, disconnect cameras (when used)
 - Clean room, disinfect equipment and supplies
9. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. N/A
 10. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: N/A
 11. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. N/A
 12. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: N/A
 13. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: N/A
 14. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:

Code	Equipment
EQ047	Air compressor, safety
EF009	Chair, medical recliner
NEW Equipment	EEG, digital, prolonged testing system, with video, ambulatory

15. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:
16. If there is any other item on your spreadsheet that needs further explanation please include here:
17. Please include an explanation of each line item:

Lines 11 & 12 of the PE survey – We acknowledge an anomaly in the survey results stating that 100% of these patients for this scenario are in the physician’s office setting, we do not agree with this portion of the survey as we believe there is closer to 50-50 percentage of IDTF and physician office use.

CPT Codes 95706, 95709, 95712, 95715

Specialties: American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN)

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

Meeting Date: October 2018 Revised 10-22-18

CPT code	CPT Long Descriptor	Global Period
95706	Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and maintenance	XXX
95709	Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	XXX
95712	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring, and maintenance	XXX
95715	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	XXX

- Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel: The joint societies including the American Academy of Neurology (AAN), the American Clinical Neurophysiology Society (ACNS), the American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN) surveyed members totaling 5532. We received responses from 139 to 33 completing various aspects of the detailed PE survey tool that was approved by research. Additionally, the AMA staff performed a webinar for any available and interested members of the EEG technologist community, the webinar was recorded and made available for anyone taking the PE survey.

We have included the results of the survey in a separate file attached. The consensus panel reviewed the median and 25th percentile times and the median results of the survey for supplies and equipment.

A consensus panel consisting of EEG technologists, and physicians reviewed the survey data and reference code comparisons noted below to come up with the final recommendations presented in the PE worksheet. In some instances, we accepted the survey median supply and when survey results did not agree with the consensus panels expert opinion, we used the existing inputs.

Upon further review (and discussion with AMA RUC staff) we observed that the minutes for monitoring did not make sense and re-ran the analysis removing those responses that indicated a 0 for the number of monitored patients. Those technologists that responded 0 noted in the comments that they did not personally monitor, rather were the technologist assigned to set up / take down, or to troubleshoot to. Therefore, removing the 0 responses gave us a realistic number of patients that were monitored.

Specialties: American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN)

We also carefully reviewed the questions and it appeared to us that the technologists misunderstood the question on monitoring for the time period to mean checking rather than the actual monitoring. We did not see any fields where they would have put the time for the actual monitoring. Therefore, we believe this element was missing after looking at all the other clinical activity times. We added row 54 on the PE spreadsheet and calculated the monitoring times based on the typical time and the number of patients that were monitored per the re-run data. In comparing the monitoring time of RUC reviewed code 95956, plus the additional activities for a 24 hour service, we feel the total time is now appropriate.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here: [CPT 95950 and 95953, 95956 \(presented February 2010\) as references plus survey data, reviewed by consensus of experts.](#)
3. Is this code(s) typically billed with an E/M service? **No**
Is this code(s) typically billed with the E/M service in the nonfacility? **No**
(Please see provided data in PE Subcommittee folder)
 - [95950 – Neurology – 74%](#)
 - [95951 – IDTF – 51%](#)
 - [95953 – Neurology – 91%](#)
 - [95956 – Neurology – 51%](#)
4. What specialty is the dominant provider in the nonfacility? [Neurology](#)
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different then for the global? **No**
(Please see provided data in PE Subcommittee folder)
5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
Compelling Evidence for Tab 13 Long Term EEG Codes 95X01 to 95X13 (see [Compelling Evidence handout](#))
 - [Technique \(there are now varying levels of monitoring, whereas previously there was only monitored or unmonitored\)](#)
 - [Site of service \(due to population shift services are now performed in the outpatient / ambulatory setting, and patients' homes and not exclusively in the inpatient\)](#)
 - [Technology changes and advancements \(improved technology has created more options for remote / ambulatory monitoring of patients in various settings; increased remote video capabilities.\)](#)
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time. [N/A](#)
7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:

CPT Codes 95706, 95709, 95712, 95715

Specialties: American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN)

8. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

Row 54 on spreadsheet CAO21:

Actual monitoring time (do not include initial set-up)

(95706 - 40 minutes, 95709 – 120 minutes, 95712 – 40 minutes, 95715 – 120 minutes)

Explanation of monitoring minutes:

2-12-hour codes we assume **8 hours** is the typical length of service.

- Intermittent: Per survey data 12 is the typical number of patients monitored so we divide the 480 minutes by 12 which equals 40 minutes of monitoring.

12-16-hour codes we assume **24 hours** is the typical length of service.

- Intermittent: Per survey data 12 is the typical number of patients monitored so we divide the 1440 minutes by 12 which equals get 120 minutes of monitoring

Row 55 on PE spreadsheet total times:

- 95706 – ~~93~~ **57** minutes
- 95709 – ~~115~~ ~~79~~ **50** minutes
- 95712 – ~~96~~ **61** minutes
- 95715 – ~~146~~ ~~100~~ **70** minutes

CAO21 activities are broken out as follows:

In office or remote, real-time EEG monitoring with or without video

(95706 - ~~23~~ **10 minutes, 95709 – ~~24~~ **10** minutes, 95712 – ~~20~~ **10** minutes, 95715 – ~~30~~ **10** minutes)**

- Review patient clinical history, current medications, and prior monitoring notes (follow up on notes from previous sessions)

Maintenance during patient session (do not include initial set-up) only included for 2-12 hour codes

(95706 - 20 minutes, 95709 – 0 minutes, 95712 – 21 minutes, 95715 – 0 minutes)

- Contact/initiate on-call maintenance support, if needed
- Repair electrodes, video (when used), laptop, or other faulty equipment, if needed
- Validate repairs are complete, if needed
- New electrode placement, if needed
- Check electrode impedances for quality of each new EEG electrode, if needed
- Reposition/reactivate/reset video equipment, when used
- Reposition/reactivate/reset laptop/computer and internet connections, when used

Patient/family education

(95706 - ~~13~~ **0 minutes, 95709 – ~~12~~ **0** minutes, 95712 – ~~15~~ **0** minutes, 95715 – ~~15~~ **0** minutes)**

Internal communication

(95706 - ~~10~~ **0 minutes, 95709 – ~~10~~ **0** minutes, 95712 – ~~10~~ **0** minutes, 95715 – ~~11~~ **0** minutes)**

CPT Codes 95706, 95709, 95712, 95715

Specialties: American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN)

Prepare data (when done during patient session

(95706 - 27 minutes, 95709 – 40 minutes, 95712 – 30 minutes, 95715 – 60 minutes)

- Review and prepare data for physician
- Annotate EEG and/or VEEG
- Note spike generator location
- Document technologist initial notes
- Send all data to physician for reading

Row 89 on PE spreadsheet CA038:

Data retrieval and management: (95706 - ~~22~~ 11 minutes, 95709 – 44 22 minutes, 95712 – ~~22~~ 11 minutes, 95715 – 44-22minutes) EXPERT PANEL consistent with current codes

Original recommendation based on EXPERT PANEL consistent with current code (95950) – reduced by 50% taking partial automation of the activity into consideration.

- Merge EEG and Video files (partially automated program), confirm transfer of data, delete from laptop/computer if necessary.
- *Associated Equipment time (Row 145 – EQ050) remains 44 and 22 minutes based on crosswalk to activities for RUC reviewed code 95950.*

9. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. N/A
10. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: N/A
11. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. N/A
12. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: N/A
13. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: N/A
14. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:
95706 –
95709 –

CPT Codes 95706, 95709, 95712, 95715

Specialties: American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN)

Code	Equipment	Codes used
EF003	bedroom furniture (hospital bed, table, reclining chair)	95706, 95712
ED050	Technologist PAC workstation for storing data	95706, 95709, 95712, 95715
EQ016	EEG review station, ambulatory	95706, 95709, 95712, 95715
NEW Equipment	EEG, digital, prolonged testing system, with video, ambulatory	95715
EQ014	EEG monitor, digital, portable	95706, 95709
EQ017	EEG, digital, prolonged testing system (computer w-remote camera)	95712

EQ016 EEG review station, ambulatory – monitoring time + total “Prepare data (when done during patient session)” part of the 2nd CA021 and on line 55 of the spreadsheet

15. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: [N/A](#)
16. If there is any other item on your spreadsheet that needs further explanation please include here: [N/A](#)
17. Please include an explanation of each line item:

CPT Codes 95707, 95710, 95713, 95716

Specialties: American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN)

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

Meeting Date: October 2018 Revised 10-22-18

CPT code	CPT Long Descriptor	Global Period
95707	Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	XXX
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	XXX
95713	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	XXX
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	XXX

- Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel: The joint societies including the American Academy of Neurology (AAN), the American Clinical Neurophysiology Society (ACNS), the American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN) surveyed members totaling 5532. We received responses from 139 to 33 completing various aspects of the detailed PE survey tool that was approved by research. Additionally, the AMA staff performed a webinar for any available and interested members of the EEG technologist community, the webinar was recorded and made available for anyone taking the PE survey.

We have included the results of the survey in a separate file attached. The consensus panel reviewed the median and 25th percentile times and the median results of the survey for supplies and equipment.

A consensus panel consisting of EEG technologists, and physicians reviewed the survey data and reference code comparisons noted below to come up with the final recommendations presented in the PE worksheet. In some instances, we accepted the survey median supply and when survey results did not agree with the consensus panels expert opinion, we used the existing inputs. Upon further review (and discussion with AMA RUC staff) we observed that the minutes for monitoring did not make sense and re-ran the analysis removing those responses that indicated a 0 for the number of monitored patients. Those technologists that responded 0 noted in the comments that they did not personally monitor, rather were the technologist assigned to set up / take down, or to troubleshoot to. Therefore, removing the 0 responses gave us a realistic number of patients that were monitored.

We also carefully reviewed the questions and it appeared to us that the technologists misunderstood the question on monitoring for the time period to mean checking rather than the

Specialties: American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN)

actual monitoring. We did not see any fields where they would have put the time for the actual monitoring. Therefore, we believe this element was missing after looking at all the other clinical activity times. We added row 54 on the PE spreadsheet and calculated the monitoring times based on the typical time and the number of patients that were monitored per the re-run data. In comparing the monitoring time of RUC reviewed code 95956, plus the additional activities for a 24 hour service, we feel the total time is now appropriate.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here: [CPT 95950 and 95953, 95956 \(presented February 2010\) as references plus survey data, reviewed by consensus of experts.](#)
3. Is this code(s) typically billed with an E/M service? [No](#)
Is this code(s) typically billed with the E/M service in the nonfacility? [No](#)
(Please see provided data in PE Subcommittee folder)
4. What specialty is the dominant provider in the nonfacility? [Neurology](#)
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different then for the global? [No](#)
(Please see provided data in PE Subcommittee folder)
[95950 – Neurology – 74%](#)
[95951 – IDTF – 51%](#)
[95953 – Neurology – 91%](#)
[95956 – Neurology – 51%](#)
5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
Compelling Evidence for Tab 13 Long Term EEG Codes 95X01 to 95716 (see *Compelling Evidence* handout)
 - Technique (there are now varying levels of monitoring, whereas previously there was only monitored or unmonitored)
 - 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)
 - Technology changes and advancements (improved technology has created more options for remote / ambulatory monitoring of patients in various settings; increased remote video capabilities.)
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time. [N/A](#)
7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: [N/A](#)
8. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

CPT Codes 95707, 95710, 95713, 95716

Specialties: American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN)

Row 54 on spreadsheet CA021:

Actual monitoring time (do not include initial set-up)

(95707 - 120 minutes, 95710 – 360 minutes, 95713 – 120 minutes, 95716 – 360 minutes)

Explanation of monitoring minutes:

2-12-hour codes we assume 8 hours is the typical length of service.

- Continuous: 4 patients is the typical number of patients monitored. 8 times 60 minutes = 480 minutes, divide the 480 by 4 which equals 120 minutes of monitoring.

12-16-hour codes we assume 24 hours is the typical length of service.

- Continuous: 4 patients is the typical number of patients monitored. 24 times 60 minutes = 1440 minutes, divide the 1440 by 4 which equals 360 minutes of monitoring.

Row 55 on PE spreadsheet CA021 total times:

- 95707 – ~~100~~ 60 minutes
- 95710 – ~~126~~ 50 minutes
- 95713 – ~~120~~ 72 minutes
- 95716 – ~~152~~ 65 minutes

CA021 activities are broken out as follows:

In office or remote, real-time EEG monitoring with or without video

(95707 – ~~30~~ 10 minutes, 95710 – ~~40~~ 10 minutes, 95713 – ~~38~~ 10 minutes, 95716 – 44 10 minutes)

- Review patient clinical history, current medications, and prior monitoring notes (follow up on notes from previous sessions)

Maintenance during patient session (do not include initial set-up)

(95707 - 20 minutes, 95710 – 0 minutes, 95713 – 28 minutes, 95716 – 0 minutes)

- Contact/initiate on-call maintenance support, if needed
- Repair electrodes, video (when used), laptop, or other faulty equipment, if needed,
- Validate repairs are complete, if needed
- New electrode placement, if needed
- Check electrode impedances for quality of each new EEG electrode, if needed
- Reposition/reactivate/reset video equipment (when used)
- Reposition/reactivate/reset laptop/computer and internet connections (when used)

Patient/family education

(95707 - ~~10~~ 0 minutes, 95710 – ~~10~~ 0 minutes, 95713 – ~~10~~ 0 minutes, 95716 – ~~10~~ 0 minutes)

Internal communication

(95707 - ~~10~~ 0 minutes, 95710 – ~~10~~ 0 minutes, 95713 – ~~10~~ 0 minutes, 95716 – ~~13~~ 0 minutes)

Prepare data (when done during patient session)

(95707 - 30 minutes, 95710 – 40 minutes, 95713 – 34 minutes, 95716 – 55 minutes)

- Review and prepare data for physician
- Annotate EEG and/or VEEG,

CPT Codes 95707, 95710, 95713, 95716

Specialties: American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN)

- Note spike generator location
- Document technologist initial notes
- send all data to physician for reading.

Row 89 on PE spreadsheet CA038:

Data retrieval and management: (95707 - ~~22~~ 11 minutes, 95710 – 44 22 minutes, 95713 – ~~22~~ 11 minutes, 95716 – 44 22 minutes) Original recommendation based on EXPERT PANEL consistent with current code (95950) – reduced by 50% taking partial automation of the activity into consideration.

- Merge EEG and Video files (partially automated program), confirm transfer of data, delete from laptop/computer if necessary.
- *Associated Equipment time (Row 145 – EQ050) remains 44 and 22 minutes based on crosswalk to activities for RUC reviewed code 95950.*

- If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*
- If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*
- If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*
- If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
- If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
- List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:

Code	Equipment	Codes used
EF003	bedroom furniture (hospital bed, table, reclining chair)	95707, 95713
ED050	Technologist PAC workstation for storing data	95707, 95710, 95713, 95716
EQ016	EEG review station, ambulatory	95707, 95710, 95713, 95716
NEW Equipment	EEG, digital, prolonged testing system, with video, ambulatory	95716

CPT Codes 95707, 95710, 95713, 95716

Specialties: American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN)

EQ014	EEG monitor, digital, portable	95707, 95710
EQ017	EEG, digital, prolonged testing system (computer w-remote camera)	95713

EQ016 EEG review station, ambulatory – monitoring time + total “Prepare data (when done during patient session)” part of the 2nd CA021 and on line 55 of the spreadsheet

15. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: [N/A](#)
16. If there is any other item on your spreadsheet that needs further explanation please include here: [N/A](#)
17. Please include an explanation of each line item:

Specialties: American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN)

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

Meeting Date: October 2018 Revised 10-4-18

CPT code	CPT Long Descriptor	Global Period
95705	Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored	XXX
95708	Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	XXX
95711	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; unmonitored	XXX
95714	Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored	XXX

- Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel: The joint societies including the American Academy of Neurology (AAN), the American Clinical Neurophysiology Society (ACNS), the American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN) surveyed members totaling 5532. We received responses from 139 to 33 completing various aspects of the detailed PE survey tool that was approved by research. Additionally, the AMA staff performed a webinar for any available and interested members of the EEG technologist community, the webinar was recorded and made available for anyone taking the PE survey.

We have included the results of the survey in a separate file attached. The consensus panel reviewed the median and 25th percentile times and the median results of the survey for supplies and equipment.

A consensus panel consisting of EEG technologists, and physicians reviewed the survey data and reference code comparisons noted below to come up with the final recommendations presented in the PE worksheet. In some instances, we accepted the survey median supply and when survey results did not agree with the consensus panels expert opinion, we used the existing inputs.

Upon further review (and discussion with AMA RUC staff) we observed that the minutes for monitoring did not make sense and re-ran the analysis removing those responses that indicated a 0 for the number of monitored patients. Those technologists that responded 0 noted in the comments that they did not personally monitor, rather were the technologist assigned to set up / take down, or to troubleshoot to. Therefore, removing the 0 responses gave us a realistic number of patients that were monitored.

We also carefully reviewed the questions and it appeared to us that the technologists misunderstood the question on monitoring for the time period to mean checking rather than the actual monitoring. We did not see any fields where they would have put the time for the actual monitoring. Therefore, we believe this element was missing after looking at all the other clinical activity times. We added row 54 on the PE spreadsheet and calculated the monitoring times based

Specialties: American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN)

on the typical time and the number of patients that were monitored per the re-run data. In comparing the monitoring time of RUC reviewed code 95956, plus the additional activities for a 24 hour service, we feel the total time is now appropriate.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here: [CPT 95950 and 95953, 95956 \(presented February 2010\) as references plus survey data, reviewed by consensus of experts.](#)
3. Is this code(s) typically billed with an E/M service? **No**
Is this code(s) typically billed with the E/M service in the nonfacility? **No**
(Please see provided data in PE Subcommittee folder)
4. What specialty is the dominant provider in the nonfacility? [Neurology](#)
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different then for the global? **No**
(Please see provided data in PE Subcommittee folder)
[95950 – Neurology – 74%](#)
[95951 – IDTF – 51%](#)
[95953 – Neurology – 91%](#)
[95956 – Neurology – 51%](#)
5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
Compelling Evidence for Tab 13 Long Term EEG Codes 95X01 to 95X13 (see Compelling Evidence handout)
 - Technique (there are now varying levels of monitoring, whereas previously there was only monitored or unmonitored)
 - 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)
 - Technology changes and advancements (improved technology has created more options for remote / ambulatory monitoring of patients in various settings; increased remote video capabilities.)
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time. [N/A](#)
7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: [N/A](#)
8. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

Specialties: American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN)

Row 55 CA021 on PE spreadsheet times:

- 95705 – 30 minutes
- 95708 – 34 minutes
- 95711 – 30 minutes
- 95714– 35 minutes

Prepare data (when done during patient session):

- Review and prepare data for physician
- Annotate EEG and/or VEEG
- Note spike generator location
- Prepare technical description
- Send all data to physician for reading

Row 89 on PE spreadsheet CA038:

Data retrieval and management: (95705 - ~~22~~ 11 minutes, 95708 – 44 22 minutes, 95711 – ~~22~~ 11 minutes, 95714 –44 22 minutes) Original recommendation based on EXPERT PANEL consistent with current code (95950) – reduced by 50% taking partial automation of the activity into consideration.

- Merge EEG and Video files (partially automated program), confirm transfer of data, delete from laptop/computer if necessary.
- *Associated Equipment time (Row 145 – EQ050) remains 44 and 22 minutes based on crosswalk to activities for RUC reviewed code 95950.*

9. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*
10. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*
11. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. *N/A*
12. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
13. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*
14. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:

CPT Codes 95705, 95708, 95711, 95714

Specialties: American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), American Society of Electroneurodiagnostic Technologists (ASET) and American Board of Registration of Electroencephalographic and Evoked Potential Technologists (ABRN)

Code	Equipment	Codes used
ED050	Technologist PAC workstation for storing data	95705, 95708, 95711, 95714
EQ016	EEG review station, ambulatory	95705, 95708, 95711, 95714
EQ015	EEG recorder, ambulatory	95705, 95708
NEW Equipment	EEG, digital, prolonged testing system, with video, ambulatory	95711, 95714

15. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: [N/A](#)

16. If there is any other item on your spreadsheet that needs further explanation please include here: [N/A](#)

17. Please include an explanation of each line item:

CPT Code: 95717 – 95726

**Specialty Society: American Academy of Neurology (AAN), American Clinical
Neurophysiology Society (ACNS),**

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

Meeting Date: October, 2018

CPT code	CPT Long Descriptor	Global Period
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	XXX
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	XXX
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	XXX
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	XXX
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	XXX
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)	XXX
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	XXX
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)	XXX
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	XXX
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)	XXX

Specialty Society: American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS),

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel: [An expert consensus panel \(“panel”\) composed of members of the participating societies familiar with the codes in question and the RUC process met via telephone calls and email exchanges to develop the recommendations.](#)
2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here: [As codes 95717 – 95726 are PC only codes, there are no clinical labor activities associated with the services, only the equipment used by the physician for the professional services. Code 95957 \(presented January 2016\) plus expert panel consensus was chosen for the reference code.](#)
3. Is this code(s) typically billed with an E/M service? [No](#)
Is this code(s) typically billed with the E/M service in the nonfacility? [No](#)
(Please see provided data in PE Subcommittee folder)
[95950 – Neurology – 74%](#)
[95951 – IDTF – 51%](#)
[95953 – Neurology – 91%](#)
[95956 – Neurology – 51%](#)
4. What specialty is the dominant provider in the nonfacility? [Neurology](#)
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different then for the global? [No](#)
(Please see provided data in PE Subcommittee folder)
5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: [N/A](#)
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time. [N/A](#)
7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: [N/A](#)
8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) [N/A](#)
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: [N/A](#)
9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly*

CPT Code: 95717 – 95726

Specialty Society: American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS),

related to physician work time or Perform procedure/service---NOT directly related to physician work time: N/A

10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. N/A
11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: N/A
12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. N/A
13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: N/A
14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: N/A
15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:

EQ013	EEG analysis software
EQ016	EEG review station, ambulatory
16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: N/A
17. If there is any other item on your spreadsheet that needs further explanation please include here: N/A
18. Please include an explanation of each line item:

The equipment minutes for EQ013 (EEG analysis software) is equal to the physician intra service time for each code.

The equipment minutes for EQ016 (EEG review station, ambulatory) is equal to the total physician service time (including pre / intra / post) for each code as it is utilized for the duration of the service.

Tab 13 Long Term EEG PE

	A	B	D	E	F	I	J	M	N	O	P	Q	R
1	RUC Practice Expense Spreadsheet					CURRENT		CURRENT		RECOMMENDED		CURRENT	
2		<p><i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i></p> <p><i>*Please do not modify formulas in gray shaded cells</i></p> <p><i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i></p>				95950		95953		95700		95956	
3		<u>RUC Collaboration Website</u>				Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and		Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalogram (EEG)		Electroencephalogram (EEG) continuous recording, with video when performed, set-up, patient education, and take down when performed		Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalogram	
4	Clinical Activity Code	<p>Meeting Date: October 2018 Revised 10-22-2018</p> <p>Tab: 13</p> <p>Specialty: AAN, ACNS, ASET, ABRN</p>	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute	EEG, each 24 hours 8 Channel		EEG, each 24 hours, unattended		EEG Set Up Typical is with video and 24 hours		EEG, each 24 hours, attended	
5		Assumptions: 2 to 12 hour codes, typical is 8 hours, 12 to 26 hour codes typical is 24 hours. Removed pts = 0 for analysis, then used median # of patient, for continuous all four codes # of patient =3. For intermittent varied and we maxed it out at 12 as the new code will not allow billing if more than 12 patients are monitored and those would default to unmonitored code.				EEG, each 24 hours 8 Channel		EEG, each 24 hours, unattended		EEG Set Up Typical is with video and 24 hours		EEG, each 24 hours, attended	
6		LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
7		GLOBAL PERIOD				XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				\$ 101.33	\$ -	\$ 112.24	\$ -	\$ 60.49	\$ -	\$ 848.83	\$ -
9		TOTAL CLINICAL STAFF TIME	L047B	REETG	0.47	107.0	0.0	112.0	0.0	115.0	0.0	1542.0	0.0
10		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L047B	REETG	0.47	6.0	0.0	6.0	0.0	10.0	0.0	6.0	0.0
11		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L047B	REETG	0.47	57.0	0.0	62.0	0.0	105.0	0.0	1492.0	0.0
12		TOTAL POST-SERVICE CLINICAL STAFF TIME	L047B	REETG	0.47	44.0	0.0	44.0	0.0	0.0	0.0	44.0	0.0
13		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE				\$ 50.29	\$ -	\$ 52.64	\$ -	\$ 54.05	\$ -	\$ 724.74	\$ -
14		PRE-SERVICE PERIOD											
15		Start: Following visit when decision for surgery or procedure made											
16	CA001	Complete pre-service diagnostic and referral forms	L047B	REETG	0.47								
17	CA002	Coordinate pre-surgery services (including test results)	L047B	REETG	0.47	3		3				3	
18	CA003	Schedule space and equipment in facility	L047B	REETG	0.47								
19	CA004	Provide pre-service education/obtain consent	L047B	REETG	0.47	3		3				3	
20	CA005	Complete pre-procedure phone calls and prescription	L047B	REETG	0.47					10			
21	CA006	Confirm availability of prior images/studies	L047B	REETG	0.47								
22	CA007	Review patient clinical extant information and questionnaire	L047B	REETG	0.47								
23	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L047B	REETG	0.47								
30	CA013	Prepare room, equipment and supplies	L047B	REETG	0.47					0			
31		End: When patient enters office/facility for surgery/procedure											
32		SERVICE PERIOD											
33		Start: When patient enters office/facility for surgery/procedure:											
34		Pre-Service (of service period)											
35	CA009	Greet patient, provide gowning, ensure appropriate medical records are	L047B	REETG	0.47	3		3				3	
36	CA010	Obtain vital signs	L047B	REETG	0.47	5		5		3		5	
37	CA011	Provide education/obtain consent	L047B	REETG	0.47					13			
38	CA012	Review requisition, assess for special needs	L047B	REETG	0.47								
39	CA013	Prepare room, equipment and supplies	L047B	REETG	0.47	30		30		12		20	
40	CA014	Confirm order, protocol exam	L047B	REETG	0.47								
41	CA015	Setup scope (nonfacility setting only)	L047B	REETG	0.47								
42	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L047B	REETG	0.47					45			
43	CA017	Sedate/apply anesthesia	L047B	REETG	0.47								
50		Intra-service (of service period)											
51	CA018	Assist physician or other qualified healthcare professional---directly	L047B	REETG	0.47								
52	CA019	Assist physician or other qualified healthcare professional---directly	L047B	REETG	0.47								
53	CA020	Assist physician or other qualified healthcare professional---directly	L047B	REETG	0.47								
54	CA021	Perform procedure/service---NOT directly related to physician work time	L047B	REETG	0.47							720	
55	CA021	Perform procedure/service---NOT directly related to physician work time	L047B	REETG	0.47							720	
62		Post-Service (of service period)											
63	CA011	Provide education/obtain consent	L047B	REETG	0.47					0			
64	CA022	Monitor patient following procedure/service, multitasking 1:4	L047B	REETG	0.47								
65	CA023	Monitor patient following procedure/service, no multitasking	L047B	REETG	0.47								
66	CA024	Clean room/equipment by clinical staff	L047B	REETG	0.47	18		23		22		23	
67	CA025	Clean scope	L047B	REETG	0.47								
68	CA026	Clean surgical instrument package	L047B	REETG	0.47								
69	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L047B	REETG	0.47	1		1				1	
70	CA028	Review/read post-procedure x-ray, lab and pathology reports	L047B	REETG	0.47								
71	CA029	Check dressings, catheters, wounds	L047B	REETG	0.47								

Tab 13 Long Term EEG PE

	A	B	D	E	F	I	J	M	N	O	P	Q	R
1	RUC Practice Expense Spreadsheet					CURRENT		CURRENT		RECOMMENDED		CURRENT	
2		<p><i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i></p> <p><i>*Please do not modify formulas in gray shaded cells</i></p> <p><i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i></p>				95950		95953		95700		95956	
3		<u>RUC Collaboration Website</u>				Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and		Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG)		Electroencephalogram (EEG) continuous recording, with video when performed, set-up, patient education, and take		Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry,	
4	Clinical Activity Code	<p>Meeting Date: October 2018 Revised 10-22-2018</p> <p>Tab: 13</p> <p>Specialty: AAN, ACNS, ASET, ABRN</p>	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute								
5		Assumptions: 2 to 12 hour codes, typical is 8 hours, 12 to 26 hour codes typical is 24 hours. Removed pts = 0 for analysis, then used median # of patient, for continuous all four codes # of patient =3. For intermittent varied and we maxed it out at 12 as the new code will not allow billing if more than 12 patients are monitored and those would default to unmonitored code.				EEG, each 24 hours 8 Channel		EEG, each 24 hours, unattended		EEG Set Up Typical is with video and 24 hours		EEG, each 24 hours, attended	
6		LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
7		GLOBAL PERIOD				XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				\$ 101.33	\$ -	\$ 112.24	\$ -	\$ 60.49	\$ -	\$ 848.83	\$ -
9		TOTAL CLINICAL STAFF TIME	L047B	REEGT	0.47	107.0	0.0	112.0	0.0	115.0	0.0	1542.0	0.0
10		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L047B	REEGT	0.47	6.0	0.0	6.0	0.0	10.0	0.0	6.0	0.0
11		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L047B	REEGT	0.47	57.0	0.0	62.0	0.0	105.0	0.0	1492.0	0.0
12		TOTAL POST-SERVICE CLINICAL STAFF TIME	L047B	REEGT	0.47	44.0	0.0	44.0	0.0	0.0	0.0	44.0	0.0
72	CA030	Technologist QC's images in PACS, checking for all images, reformats,	L047B	REEGT	0.47								
73	CA031	Review examination with interpreting MD/DO	L047B	REEGT	0.47								
74	CA032	Scan exam documents into PACS. Complete exam in RIS system to	L047B	REEGT	0.47								
75	CA033	Perform regulatory mandated quality assurance activity (service period)	L047B	REEGT	0.47								
76	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry	L047B	REEGT	0.47					0			
77	CA035	Review home care instructions, coordinate visits/prescriptions	L047B	REEGT	0.47					10			
78	CA036	Discharge day management	L047B	REEGT	0.47	n/a		n/a		n/a		n/a	
85		End: Patient leaves office											
86		POST-SERVICE PERIOD											
87		Start: Patient leaves office/facility											
88	CA037	Conduct patient communications	L047B	REEGT	0.47								
89	CA038	Coordinate post-procedure services	L047B	REEGT	0.47	44		44				44	
96	CA039	Post-operative visits (total time)	L047B	REEGT	0.47	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
103		End: with last office visit before end of global period											
104	Supply Code	MEDICAL SUPPLIES	PRICE	UNIT									
105		TOTAL COST OF SUPPLY QUANTITY x PRICE				\$ 40.42	\$ -	\$ 53.94	\$ -	\$ 6.17	\$ -	\$ 6.27	\$ -
106	SA002	kit, ambulatory Holter	4.449	kit		1		1					
107	SB006	drape, non-sterile, sheet 40in x 60in	0.222	item		1		1				1	
108	SB022	gloves, non-sterile	0.084	pair		2		2		3		2	
109	SB026	gown, patient	0.533	item		1		1				1	
110	SC034	needle, blunt tip	0.33	item		1		1		1		1	
111	SC051	syringe 10-12ml	0.184	item		1				1		1	
112	SD053	electrode, ECG (single)	0.09	item		2		2		2		2	
113	SD054	electrode, EEG, tin cup (12 pack uou)	18	item		1.5		2		0			
114	SD265	Imaging compatible electrodes								0		24	
115	SG021	bandage, strip 0.75in x 3in (Bandaid)	0.043	item		1						1	
116	SG051	gauze, non-sterile 4in x 4in	0.035	item		10		10		10		10	
117	SG079	tape, surgical paper 1in (Micropore)	0.002	inch		6				0		6	
118	SJ014	collodion (2oz uou)	2.611	item		1		1		1		1	
119	SJ020	electrode conductive gel	0.016	ml		5		5		10		5	
120	SJ022	electrode skin prep gel (NuPrep)	0.056	ml		2		2		5		2	
121	SJ041	povidone soln (Betadine)	0.008	ml		15		15		0		15	
122	SJ053	swab-pad, alcohol	0.013	item		2		2		2		2	
123	SK007	audio cassette tape 60 min	0.76	item		1							
124	SK011	battery, AAA	0.485	item		4				0			
125	SK048	measuring tape, paper	0.041	item		1		1		1		1	
126	SK075	skin marking pen, sterile (Skin Scribe)	1.048	item		1		1		1		1	
127	SL001	acetone	0.014	ml		15		15		15		15	
128	SC055	syringe 3ml	0.096	item				1					
129	SG017	bandage, Kling, non-sterile 2in	0.363	item				20		1			

	A	B	D	E	F	I	J	M	N	O	P	Q	R
1	RUC Practice Expense Spreadsheet					CURRENT		CURRENT		RECOMMENDED		CURRENT	
2		<p><i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i></p> <p><i>*Please do not modify formulas in gray shaded cells</i></p> <p><i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i></p>				95950		95953		95700		95956	
3		<u>RUC Collaboration Website</u>				Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation		Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, interpretation, and take		Electroencephalogram (EEG) continuous recording, with video when performed, set-up, patient education, and take		Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, interpretation	
4	Clinical Activity Code	<p>Meeting Date: October 2018 Revised 10-22-2018</p> <p>Tab: 13</p> <p>Specialty: AAN, ACNS, ASET, ABRN</p>	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute								
5		Assumptions: 2 to 12 hour codes, typical is 8 hours, 12 to 26 hour codes typical is 24 hours. Removed pts = 0 for analysis, then used median # of patient, for continuous all four codes # of patient =3. For intermittent varied and we maxed it out at 12 as the new code will not allow billing if more than 12 patients are monitored and those would default to unmonitored code.				EEG, each 24 hours 8 Channel		EEG, each 24 hours, unattended		EEG Set Up Typical is with video and 24 hours		EEG, each 24 hours, attended	
6		LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
7		GLOBAL PERIOD				XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				\$ 101.33	\$ -	\$ 112.24	\$ -	\$ 60.49	\$ -	\$ 848.83	\$ -
9		TOTAL CLINICAL STAFF TIME	L047B	REEGT	0.47	107.0	0.0	112.0	0.0	115.0	0.0	1542.0	0.0
10		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L047B	REEGT	0.47	6.0	0.0	6.0	0.0	10.0	0.0	6.0	0.0
11		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L047B	REEGT	0.47	57.0	0.0	62.0	0.0	105.0	0.0	1492.0	0.0
12		TOTAL POST-SERVICE CLINICAL STAFF TIME	L047B	REEGT	0.47	44.0	0.0	44.0	0.0	0.0	0.0	44.0	0.0
130	SG077	tape, porous-hypoallergenic 2in (Scanpore)	0.017	inch				6		6			
131	SJ061	tongue depressor	0.012	item						1			
132	SG030	cotton balls, non-sterile	0.004	item						4			
133	SL020	bleach	0.001	ml						1			
134	SK057	paper, laser printing (each sheet)	0.005	item						1			
135	SB036	paper, exam table	0.014	foot						0			
136	SJ041	povidone soln (Betadine)	0.008	ml						0			
137													
138		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A											
140	Equipment Code	EQUIPMENT	Purchase Price	Equipment Formula	Cost Per Minute								
141		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE				\$ 10.62	\$ -	\$ 5.67	\$ -	\$ 0.27	\$ -	\$ 117.82	\$ -
142	EQ047	air compressor, safety	575	Other Formula	0.001400662	69		69		45		51	
143	EF009	chair, medical recliner	829.03	Default	0.002200019	69		69		95			
144	EF003	bedroom furniture (hospital bed, table, reclining chair)	2416.99	Monitoring	0.005887627							771	
145	ED050	Technologist PACS workstation	5557	PACS	0.022017924	69		69					
146	EQ016	EEG review station, ambulatory	7950	Other Formula	0.03149946	69							
147	EQ015	EEG recorder, ambulatory	12500	Other Formula	0.0403454	69				0			
148	EQ014	EEG monitor, digital, portable	17500	Other Formula	0.05648356	69		69					
149	NEW EQUIP	EEG, digital, prolonged testing system with remote video, for patients home use	20000	Other Formula						73			
150	EQ017	EEG, digital, prolonged testing system (computer w-remote camera)	46750	Other Formula	0.146828174					0		771	
151		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A											

Tab 13 Long Term EEG PE

	A	B	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH
1	RUC Practice	Expense Spreadsheet	RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED	
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>	95707		95710		95713		95716		95706		95709		95712		95715	
3		<u>RUC Collaboration Website</u>	Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous real time		Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each increment of 12-24 hours with		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous real time		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-24 hours with		Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring and		Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each increment of 12-24 hours with intermittent		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-24 hours with intermittent	
4	Clinical Activity Code	Meeting Date: October 2018 Revised 10-22-2018 Tab: 13 Specialty: AAN, ACNS, ASET, ABRN	EEG, NO video, 2-12 hrs, continuous monitoring		EEG, NO Video, 12-26 hrs, continuous monitoring		Video-EEG, 2-12 hrs, continuous monitoring		Video-EEG, 12-26 hrs, continuous monitoring		EEG, NO video, 2-12 hrs, intermittent monitoring		EEG, NO Video, 12-26 hrs, intermittent monitoring		Video-EEG, 2-12 hrs, intermittent monitoring		Video-EEG, 12-26 hrs, intermittent monitoring	
5		Assumptions: 2 to 12 hour codes, typical is 8 hours, 12 to 26 hour codes typical is 24 hours. Removed pts = 0 for analysis, then used median # of patient, for continuous all four codes # of patient =3. For intermittent varied and we maxed it out at 12 as the new code will not allow billing if more than 12 patients are monitored and those would default to unmonitored code.																
6		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
7		GLOBAL PERIOD	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 136.26	\$ -	\$ 331.96	\$ -	\$ 185.39	\$ -	\$ 258.15	\$ -	\$ 83.29	\$ -	\$ 177.59	\$ -	\$ 128.63	\$ -	\$ 106.28	\$ -
9		TOTAL CLINICAL STAFF TIME	191.0	0.0	432.0	0.0	203.0	0.0	447.0	0.0	108.0	0.0	192.0	0.0	112.0	0.0	212.0	0.0
10		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	180.0	0.0	410.0	0.0	192.0	0.0	425.0	0.0	97.0	0.0	170.0	0.0	101.0	0.0	190.0	0.0
12		TOTAL POST-SERVICE CLINICAL STAFF TIME	11.0	0.0	22.0	0.0	11.0	0.0	22.0	0.0	11.0	0.0	22.0	0.0	11.0	0.0	22.0	0.0
13		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	\$ 89.77	\$ -	\$ 203.04	\$ -	\$ 95.41	\$ -	\$ 210.09	\$ -	\$ 50.76	\$ -	\$ 90.24	\$ -	\$ 52.64	\$ -	\$ 99.64	\$ -
14		PRE-SERVICE PERIOD																
15		Start: Following visit when decision for surgery or procedure made																
16	CA001	Complete pre-service diagnostic and referral forms																
17	CA002	Coordinate pre-surgery services (including test results)																
18	CA003	Schedule space and equipment in facility																
19	CA004	Provide pre-service education/obtain consent																
20	CA005	Complete pre-procedure phone calls and prescription																
21	CA006	Confirm availability of prior images/studies																
22	CA007	Review patient clinical extant information and questionnaire																
23	CA008	Perform regulatory mandated quality assurance activity (pre-service)																
30	CA013	Prepare room, equipment and supplies																
31		End: When patient enters office/facility for surgery/procedure																
32		SERVICE PERIOD																
33		Start: When patient enters office/facility for surgery/procedure:																
34		Pre-Service (of service period)																
35	CA009	Greet patient, provide gowning, ensure appropriate medical records are																
36	CA010	Obtain vital signs																
37	CA011	Provide education/obtain consent																
38	CA012	Review requisition, assess for special needs																
39	CA013	Prepare room, equipment and supplies																
40	CA014	Confirm order, protocol exam																
41	CA015	Setup scope (nonfacility setting only)																
42	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient																
43	CA017	Sedate/apply anesthesia																
50		Intra-service (of service period)																
51	CA018	Assist physician or other qualified healthcare professional---directly																
52	CA019	Assist physician or other qualified healthcare professional---directly																
53	CA020	Assist physician or other qualified healthcare professional---directly																
54	CA021	Perform procedure/service---NOT directly related to physician work time	120		360		120		360		40		120		40		120	
55	CA021	Perform procedure/service---NOT directly related to physician work time	60		50		72		65		57		50		61		70	
62		Post-Service (of service period)																
63	CA011	Provide education/obtain consent																
64	CA022	Monitor patient following procedure/service, multitasking 1:4																
65	CA023	Monitor patient following procedure/service, no multitasking																
66	CA024	Clean room/equipment by clinical staff																
67	CA025	Clean scope																
68	CA026	Clean surgical instrument package																
69	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions																
70	CA028	Review/read post-procedure x-ray, lab and pathology reports																
71	CA029	Check dressings, catheters, wounds																

Tab 13 Long Term EEG PE

	A	B	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH
1	RUC Practice	Expense Spreadsheet	RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED	
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>	95707		95710		95713		95716		95706		95709		95712		95715	
3		<u>RUC Collaboration Website</u>	Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous monitoring		Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each increment of 12-24 hours with intermittent monitoring		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with continuous monitoring		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-24 hours with intermittent monitoring		Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours; with continuous monitoring		Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each increment of 12-24 hours with intermittent monitoring		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with intermittent monitoring		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of 12-24 hours with intermittent monitoring	
4	Clinical Activity Code	Meeting Date: October 2018 Revised 10-22-2018 Tab: 13 Specialty: AAN, ACNS, ASET, ABRN																
5		Assumptions: 2 to 12 hour codes, typical is 8 hours, 12 to 26 hour codes typical is 24 hours. Removed pts = 0 for analysis, then used median # of patient, for continuous all four codes # of patient =3. For intermittent varied and we maxed it out at 12 as the new code will not allow billing if more than 12 patients are monitored and those would default to unmonitored code.	EEG, NO video, 2-12 hrs, continuous monitoring		EEG, NO Video, 12-26 hrs, continuous monitoring		Video-EEG, 2-12 hrs, continuous monitoring		Video-EEG, 12-26 hrs, continuous monitoring		EEG, NO video, 2-12 hrs, intermittent monitoring		EEG, NO Video, 12-26 hrs, intermittent monitoring		Video-EEG, 2-12 hrs, intermittent monitoring		Video-EEG, 12-26 hrs, intermittent monitoring	
6		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
7		GLOBAL PERIOD	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 136.26	\$ -	\$ 331.96	\$ -	\$ 185.39	\$ -	\$ 258.15	\$ -	\$ 83.29	\$ -	\$ 177.59	\$ -	\$ 128.63	\$ -	\$ 106.28	\$ -
9		TOTAL CLINICAL STAFF TIME	191.0	0.0	432.0	0.0	203.0	0.0	447.0	0.0	108.0	0.0	192.0	0.0	112.0	0.0	212.0	0.0
10		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	180.0	0.0	410.0	0.0	192.0	0.0	425.0	0.0	97.0	0.0	170.0	0.0	101.0	0.0	190.0	0.0
12		TOTAL POST-SERVICE CLINICAL STAFF TIME	11.0	0.0	22.0	0.0	11.0	0.0	22.0	0.0	11.0	0.0	22.0	0.0	11.0	0.0	22.0	0.0
72	CA030	Technologist QC's images in PACS, checking for all images, reformats,																
73	CA031	Review examination with interpreting MD/DO																
74	CA032	Scan exam documents into PACS. Complete exam in RIS system to																
75	CA033	Perform regulatory mandated quality assurance activity (service period)																
76	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry																
77	CA035	Review home care instructions, coordinate visits/prescriptions																
78	CA036	Discharge day management	n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a	
85		End: Patient leaves office																
86		POST-SERVICE PERIOD																
87		Start: Patient leaves office/facility																
88	CA037	Conduct patient communications																
89	CA038	Coordinate post-procedure services	11		22		11		22		11		22		11		22	
96	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
103		End: with last office visit before end of global period																
104	Supply Code	MEDICAL SUPPLIES																
105		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
106	SA002	kit, ambulatory Holter																
107	SB006	drape, non-sterile, sheet 40in x 60in																
108	SB022	gloves, non-sterile																
109	SB026	gown, patient																
110	SC034	needle, blunt tip																
111	SC051	syringe 10-12ml																
112	SD053	electrode, ECG (single)																
113	SD054	electrode, EEG, tin cup (12 pack uou)																
114	SD265	Imaging compatible electrodes																
115	SG021	bandage, strip 0.75in x 3in (Bandaid)																
116	SG051	gauze, non-sterile 4in x 4in																
117	SG079	tape, surgical paper 1in (Micropore)																
118	SJ014	collodion (2oz uou)																
119	SJ020	electrode conductive gel																
120	SJ022	electrode skin prep gel (NuPrep)																
121	SJ041	povidone soln (Betadine)																
122	SJ053	swab-pad, alcohol																
123	SK007	audio cassette tape 60 min																
124	SK011	battery, AAA																
125	SK048	measuring tape, paper																
126	SK075	skin marking pen, sterile (Skin Scribe)																
127	SL001	acetone																
128	SC055	syringe 3ml																
129	SG017	bandage, Kling, non-sterile 2in																

	A	B	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH
1	RUC Practice	Expense Spreadsheet	RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED	
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>	95707		95710		95713		95716		95706		95709		95712		95715	
3		<u>RUC Collaboration Website</u>	Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours; with		Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each increment		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment		Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours; with		Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each increment of		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours; with		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each increment of	
4	Clinical Activity Code	Meeting Date: October 2018 Revised 10-22-2018 Tab: 13 Specialty: AAN, ACNS, ASET, ABRN																
5		Assumptions: 2 to 12 hour codes, typical is 8 hours, 12 to 26 hour codes typical is 24 hours. Removed pts = 0 for analysis, then used median # of patient, for continuous all four codes # of patient =3. For intermittent varied and we maxed it out at 12 as the new code will not allow billing if more than 12 patients are monitored and those would default to unmonitored code.	EEG, NO video, 2-12 hrs, continuous monitoring		EEG, NO Video, 12-26 hrs, continuous monitoring		Video-EEG, 2-12 hrs, continuous monitoring		Video-EEG, 12-26 hrs, continuous monitoring		EEG, NO video, 2-12 hrs, intermittent monitoring		EEG, NO Video, 12-26 hrs, intermittent monitoring		Video-EEG, 2-12 hrs, intermittent monitoring		Video-EEG, 12-26 hrs, intermittent monitoring	
6		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
7		GLOBAL PERIOD	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 136.26	\$ -	\$ 331.96	\$ -	\$ 185.39	\$ -	\$ 258.15	\$ -	\$ 83.29	\$ -	\$ 177.59	\$ -	\$ 128.63	\$ -	\$ 106.28	\$ -
9		TOTAL CLINICAL STAFF TIME	191.0	0.0	432.0	0.0	203.0	0.0	447.0	0.0	108.0	0.0	192.0	0.0	112.0	0.0	212.0	0.0
10		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	180.0	0.0	410.0	0.0	192.0	0.0	425.0	0.0	97.0	0.0	170.0	0.0	101.0	0.0	190.0	0.0
12		TOTAL POST-SERVICE CLINICAL STAFF TIME	11.0	0.0	22.0	0.0	11.0	0.0	22.0	0.0	11.0	0.0	22.0	0.0	11.0	0.0	22.0	0.0
130	SG077	tape, porous-hypoallergenic 2in (Scanpore)																
131	SJ061	tongue depressor																
132	SG030	cotton balls, non-sterile																
133	SL020	bleach																
134	SK057	paper, laser printing (each sheet)																
135	SB036	paper, exam table																
136	SJ041	povidone soln (Betadine)																
137																		
138		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A																
140	Equipment Code	EQUIPMENT																
141		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ 46.49	\$ -	\$ 128.92	\$ -	\$ 89.98	\$ -	\$ 48.06	\$ -	\$ 32.53	\$ -	\$ 87.35	\$ -	\$ 75.99	\$ -	\$ 6.64	\$ -
142	EQ047	air compressor, safety	0		0		0		0		0		0		0		0	
143	EF009	chair, medical recliner	0		0		0		0									
144	EF003	bedroom furniture (hospital bed, table, reclining chair)	480		0		480		0		480		0		480		0	
145	ED050	Technologist PACS workstation	22		44		22		44		22		44		22		44	
146	EQ016	EEG review station, ambulatory	510		1480		514		1495		67		160		70		180	
147	EQ015	EEG recorder, ambulatory	0				0		0		0		0		0		0	
148	EQ014	EEG monitor, digital, portable	480		1440						480		1440		0		0	
149	NEW EQUIP	EEG, digital, prolonged testing system with remote video, for patients home use	0		0				1440		0		0		0		1440	
150	EQ017	EEG, digital, prolonged testing system (computer w-remote camera)	0		0		480		0		0		0		480			
151		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A																

	A	B	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR
1	RUC Practice	Expense Spreadsheet	CURRENT		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED	
2		<p><i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i></p> <p><i>*Please do not modify formulas in gray shaded cells</i></p> <p><i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i></p>	95953		95705		95708		95711		95714	
3		<u>RUC Collaboration Website</u>	Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG,		Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours, unmonitored		Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each hour, unmonitored		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours, unmonitored		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each hour, unmonitored	
4	Clinical Activity Code	<p>Meeting Date: October 2018 Revised 10-22-2018</p> <p>Tab: 13</p> <p>Specialty: AAN, ACNS, ASET, ABRN</p>										
5		Assumptions: 2 to 12 hour codes, typical is 8 hours, 12 to 26 hour codes typical is 24 hours. Removed pts = 0 for analysis, then used median # of patient, for continuous all four codes # of patient =3. For intermittent varied and we maxed it out at 12 as the new code will not allow billing if more than 12 patients are monitored and those would default to unmonitored code.	EEG, each 24 hours, unattended		EEG, NO video, 2-12 hrs, unmonitored		EEG, NO Video, 12-26 hrs, unmonitored		Video-EEG, 2-12 hrs, unmonitored		Video-EEG, 12-26 hrs, unmonitored	
6		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
7		GLOBAL PERIOD	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 122.64	\$ -	\$ 40.07	\$ -	\$ 86.46	\$ -	\$ 91.18	\$ -	\$ 28.86	\$ -
9		TOTAL CLINICAL STAFF TIME	112.0	0.0	41.0	0.0	56.0	0.0	41.0	0.0	57.0	0.0
10		TOTAL PRE-SERVICE CLINICAL STAFF TIME	6.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	62.0	0.0	30.0	0.0	34.0	0.0	30.0	0.0	35.0	0.0
12		TOTAL POST-SERVICE CLINICAL STAFF TIME	44.0	0.0	11.0	0.0	22.0	0.0	11.0	0.0	22.0	0.0
13		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	\$ 52.64	\$ -	\$ 19.27	\$ -	\$ 26.32	\$ -	\$ 19.27	\$ -	\$ 26.79	\$ -
14		PRE-SERVICE PERIOD										
15		Start: Following visit when decision for surgery or procedure made										
16	CA001	Complete pre-service diagnostic and referral forms										
17	CA002	Coordinate pre-surgery services (including test results)	3									
18	CA003	Schedule space and equipment in facility										
19	CA004	Provide pre-service education/obtain consent	3									
20	CA005	Complete pre-procedure phone calls and prescription										
21	CA006	Confirm availability of prior images/studies										
22	CA007	Review patient clinical extant information and questionnaire										
23	CA008	Perform regulatory mandated quality assurance activity (pre-service)										
30	CA013	Prepare room, equipment and supplies										
31		End: When patient enters office/facility for surgery/procedure										
32		SERVICE PERIOD										
33		Start: When patient enters office/facility for surgery/procedure:										
34		Pre-Service (of service period)										
35	CA009	Greet patient, provide gowning, ensure appropriate medical records are	3									
36	CA010	Obtain vital signs	5									
37	CA011	Provide education/obtain consent										
38	CA012	Review requisition, assess for special needs										
39	CA013	Prepare room, equipment and supplies	30									
40	CA014	Confirm order, protocol exam										
41	CA015	Setup scope (nonfacility setting only)										
42	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient										
43	CA017	Sedate/apply anesthesia										
50		Intra-service (of service period)										
51	CA018	Assist physician or other qualified healthcare professional---directly										
52	CA019	Assist physician or other qualified healthcare professional---directly										
53	CA020	Assist physician or other qualified healthcare professional---directly										
54	CA021	Perform procedure/service---NOT directly related to physician work time										
55	CA021	Perform procedure/service---NOT directly related to physician work time			30		34		30		35	
62		Post-Service (of service period)										
63	CA011	Provide education/obtain consent										
64	CA022	Monitor patient following procedure/service, multitasking 1:4										
65	CA023	Monitor patient following procedure/service, no multitasking										
66	CA024	Clean room/equipment by clinical staff	23									
67	CA025	Clean scope										
68	CA026	Clean surgical instrument package										
69	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	1									
70	CA028	Review/read post-procedure x-ray, lab and pathology reports										
71	CA029	Check dressings, catheters, wounds										

Tab 13 Long Term EEG PE

	A	B	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR
1	RUC Practice	Expense Spreadsheet	CURRENT		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED	
2		<p><i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i></p> <p><i>*Please do not modify formulas in gray shaded cells</i></p> <p><i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i></p>	95953		95705		95708		95711		95714	
3		<u>RUC Collaboration Website</u>	Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG,		Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12 hours, monitored		Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each hour, 2-12 hours, monitored		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12 hours, monitored		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each hour, 2-12 hours, monitored	
4	Clinical Activity Code	<p>Meeting Date: October 2018 Revised 10-22-2018</p> <p>Tab: 13</p> <p>Specialty: AAN, ACNS, ASET, ABRN</p>	EEG, each 24 hours, unattended		EEG, NO video, 2-12 hrs, unmonitored		EEG, NO Video, 12-26 hrs, unmonitored		Video-EEG, 2-12 hrs, unmonitored		Video-EEG, 12-26 hrs, unmonitored	
5		Assumptions: 2 to 12 hour codes, typical is 8 hours, 12 to 26 hour codes typical is 24 hours. Removed pts = 0 for analysis, then used median # of patient, for continuous all four codes # of patient =3. For intermittent varied and we maxed it out at 12 as the new code will not allow billing if more than 12 patients are monitored and those would default to unmonitored code.	EEG, each 24 hours, unattended		EEG, NO video, 2-12 hrs, unmonitored		EEG, NO Video, 12-26 hrs, unmonitored		Video-EEG, 2-12 hrs, unmonitored		Video-EEG, 12-26 hrs, unmonitored	
6		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
7		GLOBAL PERIOD	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 122.64	\$ -	\$ 40.07	\$ -	\$ 86.46	\$ -	\$ 91.18	\$ -	\$ 28.86	\$ -
9		TOTAL CLINICAL STAFF TIME	112.0	0.0	41.0	0.0	56.0	0.0	41.0	0.0	57.0	0.0
10		TOTAL PRE-SERVICE CLINICAL STAFF TIME	6.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	62.0	0.0	30.0	0.0	34.0	0.0	30.0	0.0	35.0	0.0
12		TOTAL POST-SERVICE CLINICAL STAFF TIME	44.0	0.0	11.0	0.0	22.0	0.0	11.0	0.0	22.0	0.0
72	CA030	Technologist QC's images in PACS, checking for all images, reformats,										
73	CA031	Review examination with interpreting MD/DO										
74	CA032	Scan exam documents into PACS. Complete exam in RIS system to										
75	CA033	Perform regulatory mandated quality assurance activity (service period)										
76	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry										
77	CA035	Review home care instructions, coordinate visits/prescriptions										
78	CA036	Discharge day management	n/a		n/a		n/a		n/a		n/a	
85		End: Patient leaves office										
86		POST-SERVICE PERIOD										
87		Start: Patient leaves office/facility										
88	CA037	Conduct patient communications										
89	CA038	Coordinate post-procedure services	44		11		22		11		22	
96	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
103		End: with last office visit before end of global period										
104	Supply Code	MEDICAL SUPPLIES										
105		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ 54.20	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
106	SA002	kit, ambulatory Holter	1									
107	SB006	drape, non-sterile, sheet 40in x 60in	1									
108	SB022	gloves, non-sterile	2									
109	SB026	gown, patient	1									
110	SC034	needle, blunt tip	1									
111	SC051	syringe 10-12ml										
112	SD053	electrode, ECG (single)	2									
113	SD054	electrode, EEG, tin cup (12 pack uou)	2									
114	SD265	Imaging compatible electrodes										
115	SG021	bandage, strip 0.75in x 3in (Bandaïd)										
116	SG051	gauze, non-sterile 4in x 4in	10									
117	SG079	tape, surgical paper 1in (Micropore)										
118	SJ014	collodion (2oz uou)	1									
119	SJ020	electrode conductive gel	5									
120	SJ022	electrode skin prep gel (NuPrep)	2									
121	SJ041	povidone soln (Betadine)	15									
122	SJ053	swab-pad, alcohol	2									
123	SK007	audio cassette tape 60 min										
124	SK011	battery, AAA										
125	SK048	measuring tape, paper	1									
126	SK075	skin marking pen, sterile (Skin Scribe)	1									
127	SL001	acetone	15									
128	SC055	syringe 3ml	1									
129	SG017	bandage, Kling, non-sterile 2in	20									

	A	B	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR
1	RUC Practice	Expense Spreadsheet	CURRENT		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED	
2		<p><i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i></p> <p><i>*Please do not modify formulas in gray shaded cells</i></p> <p><i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i></p>	95953		95705		95708		95711		95714	
3		<u>RUC Collaboration Website</u>	Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG,		Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, 2-12		Electroencephalogram (EEG) without video, review of data, technical description by EEG technologist, each		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, 2-12		Electroencephalogram with video (VEEG), review of data, technical description by EEG technologist, each	
4	Clinical Activity Code	<p>Meeting Date: October 2018 Revised 10-22-2018</p> <p>Tab: 13</p> <p>Specialty: AAN, ACNS, ASET, ABRN</p>	EEG, each 24 hours, unattended		EEG, NO video, 2-12 hrs, unmonitored		EEG, NO Video, 12-26 hrs, unmonitored		Video-EEG, 2-12 hrs, unmonitored		Video-EEG, 12-26 hrs, unmonitored	
5		Assumptions: 2 to 12 hour codes, typical is 8 hours, 12 to 26 hour codes typical is 24 hours. Removed pts = 0 for analysis, then used median # of patient, for continuous all four codes # of patient =3. For intermittent varied and we maxed it out at 12 as the new code will not allow billing if more than 12 patients are monitored and those would default to unmonitored code.	EEG, each 24 hours, unattended		EEG, NO video, 2-12 hrs, unmonitored		EEG, NO Video, 12-26 hrs, unmonitored		Video-EEG, 2-12 hrs, unmonitored		Video-EEG, 12-26 hrs, unmonitored	
6		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
7		GLOBAL PERIOD	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
8		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 122.64	\$ -	\$ 40.07	\$ -	\$ 86.46	\$ -	\$ 91.18	\$ -	\$ 28.86	\$ -
9		TOTAL CLINICAL STAFF TIME	112.0	0.0	41.0	0.0	56.0	0.0	41.0	0.0	57.0	0.0
10		TOTAL PRE-SERVICE CLINICAL STAFF TIME	6.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	62.0	0.0	30.0	0.0	34.0	0.0	30.0	0.0	35.0	0.0
12		TOTAL POST-SERVICE CLINICAL STAFF TIME	44.0	0.0	11.0	0.0	22.0	0.0	11.0	0.0	22.0	0.0
130	SG077	tape, porous-hypoallergenic 2in (Scanpore)	6									
131	SJ061	tongue depressor	6									
132	SG030	cotton balls, non-sterile	6									
133	SL020	bleach	6									
134	SK057	paper, laser printing (each sheet)	6									
135	SB036	paper, exam table	6									
136	SJ041	povidone soln (Betadine)	6									
137			6									
138		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A										
140	Equipment Code	EQUIPMENT										
141		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ 15.80	\$ -	\$ 20.80	\$ -	\$ 60.14	\$ -	\$ 71.91	\$ -	\$ 2.07	\$ -
142	EQ047	air compressor, safety	69		0		0		0		0	
143	EF009	chair, medical recliner	69									
144	EF003	bedroom furniture (hospital bed, table, reclining chair)			0		0		0		0	
145	ED050	Technologist PACS workstation	69		22		44		22		44	
146	EQ016	EEG review station, ambulatory			30		34		30		35	
147	EQ015	EEG recorder, ambulatory			480		1440		0		0	
148	EQ014	EEG monitor, digital, portable	69		0		0		0		0	
149	NEW EQUIP	EEG, digital, prolonged testing system with remote video, for patients home use									1440	
150	EQ017	EEG, digital, prolonged testing system (computer w-remote camera)	69						480		0	
151		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A										

	A	B	D	E	F	G	H	I	J	K	L
1	RUC Practice	Expense Spreadsheet				REFERENCE CODE		RECOMMENDED		RECOMMENDED	
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>				95957		95717		95718	
3		RUC Collaboration Website				Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)		EEG, physician review/report 2-12 hours of recording; without video		EEG, physician review/report 2-12 hours of recording; with video	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 13 Specialty: AAN, ACNS	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5		LOCATION				XXX		XXX		XXX	
6		GLOBAL PERIOD									
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				\$ 41.41	\$ -	\$ 1.51	\$ -	\$ 1.73	\$ -
8		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	0.0	0.0	0.0	0.0	0.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	0.0	0.0	0.0	0.0	0.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	0.0	0.0	0.0	0.0	0.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE				\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
13	PRE-SERVICE PERIOD										
14		Start: Following visit when decision for surgery or procedure made									
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37						
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37						
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37						
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37						
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37						
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37						
21	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37						
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37						
29		End: When patient enters office/facility for surgery/procedure									
30	SERVICE PERIOD										
31		Start: When patient enters office/facility for surgery/procedure:									
32		Pre-Service (of service period)									
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	L037D	RN/LPN/MTA	0.37						
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37						
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37						
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37						
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37						
38	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37						
39	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37						
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37						
41	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37						
48		Intra-service (of service period)									
49	CA018	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37						
50	CA019	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37						
51	CA020	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37						
52	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37						
59		Post-Service (of service period)									
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37						
61	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37						
62	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37						
63	CA025	Clean scope	L037D	RN/LPN/MTA	0.37						
64	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37						
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37						
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37						
67	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37						
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,	L037D	RN/LPN/MTA	0.37						
69	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37						
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to	L037D	RN/LPN/MTA	0.37						
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37						
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry	L037D	RN/LPN/MTA	0.37						
73	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37						
74	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	n/a		n/a		n/a	
81		End: Patient leaves office									
82	POST-SERVICE PERIOD										
83		Start: Patient leaves office/facility									
84	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37						
85	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37						
86		Office visits: List Number and Level of Office Visits	MINUTES			# visits	# visits	# visits	# visits	# visits	# visits
87		99211 16 minutes	16								
88		99212 27 minutes	27								
89		99213 36 minutes	36								
90		99214 53 minutes	53								
91		99215 63 minutes	63								
92	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	0.0	0.0	0.0	0.0	0.0	0.0
99		End: with last office visit before end of global period									

	A	B	M	N	O	P	Q	R	S	T	U	V
1	RUC Practice	Expense Spreadsheet	RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED	
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>	95719		95720		95721		95722		95723	
3		<u>RUC Collaboration Website</u>	EEG, physician review / report after each 24 hours; without video		EEG, physician review / report after each 24 hours; with video		EEG, physician review / report at conclusion of study, 36-60 hours of recording, without video		EEG, physician review / report at conclusion of study, 36-60 hours of recording, with video		EEG, physician review / report at conclusion of study, 60-84 hours of recording, without video	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 13 Specialty: AAN, ACNS										
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	XXX		XXX		XXX		XXX		XXX	
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 1.89	\$ -	\$ 2.36	\$ -	\$ 2.68	\$ -	\$ 3.15	\$ -	\$ 3.46	\$ -
8		TOTAL CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
13		PRE-SERVICE PERIOD										
14		Start: Following visit when decision for surgery or procedure made										
15	CA001	Complete pre-service diagnostic and referral forms										
16	CA002	Coordinate pre-surgery services (including test results)										
17	CA003	Schedule space and equipment in facility										
18	CA004	Provide pre-service education/obtain consent										
19	CA005	Complete pre-procedure phone calls and prescription										
20	CA006	Confirm availability of prior images/studies										
21	CA007	Review patient clinical extant information and questionnaire										
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)										
29		End: When patient enters office/facility for surgery/procedure										
30		SERVICE PERIOD										
31		Start: When patient enters office/facility for surgery/procedure:										
32		Pre-Service (of service period)										
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are										
34	CA010	Obtain vital signs										
35	CA011	Provide education/obtain consent										
36	CA012	Review requisition, assess for special needs										
37	CA013	Prepare room, equipment and supplies										
38	CA014	Confirm order, protocol exam										
39	CA015	Setup scope (nonfacility setting only)										
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient										
41	CA017	Sedate/apply anesthesia										
48		Intra-service (of service period)										
49	CA018	Assist physician or other qualified healthcare professional---directly										
50	CA019	Assist physician or other qualified healthcare professional---directly										
51	CA020	Assist physician or other qualified healthcare professional---directly										
52	CA021	Perform procedure/service---NOT directly related to physician work time										
59		Post-Service (of service period)										
60	CA022	Monitor patient following procedure/service, multitasking 1:4										
61	CA023	Monitor patient following procedure/service, no multitasking										
62	CA024	Clean room/equipment by clinical staff										
63	CA025	Clean scope										
64	CA026	Clean surgical instrument package										
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions										
66	CA028	Review/read post-procedure x-ray, lab and pathology reports										
67	CA029	Check dressings, catheters, wounds										
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,										
69	CA031	Review examination with interpreting MD/DO										
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to										
71	CA033	Perform regulatory mandated quality assurance activity (service period)										
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry										
73	CA035	Review home care instructions, coordinate visits/prescriptions										
74	CA036	Discharge day management	n/a		n/a		n/a		n/a		n/a	
81		End: Patient leaves office										
82		POST-SERVICE PERIOD										
83		Start: Patient leaves office/facility										
84	CA037	Conduct patient communications										
85	CA038	Coordinate post-procedure services										
86		Office visits: List Number and Level of Office Visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
87		99211 16 minutes										
88		99212 27 minutes										
89		99213 36 minutes										
90		99214 53 minutes										
91		99215 63 minutes										
92	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
99		End: with last office visit before end of global period										

[illegible]

	A	B	W	X	Y	Z	AA	AB
1	RUC Practice	Expense Spreadsheet	RECOMMENDED		RECOMMENDED		RECOMMENDED	
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>	95724		95725		95726	
3		<u>RUC Collaboration Website</u>	EEG, physician review / report at conclusion of study, 60-84 hours of recording, with video		EEG, physician review / report at conclusion of study, >84 hours of recording, without video		EEG, physician review / report at conclusion of study, >84 hours of recording, with vide	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 13 Specialty: AAN, ACNS						
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	XXX		XXX		XXX	
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 4.09	\$ -	\$ 4.09	\$ -	\$ 5.04	\$ -
8		TOTAL CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
13		PRE-SERVICE PERIOD						
14		Start: Following visit when decision for surgery or procedure made						
15	CA001	Complete pre-service diagnostic and referral forms						
16	CA002	Coordinate pre-surgery services (including test results)						
17	CA003	Schedule space and equipment in facility						
18	CA004	Provide pre-service education/obtain consent						
19	CA005	Complete pre-procedure phone calls and prescription						
20	CA006	Confirm availability of prior images/studies						
21	CA007	Review patient clinical extant information and questionnaire						
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)						
29		End: When patient enters office/facility for surgery/procedure						
30		SERVICE PERIOD						
31		Start: When patient enters office/facility for surgery/procedure:						
32		Pre-Service (of service period)						
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are						
34	CA010	Obtain vital signs						
35	CA011	Provide education/obtain consent						
36	CA012	Review requisition, assess for special needs						
37	CA013	Prepare room, equipment and supplies						
38	CA014	Confirm order, protocol exam						
39	CA015	Setup scope (nonfacility setting only)						
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient						
41	CA017	Sedate/apply anesthesia						
48		Intra-service (of service period)						
49	CA018	Assist physician or other qualified healthcare professional---directly						
50	CA019	Assist physician or other qualified healthcare professional---directly						
51	CA020	Assist physician or other qualified healthcare professional---directly						
52	CA021	Perform procedure/service---NOT directly related to physician work time						
59		Post-Service (of service period)						
60	CA022	Monitor patient following procedure/service, multitasking 1:4						
61	CA023	Monitor patient following procedure/service, no multitasking						
62	CA024	Clean room/equipment by clinical staff						
63	CA025	Clean scope						
64	CA026	Clean surgical instrument package						
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions						
66	CA028	Review/read post-procedure x-ray, lab and pathology reports						
67	CA029	Check dressings, catheters, wounds						
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,						
69	CA031	Review examination with interpreting MD/DO						
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to						
71	CA033	Perform regulatory mandated quality assurance activity (service period)						
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry						
73	CA035	Review home care instructions, coordinate visits/prescriptions						
74	CA036	Discharge day management	n/a		n/a		n/a	
81		End: Patient leaves office						
82		POST-SERVICE PERIOD						
83		Start: Patient leaves office/facility						
84	CA037	Conduct patient communications						
85	CA038	Coordinate post-procedure services						
86		Office visits: List Number and Level of Office Visits	# visits	# visits	# visits	# visits	# visits	# visits
87		99211 16 minutes						
88		99212 27 minutes						
89		99213 36 minutes						
90		99214 53 minutes						
91		99215 63 minutes						
92	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0
99		End: with last office visit before end of global period						

	A	B	W	X	Y	Z	AA	AB
1	RUC Practice Expense Spreadsheet		RECOMMENDED		RECOMMENDED		RECOMMENDED	
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i> <i>*Please do not modify formulas in gray shaded cells</i> <i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>						
3		<u>RUC Collaboration Website</u>						
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 13 Specialty: AAN, ACNS	EEG, physician review / report at conclusion of study, 60-84 hours of recording, with video		EEG, physician review / report at conclusion of study, >84 hours of recording, without video		EEG, physician review / report at conclusion of study, >84 hours of recording, with vide	
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	XXX		XXX		XXX	
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 4.09	\$ -	\$ 4.09	\$ -	\$ 5.04	\$ -
8		TOTAL CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0
100	Supply Code	MEDICAL SUPPLIES						
101		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
102								
110	Equipment Code	EQUIPMENT						
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ 4.09	\$ -	\$ 4.09	\$ -	\$ 5.04	\$ -
112								
113	EQ013	EEG analysis software	0		0		0	
114	EQ016	EEG review station, ambulatory	130		130		160	
115								
116								
117		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A						

Compelling Evidence for Tab 13 Long Term EEG Codes 95700 to 95716 Practice Expense

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)
3. Technology changes and advancements (improved technology has created more options for remote / ambulatory monitoring of patients in various settings; increased remote video capabilities.)

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 brought forward through a RAW review. The joint societies recommended the family go back to CPT for revisions as the services have changed over time. Specifically, as evidenced by a split of PC and TC codes (because the professional services would not match the new possibilities of technical variations) in these services we will now have 13 new codes to describe the technical long-term EEG services. The technical services have 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 of the studies are reported as unmonitored.

Continuous real-time monitoring (may be provided remotely): 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 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 the patients' home with monitoring through advanced technologies.

We have referenced several guidelines from societies for your information.

<https://www.aset.org/i4a/pages/index.cfm?pageid=4190>

<https://www.acns.org/pdf/guidelines/Guideline-14-pocket-version.pdf>

[https://www.acns.org/UserFiles/file/Guideline Twelve Guidelines for Long Term.8.pdf](https://www.acns.org/UserFiles/file/Guideline%20Twelve%20Guidelines%20for%20Long%20Term.8.pdf)

Our compelling arguments are supported and identified in three of the PE approved 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)
3. Technology changes and advancements (improved technology has created more options for remote / ambulatory monitoring of patients in various settings; increased remote video capabilities.)

We therefore request approval of compelling evidence for CPT codes 95700 to 95716.

AMA/Specialty Society RVS Update Committee Summary of Recommendations
****CMS Request - NPRM for 2016 and CMS High Expenditure Procedural Codes****

January 2016

Electroencephalogram (EEG)

Following publication of the 2014 Final Rule, the RUC solicited feedback from the specialties societies regarding CPT codes potentially impacted by the OPPS/ASC Payment Cap. Specialty societies indicated an interest in re-reviewing or validating a recent RUC review for PE only, for 58 of the 211 codes identified through the cap. The PE Subcommittee reviewed the codes identified by specialty societies, grouped by families, at the April 2014 RUC meeting and provide CMS with the recommendations as a sample subset of the codes impacted by the cap. CPT codes 95812 and 95813 were included in these recommendations. CMS chose not to implement the RUC recommendations for 2015, but has reviewed and accepted the recommendations with refinement for 2016. CMS expressed concern about the way the services were selected for review and limiting the review to PE only. The RUC understands CMS' concerns about implementing PE inputs without the corresponding work being reviewed. We analyzed the 58 services that the RUC submitted PE recommendations for and determined that one or more of the following is true of many of the codes: frequency less than 10,000; reviewed for work within the last five years; included in the list of proposed potentially misvalued codes identified through high expenditure by specialty screen that CMS included in the proposed rule for 2016. If you apply these criteria only 6 codes remain. The codes are 10021, 30903, 88333, 88334, 95812 and 95813.

In the NPRM for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 95957 was identified by this screen. This service was presented for review of physician work and practice expense at the January 2016 RUC meeting.

95812 Electroencephalogram (EEG) extended monitoring; 41-60 minutes

The RUC reviewed the survey results from 87 practicing neurologists and agreed with the following survey median physician time components: pre-service evaluation time of 5 minutes, intra-service time of 15 minutes and immediate post-service time of 5 minutes. The RUC discussed the inaccurate physician time currently assigned to the code (intra-service time= 55 minutes). The RUC noted that this past survey was conducted in May 1994 and appeared to, at the time, have significant issues. The CPT descriptor at the time for CPT code 95812 was *EEG monitoring; up to one hour*. It is clear from the survey time that the respondents were confused, as they assigned the entire monitoring time to physician work. After the direct practice expenses became resource-based in 1999, this time discrepancy would not have been allowed. Therefore, the RUC agreed that the current physician time for this service is inaccurate and thus should not be used to discount the current work value.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey's 25th percentile work RVU of 1.20 overestimates the physician work of this service. To determine an appropriate value, the RUC noted that there is no compelling evidence that the current value may be inaccurate and recommends the current work RVU of 1.08. To justify a work RVU of 1.08, the RUC compared the surveyed code to the top key reference code 95816 *Electroencephalogram (EEG); including recording awake and drowsy* (work RVU= 1.08, intra time= 15 minutes) and agreed that since both codes have identical intra-service time and comparable physician work, both services should be valued the same. The RUC also reviewed the second key reference code 95805 *Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness* (work RVU= 1.20, intra time= 20 minutes) and that since the reference code has 5 additional minutes of intra-service time compared to code 95812, the reference code is accurately valued higher. **The RUC recommends a work RVU of 1.08 for CPT code 95812.**

95813 *Electroencephalogram (EEG) extended monitoring; greater than 1 hour*

The RUC reviewed the survey results from 87 practicing neurologists and agreed with the following survey median physician time components: pre-service evaluation time of 5 minutes, intra-service time of 25 minutes and immediate post-service time of 5 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey's 25th percentile work RVU of 1.63, lower than the current value, is appropriate for this code. To justify a work RVU of 1.63, the RUC compared the surveyed code to MPC code 95805 *Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness* (work RVU= 1.20, intra time= 20 minutes) and agreed that since code 95813 has more intra-service time, it is appropriately valued higher than the reference code. The RUC also reviewed CPT codes 93295 *Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional* (work RVU= 1.29, intra time= 22.5) and 95908 *Nerve conduction studies; 3-4 studies* (work RVU= 1.25, intra time= 22 minutes) and agreed that since both these reference services have less intra-service time, the recommended value for 95813 is appropriately valued higher. **The RUC recommends a work RVU of 1.63 for CPT code 95813.**

95957 *Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)*

The RUC reviewed the survey results from 54 practicing neurologists and agreed with the following survey median physician time components: pre-service evaluation time of 15 minutes, intra-service time of 30 minutes and immediate post-service time of 10 minutes. The RUC again noted the inaccurate current intra-service time of 60 minutes for this procedure. When this service was last reviewed in May 1994, this service was surveyed as an add-on code; however it was assigned a XXX global period when it was implemented in 1995. Therefore, the current time included pre- and post-service work and time in the intra-service period. Adjusting for these anomalies, the current survey, which separates these times out, represents only a minor reduction in total time. There exists no clinical basis to discount this minor reduction in time from the current work value.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey's 25th percentile work RVU of 2.00 slightly overestimates the physician work of this service. To determine an appropriate value, the RUC noted that there is no compelling evidence that the current value may be inaccurate and recommends the current work RVU of 1.98. To justify a work RVU of 1.98, the RUC compared the surveyed code to the top two key reference codes 95810 *Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU= 2.50, intra time= 36.5 minutes) and 95939 *Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs* (work RVU= 2.25, intra time= 30 minutes) and agreed that both services, with comparable physician time and work, provide accurate comparisons to ensure the recommended value is accurate. The RUC recommends a work RVU of 1.98 for CPT code 95957.

Practice Expense:

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

Work Neutrality

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

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
95812	Electroencephalogram (EEG) extended monitoring; 41-60 minutes	XXX	1.08 (No Change)
95813	Electroencephalogram (EEG) extended monitoring; greater than 1 hour	XXX	1.63
95957	Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)	XXX	1.98 (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 95812	Tracking Number	Original Specialty Recommended RVU: 1.08
		Presented Recommended RVU: 1.08
Global Period: XXX		RUC Recommended RVU: 1.08
CPT Descriptor: Electroencephalogram (EEG) extended monitoring: 41-60 minutes		

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient has had recurrent episodes of neurologic symptoms suspected to be seizures. An extended EEG to allow sleep without pharmacological sedation is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 15%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 3%

Description of Pre-Service Work: Review relevant portions of the patient's medical record to determine if this type of EEG study is most appropriate for the patient. Review the results of any prior EEG tests performed. Instruct the technologist about any special techniques or montages required

Description of Intra-Service Work: Supervise the technologist's preparation and performance of the test. Review the recorded data including remontage and refilter as needed. Review the activation procedures performed including hyperventilation and photic stimulation. Assess the normal and abnormal findings. Interpret the findings considering the clinical context and determine clinical correlation of the findings based on the patient's history. Generate a diagnostic interpretation report with clinical correlations based on the test's findings.

Description of Post-Service Work: Make appropriate recommendations for further management and communicate with the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2016				
Presenter(s):	Marianna Spanaki, MD, PhD; Marc Nuwer, MD, PhD				
Specialty(s):	American Academy of Neurology; American Clinical Neurophysiology Society				
CPT Code:	95812				
Sample Size:	1251	Resp N:	87	Response: 6.9 %	
Description of Sample:	AAN: A sample of members of the clinical neurophysiology section (current US active members.) ACNS: A sample of current US active members.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	50.00	133.00	1500.00
Survey RVW:	0.50	1.20	1.50	1.80	3.50
Pre-Service Evaluation Time:			5.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	1.00	14.00	15.00	20.00	60.00
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	95812	Recommended Physician Work RVU: 1.08		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	5.00	0.00	5.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	15.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	5.00	0.00	5.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95816	XXX	1.08	RUC Time

CPT Descriptor Electroencephalogram (EEG); including recording awake and drowsy

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95805	XXX	1.20	RUC Time

CPT Descriptor Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99231	XXX	0.76	RUC Time	9,707,427

CPT Descriptor 1 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95805	XXX	1.20	RUC Time	5,387

CPT Descriptor 2 Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 30 % of respondents: 34.4 %

Number of respondents who choose 2nd Key Reference Code: 29 % of respondents: 33.3 %

TIME ESTIMATES (Median)

	CPT Code: <u>95812</u>	Top Key Reference CPT Code: <u>95816</u>	2nd Key Reference CPT Code: <u>95805</u>
Median Pre-Service Time	5.00	5.00	15.00
Median Intra-Service Time	15.00	15.00	20.00
Median Immediate Post-service Time	5.00	6.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	25.00	26.00	50.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

**Top Key
Ref Code**

**2nd Key
Ref Code**

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	0.40	0.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	0.47	0.62
Urgency of medical decision making	0.47	1.03

Technical Skill/Physical Effort (Mean)

Technical skill required	0.13	0.59
Physical effort required	0.53	0.21

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	0.23	0.62
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Outcome depends on the skill and judgment of physician	0.37	0.97
--	------	------

Estimated risk of malpractice suit with poor outcome	0.50	0.76
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INTENSITY/COMPLEXITY MEASURES**Top Key**
Ref Code**2nd Key**
Ref Code**Time Segment (Mean)**

Overall intensity/complexity	0.50	0.76
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Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As part of the 2014 Proposed Rule, CMS identified several codes (including 95812) as potentially misvalued and proposed reductions to the codes as part of the OPPS / ASC payment cap policy proposal. The proposal was to limit the practice expense payment through the physician payment schedule at the lower of two facility payment schedules, either the OPPS or ASC payment schedule. The RUC solicited feedback from specialty societies who were given the opportunity to develop Practice Expense Recommendations at the April 2014 meeting. The AAN reviewed the Practice Expense inputs for 95812 at that time making downward adjustments due to implementation of electronic medical records and to align with other recently RUC reviewed EEG codes. The RUC accepted the specialty society recommendations. CMS had concerns about implementing PE inputs without the corresponding work being reviewed therefore the RUC requested the specialty society survey and submit recommendations for 95812 at the January 2016 meeting.

An expert consensus panel composed of members of the participating societies familiar with the code in question and the RUC process reviewed the results. The panel confirmed the reliability of the survey and feels the 25th percentile RVW of 1.20 does not accurately represent the physician work, therefore **recommends maintaining the existing RVW of 1.08**. This value is supported by the key reference service, 95816 (Electroencephalogram; including recording awake and drowsy) which was surveyed in 2012.

The panel agrees with the survey median pre-service time of 5 minutes as an accurate representation of the work performed. The survey median post-service time of 10 minutes exceeds the current time and the panel asserts is not an appropriate representation of the post-service, rather the current post-service time of 5 minutes should be maintained. The panel further asserts the survey population likely included the report generation time in their post-service estimation, which should be represented in the intra-service time. It is the recommendation of the panel that the 5 minutes estimated for report generation be moved from the post-service to intra-service time; which is supported by the 75th percentile at 20 minutes. **Therefore, the panel recommendation is 5 minutes pre-service / 20 minutes intra service / 5 minutes post service.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.

- ☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95812

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 72435

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This number is three times the 2014 medicare claims reporting data for 95812, which we feel accurately represents the national reporting of this code for one year.

Specialty Neurology Frequency 67365 Percentage 93.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 24,145 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This number is the 2014 Medicare utilization from the RUC database.

Specialty Neurology Frequency 22455 Percentage 93.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Tests

BETOS Sub-classification:

Other tests

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 95812

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 95813	Tracking Number	Original Specialty Recommended RVU: 1.63
		Presented Recommended RVU: 1.63
Global Period: XXX		RUC Recommended RVU: 1.63

CPT Descriptor: Electroencephalogram (EEG) extended monitoring; greater than 1 hour.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient reports recurrent episodes of staring and confusion multiple times a day. Outpatient EEG with extended monitoring is being performed to capture the spells.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 15%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 2%

Description of Pre-Service Work: Review relevant portions of the patient's medical record to determine that this procedure is medically necessary. Review the results of any prior EEG tests performed. Instruct the technologist about any special techniques or montages required.

Description of Intra-Service Work: Supervise the technologist's preparation and performance of the test. Review the 60 minutes or greater of recorded data assessing for background rhythm, and physiologic and abnormal wave form changes (e.g., sharp waves, spike waves, spindles) during wakefulness and sleep, while adjusting the montage and filter accordingly to reduce artifacts and optimize visualization of various wave forms. Review the wave form changes specifically in response to activation procedures performed. Assess the normal and abnormal findings. Interpret the findings considering the clinical context and determine clinical correlation of the findings based on the patient's history. Generate a diagnostic interpretation report with clinical correlations based on the test's findings

Description of Post-Service Work: Make appropriate recommendations for further management and communicate with the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2016				
Presenter(s):	Marianna Spanaki, MD, PhD, MBA; Marc R. Nuwer, MD, PhD				
Specialty(s):	American Academy of Neurology, American Clinical Neurophysiology Society				
CPT Code:	95813				
Sample Size:	1251	Resp N:	87	Response: 6.9 %	
Description of Sample:	US members of the AAN's Clinical Neurophysiology section and current US members of ACNS				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	40.00	100.00	700.00
Survey RVW:	0.50	1.63	1.99	2.35	4.50
Pre-Service Evaluation Time:			5.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	1.00	19.00	25.00	30.00	60.00
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	95813	Recommended Physician Work RVU: 1.63		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	5.00	0.00	5.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	25.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	5.00	0.00	5.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
95864	XXX	1.99	RUC Time

CPT Descriptor Needle electromyography; 4 extremities with or without related paraspinal areas**SECOND HIGHEST KEY REFERENCE SERVICE:**

Key CPT Code	Global	Work RVU	Time Source
95810	XXX	2.50	RUC Time

CPT Descriptor Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95805	XXX	1.20	RUC Time	5,387

CPT Descriptor 1 Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99221	XXX	1.92	RUC Time	1,786,311

CPT Descriptor 2 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 14 **% of respondents:** 16.0 %

Number of respondents who choose 2nd Key Reference Code: 14 **% of respondents:** 16.0 %

TIME ESTIMATES (Median)

	CPT Code: <u>95813</u>	Top Key Reference CPT Code: <u>95864</u>	2nd Key Reference CPT Code: <u>95810</u>
Median Pre-Service Time	5.00	10.00	15.00
Median Intra-Service Time	25.00	50.00	36.50
Median Immediate Post-service Time	5.00	13.50	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	35.00	73.50	66.50
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Intensity & Complexity Rating Scale: (much less= -2.00, somewhat less= -1.00, identical= 0.00, somewhat more= 1.00, much more= 2.00)

	<u>Top Key Ref Code</u>	<u>2nd Key Ref Code</u>
<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of management options that must be considered	0.50	1.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	0.79	0.93
Urgency of medical decision making	1.36	1.50

Technical Skill/Physical Effort (Mean)

Technical skill required	0.43	1.00
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Physical effort required	0.21	0.21
<u>Psychological Stress (Mean)</u>		
The risk of significant complications, morbidity and/or mortality	0.43	1.21
Outcome depends on the skill and judgment of physician	0.71	1.14
Estimated risk of malpractice suit with poor outcome	0.79	1.14

INTENSITY/COMPLEXITY MEASURES**Top Key
Ref Code****2nd Key
Ref Code****Time Segment (Mean)**

Overall intensity/complexity	0.57	1.29
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Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As part of the 2014 Proposed Rule, CMS identified several codes (including 95813) as potentially misvalued and proposed reductions to the codes as part of the OP/PS / ASC payment cap policy proposal. The proposal was to limit the practice expense payment through the physician payment schedule at the lower of two facility payment schedules, either the OP/PS or ASC payment schedule. The RUC solicited feedback from specialty societies who were given the opportunity to develop Practice Expense Recommendations at the April 2014 meeting. The AAN reviewed the Practice Expense of 95813 at that time making downward adjustments to due to implementation of electronic medical records and to align with other recently RUC reviewed EEG codes. The RUC accepted the specialty society recommendations. CMS had concerns about implementing PE inputs without the corresponding work being reviewed therefore the RUC requested the specialty survey and submit recommendations for 95813 at the January 2016 meeting.

An expert consensus panel composed of members of the participating societies familiar with the code in question and the RUC process reviewed the results. The panel confirmed the reliability of the survey and feels the 25th percentile RVW of 1.63 is an accurate representation of the physician work, therefore **recommends the 25th percentile RVW of 1.63.**

The panel agrees with the survey median pre-service time of 5 minutes as an accurate representation of the work performed. The survey median post-service time of 10 minutes is a reduction from the current time which the panel feels could be further reduced as is not an appropriate representation of the post-service activities. The panel further asserts the survey population likely included the report generation time in their post-service estimation, which should be represented in the intra-service time. It is the recommendation of the panel that the 5 minutes estimated for report generation be included in the intra-service time; which is the current time of 30 minutes. **Therefore, the panel recommendation is 5 minutes pre-service / 30 minutes intra service / 5 minutes post service.**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95813

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 66846

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This number is three times the 2014 medicare claims reporting data for 95813, which we feel accurately represents the national reporting of this code for one year.

Specialty Neurology Frequency 64841 Percentage 97.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

22,282 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This number is the 2014 Medicare utilization from the RUC database.

Specialty Neurology Frequency 21614 Percentage 97.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Tests

BETOS Sub-classification:

Other tests

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 95813

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 95957	Tracking Number	Original Specialty Recommended RVU: 1.98
		Presented Recommended RVU: 1.98
Global Period: XXX		RUC Recommended RVU: 1.98

CPT Descriptor: Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with intractable localization-related epilepsy is undergoing presurgical evaluation for resection of the epileptogenic region. Previous (separately reported) EEGs interpreted visually and using automated spike detection suggest right hemispheric onsets. In order to localize the seizure focus with greater accuracy, EEG digital analysis of the previously obtained EEGs is ordered using a 3D single dipole source localization analysis of averaged epileptogenic spikes.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 19%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 4%

Description of Pre-Service Work: Identify portions of previously performed EEG recordings suitable for analysis based on the presence of sufficient epileptic spikes and relative absence of confounding factors such as muscle activity.

Description of Intra-Service Work: The physician reviews each spike's time markings and categories as have been separated and flagged by the EEG technologist. Outlier spikes are reviewed. For each outlier, the physician decides whether to change the spike's category or eliminate it. Spikes in each final category are averaged together. The physician reviews a three-dimensional map of the spike generator location for each spike category that has been co-registered onto the patient's MRI image or displayed in a similar manner so as to correlate the locations with the patient's anatomical structures. Assess the statistical quality of the analysis, and assure that the locations determined are clinically reliable. Review the patient's medical records for clinical correlations with MRI, PET, MEG, video-EEG recordings, neuropsychometric testing, seizure semiology, and other clinical relevant information. Determine if additional mappings are necessary for additional review. Review the technologist's report that identifies location of each identified epileptic spike generators. Compose a report interpreting the meaning of these results in the clinical context of the patient's presentation.

Description of Post-Service Work: Generate digital analysis findings for presentation at surgical case conference. Make appropriate recommendations for further management, e.g. impact on location of proposed surgical cortical resection. Communicate with the referring physician and surgeon.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2016				
Presenter(s):	Marianna Spanaki, MD, PhD, MBA; Marc R. Nuwer, MD, PhD				
Specialty(s):	American Academy of Neurology, American Clinical Neurophysiology Society				
CPT Code:	95957				
Sample Size:	1251	Resp N:	54	Response:	4.3 %
Description of Sample:	US members of the AAN's Clinical Neurophysiology section and current US members of ACNS				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	10.00	50.00	1000.00
Survey RVW:	0.50	2.00	2.45	2.74	6.00
Pre-Service Evaluation Time:			15.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	0.00	20.00	30.00	49.00	240.00
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	95957	Recommended Physician Work RVU: 1.98		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	15.00	0.00	15.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	30.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	10.00	0.00	10.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95810	XXX	2.50	RUC Time

CPT Descriptor Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95939	XXX	2.25	RUC Time

CPT Descriptor Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95861	XXX	1.54	RUC Time	33,081

CPT Descriptor 1 Needle electromyography; 2 extremities with or without related paraspinal areas.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99215	XXX	2.11	RUC Time	9,240,506

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99223	XXX	2.00	RUC Time

CPT Descriptor Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the

patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 21 % of respondents: 38.8 %

Number of respondents who choose 2nd Key Reference Code: 9 % of respondents: 16.6 %

TIME ESTIMATES (Median)

	CPT Code: <u>95957</u>	Top Key Reference CPT Code: <u>95810</u>	2nd Key Reference CPT Code: <u>95939</u>
Median Pre-Service Time	15.00	15.00	15.00
Median Intra-Service Time	30.00	36.50	30.00
Median Immediate Post-service Time	10.00	15.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	55.00	66.50	60.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Intensity & Complexity Rating Scale: (much less= -2.00, somewhat less= -1.00, identical= 0.00, somewhat more= 1.00, much more= 2.00)

	<u>Top Key Ref Code</u>	<u>2nd Key Ref Code</u>
<u>Mental Effort and Judgment (Mean)</u>		
The number of possible diagnosis and/or the number of management options that must be considered	0.52	0.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.43	1.33
Urgency of medical decision making	1.10	0.44

Technical Skill/Physical Effort (Mean)

Technical skill required	1.14	1.33
--------------------------	------	------

Physical effort required	0.67	1.11
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.00	0.44
---	------	------

Outcome depends on the skill and judgment of physician	1.24	0.67
--	------	------

Estimated risk of malpractice suit with poor outcome	0.95	0.56
--	------	------

INTENSITY/COMPLEXITY MEASURES**Top Key
Ref Code****2nd Key
Ref Code****Time Segment (Mean)**

Overall intensity/complexity	1.29	1.33
------------------------------	------	------

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As part of the NPRM for 2016 CMS ran a high expenditure screen across specialties with Medicare allowed charges of \$10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges. Code 95957 was identified in this screen prompting the specialty societies to survey and develop recommendations for the January 2016 meeting.

An expert consensus panel composed of members of the participating societies familiar with the code in question and the RUC process reviewed the results. The panel confirmed the reliability of the survey and feels the 25th percentile RVW of 2.00 is slightly high representation of the physician work, therefore **recommends maintaining the existing RVW of 1.98**. This value is supported by crosswalk comparison to Subsequent Hospital Care code 99223 which has a work RVW of 2.00 and pre / intra / post-times of 10 / 30 / 15 with an IWP/UT of 0.0480.

The panel agrees with the survey median pre-service time of 15 minutes as well as the survey median intra-service time of 30 minutes and the survey median post-service time of 10 minutes, therefore recommends **15 minutes pre-service / 30 minutes intra service / 10 minutes post service**. This recommendation is a reduction to intra-service time of 30 minutes, however an increase to both the pre and post service time. The panel asserts that the current pre / intra / post-service times are not an accurate reflection of the actual service times, specifically as there is no pre or post time currently assigned to the service. The current time allocations across pre / intra / post services times are incorrect due to flawed methodology used to establish time in 1994 when the code was established.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 95957

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 166,785

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This number is three times the 2014 medicare claims reporting data for 95957, which we feel accurately represents the national reporting of this code for one year.

Specialty Neurology Frequency 156778 Percentage 94.00 %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

55,595 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This number is the 2014 Medicare utilization from the RUC database.

Specialty Neurology Frequency 52260 Percentage 94.00 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Tests

BETOS Sub-classification:

Other tests

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 95957

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
3	<div>ISSUE: Electroencephalogram</div> <div>TAB: 50</div>																			
4																				
5																				
6																				
7						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
8	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
9	1st REF	95816	EEG Awake and drowsy	30	0.056			1.08			26	5				15				6
10	2nd REF	95805	Multiple sleep latency test	29	0.026			1.20			50	15				20				15
11	CURRENT	95812	EEG 41-60 minutes		0.016			1.08			65	5				55				5
12	SVY	95812	EEG 41-60 minutes	87	0.078	0.50	1.20	1.50	1.80	3.50	30	5			1	14	15	20	60	10
13	REC	95812	EEG 41-60 minutes		0.057	1.08					25	5				15				5
14																				
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
17	1st REF	95864	Muscle test 4 limbs	14	0.029			1.99			73.5	10				50				13.5
18	2nd REF	95810	Polysom 6/> yrs 4/> paramaters	14	0.050			2.50			66.5	15				37				15
19	CURRENT	95813	EEG over 1 hour		0.035			1.73			60	15				30				15
20	SVY	95813	EEG over 1 hour	87	0.066	0.50	1.63	1.99	2.35	4.50	40	5			1	19	25	30	60	10
21	REC	95813	EEG over 1 hour		0.056	1.63					35	5				25				5
22																				
23						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
24	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
25	1st REF	95810	Polysom 6/> yrs 4/> paramaters	21	0.050			2.50			66.5	15				37				15
26	2nd REF	95939	C motor evoked upr & lwr limb	9	0.053			2.25			60	15				30				15
27	CURRENT	95957	EEG digital analysis		0.033			1.98			60					60				
28	SVY	95957	EEG digital analysis	54	0.063	0.50	2.00	2.45	2.74	6.00	55	15			0	20	30	49	240	10
29	REC	95957	EEG digital analysis		0.047	1.98					55	15				30				10

____50____
Tab Number

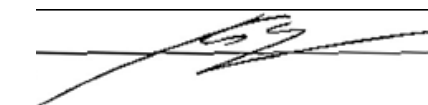
____Electroencephalogram____
Issue

____95812, 95813, 95957____
Code Range

Attestation Statement

This form needs to be completed by any **RUC Advisor** whose specialty society is developing a recommendation to be reviewed by the RUC.

As a RUC Advisor, I attest that the integrity of the RUC survey, summary of recommendation forms and practice expense recommendations are based on accurate and complete data to the best of my knowledge. As a RUC advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair , AMA Representative and Alternate AMA Representative.)



Signature

____Marianna V. Spanaki MD, PhD_____
Printed Signature

____American Academy of Neurology_____
Specialty Society

____12/14/2015_____
Date

50
Tab Number

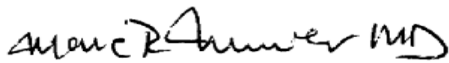
EEG
Issue

95812-95813, 95957
Code Range

Attestation Statement

This form needs to be completed by any **RUC Advisor** whose specialty society is developing a recommendation to be reviewed by the RUC.

As a RUC Advisor, I attest that the integrity of the RUC survey, summary of recommendation forms and practice expense recommendations are based on accurate and complete data to the best of my knowledge. As a RUC advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair , AMA Representative and Alternate AMA Representative.)



Signature

Marc R Nuwer
Printed Signature

American Clinical Neurophysiology Society
Specialty Society

Dec 11, 2015
Date

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs**

CPT Long Descriptor:

Electroencephalogram (EEG) extended monitoring; 41-60 minutes

Global Period: XXX Meeting Date: January 2016

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Advisors and subject matter experts from AAN and ACNS met by phone and via email to review the inputs and make recommendations

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

The PE inputs for 95812 were reviewed and accepted by the RUC in April of 2014, however were reduced as part of the PE Refinement process by CMS in the 2016 Final Rule. The revised PE inputs for 95812 were used as starting point, with adjustments made to reaffirm the inputs previously approved by the RUC which the specialty societies feel accurately reflect the service. The CMS rationale for reducing clinical labor inputs for “assist physician in performing procedure” was to “*refine clinical labor time to match physician intra-service time.*” The specialty society expert panel disagrees as a portion of 95812 is performed and attended by the technologist without the physician present and exceeds the physician time; therefore the clinical labor and physician times are not congruent.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

The specialty societies are reaffirming the PE inputs approved by the PE Subcommittee at the April 2014 meeting. The current inputs reflect PE refinements implemented by CMS as part of the 2016 Final Rule. The societies disagree with the CMS rationale and are requesting the previously RUC approved inputs.

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Review requisition. Assess for special needs. Give patient/family member instructions for test preparation (e.g. hair preparation instructions, etc.) and what to expect on the day of testing. Prepare room, supplies, and equipment.

Intra-Service Clinical Labor Activities:

Greet and gown patient. Explain procedure. Take a brief history. Have patient use the bathroom; position patient for testing. Measure precise head positions and glue on 25-33 electrodes. Check impedances, and correct impedance problems. Calibrate system. Coach patient on how to relax during the testing, and readjust patient position to minimize muscle tension. Record EEG for 50 minutes. Troubleshoot as needed. Monitor continuously for abnormalities. Adjust filters, montages as needed to define better any abnormalities. Hyperventilate patient for 3 minutes, and observe post-hyperventilation state for another 3 minutes. Position photic stimulator, and deliver photic stimulation at 10 frequencies. Document activation techniques and events. Remove electrodes. Wash paste out of patient's hair at each electrode site. Review results. Complete worksheets and technical interpretation. Release patient. Give discharge instructions.

Post-Service Clinical Labor Activities:

Prepare technical and coding worksheet reports. Complete Medical Record and EEG log book. Transfer file onto storage disk. Transfer file onto physician's review station. Restock supplies and clean electrodes.

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs**

CPT Long Descriptor:

Electroencephalogram (EEG) extended monitoring; greater than 1 hour

Global Period: XXX Meeting Date: January 2016

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Advisors and subject matter experts from AAN and ACNS met by phone and via email to review the inputs and make recommendations

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

The PE inputs for 95813 were reviewed and accepted by the RUC in April of 2014, however were reduced as part of the PE Refinement process by CMS in the 2016 Final Rule. The revised PE inputs for 95813 were used as starting point, with adjustments made to reaffirm the inputs previously approved by the RUC which the specialty societies feel accurately reflect the service. The CMS rationale for reducing clinical labor inputs for “assist physician in performing procedure” was to “*refine clinical labor time to match physician intra-service time.*” The specialty society expert panel disagrees as a portion of 95813 is performed and attended by the technologist without the physician present and exceeds the physician time; therefore the clinical labor and physician times are not congruent.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

The specialty societies are reaffirming the PE inputs approved by the PE Subcommittee at the April 2014 meeting. The current inputs reflect PE refinements implemented by CMS as part of the 2016 Final Rule. The societies disagree with the CMS rationale and are requesting the previously RUC approved inputs.

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Review requisition. Assess for special needs. Give patient/family member instructions for test preparation (e.g. hair preparation instructions, etc.) and what to expect on the day of testing. Prepare

room, supplies, and equipment.

Intra-Service Clinical Labor Activities:

Greet and gown patient. Explain procedure. Take a brief history. Have patient use the bathroom; position patient for testing. Measure precise head positions and glue on 25-33 electrodes. Check impedances, and correct impedance problems. Calibrate system. Coach patient on how to relax during the testing, and readjust patient position to minimize muscle tension. Record EEG for 80 minutes. Troubleshoot as needed. Monitor continuously for abnormalities. Adjust filters, montages as needed to define better any abnormalities. Hyperventilate patient for 3 minutes, and observe post-hyperventilation state for another 3 minutes. Position photic stimulator, and deliver photic stimulation at 10 frequencies. Document activation techniques and events. Remove electrodes. Wash paste out of patient's hair at each electrode site. Review results. Complete worksheets and technical interpretation. Release patient. Give discharge instructions

Post-Service Clinical Labor Activities:

Prepare technical and coding worksheet reports. Complete Medical Record and EEG log book. Transfer file onto storage disk. Transfer file onto physician's review station. Restock supplies and clean electrodes.

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs**

CPT Long Descriptor:

Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)

Global Period: XXX Meeting Date: January 2016

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

Advisors and subject matter experts from AAN and ACNS met by phone and via email to review the inputs and make recommendations

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale:

We used the existing PE inputs for 95957, as a starting point and made updates to reflect new time standards and change in technology since that time.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time:

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

The expert panel recommends an intra service time of 111 minutes for the clinical labor activities which is an increase from the current inputs of 30 minutes intra time. Please note the recommended *total* clinical labor time is an increase of 6 minutes (105 – 111). The recommendation of 111 minutes was arrived at by polling active US members of the National Association of Epilepsy Centers on the typical amount of minutes the technologist spends on activities for code 95957. The mean response was 111 minutes, 22 for pre-service activities and 89 minutes for intra-service activities.

The expert panel asserts the existing clinical labor inputs are incorrect due to flawed methodology used to establish clinical labor minutes in 1994 when the code was established. Inputs from existing routine electroencephalogram codes were extrapolated to develop the breakout of minutes based upon the accepted practice in use at that time. This is no longer accurate as the work involved in the digital analysis of an EEG is inherently different from that of a routine EEG.

All supply inputs as well as clinical labor minutes allocated to patient interaction (75 minutes) have been removed as the patient is not present for the service. The reduction in minutes does not signify activities that are no longer performed by the technologist, rather the original inputs were incorrect.

5. Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Import into the analysis system the EEG recordings identified by the physician as suitable for analysis based on the presence of sufficient epileptic spikes and lack of confounding factors.
- Identify that the EEGs were recorded in a manner technically compatible with the dipole analysis software.
- Obtain medical records for use in the clinical correlation.
- Locate, select and obtain digital access to the patient's brain MRI images for co-registration.

Intra-Service Clinical Labor Activities:

- Using spike detection software, run an initial dipole analysis on the averaged spikes in each category.
- Separate and identify each spike's time markings and category for physician review.
- Identify outlier spikes through goodness of fit routines.
- After physician review of outliers, run additional dipole analysis. A three-dimensional map of the spike generator location is created for each spike category.
- Each spike generator location and its dipole direction is co-registered onto the patient's MRI image or displayed in a similar manner so as to correlate the locations with the patient's anatomical structures.
- This process is typically repeated at least one additional time pending physician review and request for additional mappings in order to complete additional review.
- Initiate a template report indicating the location of the identified epileptic spike generators.

Post-Service Clinical Labor Activities:

No post service activities

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	Please note: if a supply has a purchase price of \$100 or more please bold the item name and CMS code.			REFERENCE CODE		REFERENCE CODE				REFERENCE CODE					
2				95812		95812		95813		95813		95857		95857	
3	Meeting Date: January 2016 Tab: 50-REVISED Specialty: AAN, ACNS	CMS Code	Staff Type	Electroencephalogram (EEG) extended monitoring, greater than 41-60 minutes		Electroencephalogram (EEG) extended monitoring, greater than 41-60 minutes		Electroencephalogram (EEG) extended monitoring, greater than 1 hour		Electroencephalogram (EEG) extended monitoring, greater than 1 hour		Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)		Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)	
4	LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
5	GLOBAL PERIOD			XXX		XXX		XXX		XXX		XXX		XXX	
6	TOTAL CLINICAL LABOR TIME	L047B	REETG	108.0	0.0	114.0	6.0	138.0	0.0	148.0	6.0	105.0	0.0	111.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L047B	REETG	6.0	0.0	6.0	6.0	6.0	0.0	6.0	6.0	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L047B	REETG	102.0	0.0	108.0	0.0	132.0	0.0	142.0	0.0	105.0	0.0	111.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L047B	REETG	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10	PRE-SERVICE														
11	Start: Following visit when decision for surgery or procedure made														
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA			3	3			3	3				
13	Coordinate pre-surgery services	L047B	REETG	3				3							
14	Schedule space and equipment in facility														
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3		3	3			3	3				
16	Follow-up phone calls & prescriptions														
17	Other Clinical Activity - specify:														
18	End: When patient enters office/facility for surgery/procedure														
19	SERVICE PERIOD														
20	Start: When patient enters office/facility for surgery/procedure:														
21	Greet patient, provide gowning, ensure appropriate medical records are available	L047B	REETG	3		3		3		3					
22	Obtain vital signs	L047B	REETG	3		0		3		0					
23	Provide pre-service education/obtain consent														
24	Prepare room, equipment, supplies														
25	Setup scope (non facility setting only)														
26	Prepare and position patient/ monitor patient/ set up IV														
27	Sedate/apply anesthesia														
28	Other Clinical Activity - specify: (95812, 95813) Measure and mark head. Apply and secure electrodes to head and chest. Check impedances, reapply electrodes as needed.	L047B	REETG	20		20		20		20					
29	Other Clinical Activity - specify: (95857) Import EEG recordings, confirm EEG recordings are compatible with dipole analysis software, obtain medical records and MRI images for co-registration													22	
30	Intra-service														
31	Perform procedure	L047B	REETG	50		62		80		96					
32	Assist physician/moderate sedation (% of physician time)														
33	Prep and position patient	L047B	REETG									30		0	
34	Calibrate equipment	L047B	REETG									15		0	
35	Teach patient to use equipment	L047B	REETG									5		0	
36	Remove wires from patient and clean patient	L047B	REETG									25		0	
37	Prepare data for physician review 95857 (Prepare dipole analysis data for physician review, generate 3-D mapping and template report of spike generator location)	L047B	REETG									30		89	
38	Post-Service														
39	Monitor pt. following moderate sedation														
40	Monitor pt. following service/check tubes, monitors, drains (not related to moderate sedation)														
41	Clean room/equipment by physician staff	L047B	REETG	3		3		3		3					
42	Clean Scope														
43	Clean Surgical Instrument Package														
44	Complete diagnostic forms, lab & X-ray requisitions	L047B	REETG	3		0		3		0					
45	Review/read X-ray, lab, and pathology reports														
46	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions														
47	Other Clinical Activity - specify: clean patient, remove electrodes	L047B	REETG	20		20		20		20					
48	Dischrg mgmt same day (0.5 x 99238) (enter 6 min)			n/a		n/a		n/a		n/a		n/a		n/a	
49	Dischrg mgmt (1.0 x 99238) (enter 12 min)			n/a		n/a		n/a		n/a		n/a		n/a	
50	Dischrg mgmt (1.0 x 99239) (enter 15 min)			n/a		n/a		n/a		n/a		n/a		n/a	
51	End: Patient leaves office														
52	POST-SERVICE Period														
53	Start: Patient leaves office/facility														
54	Conduct phone calls/call in prescriptions														
55	Office visits: List Number and Level of Office Visits			# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
56	99211 16 minutes		16												
57	99212 27 minutes		27												
58	99213 36 minutes		36												
59	99214 53 minutes		53												
60	99215 63 minutes		63												
61	Total Office Visit Time			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
62	Other Clinical Activity - specify:														
63	Prepare technician report in EEG file	L047B	REETG	3		3		3		3					
64	Enter patient information into laboratory log book	L047B	REETG	0				0							
65	Transfer data to reading station & archive data	L047B	REETG	2		2		2		2					
66	End: with last office visit before end of global period														
67	MEDICAL SUPPLIES*	CODE	UNIT												
68	pack, minimum multi-specialty visit	SA048	pack												
69	electrode, EEG, tin cup (12 pack uou)	S0054	item	2		2		2		2					
70	electrode skin prep gel (NuPrep)	SJ022	ml	100		100		100		100		10		0	
71	collodion (2oz uou)	SJ014	item	1		1		1		1		1		0	
72	bandage, Kling, non-sterile 2in	SG017	item	2		2		2		2		20		0	
73	gown, patient	SB026	item	1		1		1		1		1		0	
74	needle, blunt tip	SC034	item	1		1		1		1		1		0	
75	drape, non-sterile, sheet 40in x 60in	SB006	item	1		1		1		1		1		0	
76	paper, exam table	SB036	foot									7		0	
77	acetone	SL001	ml	15		15		15		15		15		0	
78	electrode, ECG (single)	S0053	item	3		3		3		3		2		0	
79	gloves, non-sterile	SB022	pair	1		1		1		1		2		0	
80	skin marking pen, sterile (Skin Scribe)	SK075	item	0.1		0.1		0.1		0.1					
81	syringe 3ml	SC055	item	1		1		1		1		1		0	
82	tape, surgical paper 1in (Micropore)	SG079	inch	42		42		42		42					
83	electrode conductive gel	SJ020	ml	5		5		5		5		1		0	
84	povidone soln (Betadine)	SJ041	ml	10		10		10		10		10		0	
85	measuring tape, paper	SK048	item	1		1		1		1		1		0	
86	gauze, non-sterile 4in x 4in	SG051	item	1		1		1		1					
87	gauze, sterile 4in x 4in (10 pack uou)	SG056	item									1		0	
88	swab-pad, alcohol	SJ053	item	2		2		2		2		2		0	
89	tape, porous-hypoallergenic 2in (Scanpore)	SG077	inch									6		0	
90	EQUIPMENT	CODE													
91	bedroom furniture (hospital bed, table, reclining chair)	EF003		99		108		129		142					
92	air compressor, safety	EQ047		20		20		20		20					
93	EEG, digital, prolonged testing system (computer with remote camera)	EQ017		99		108		129		142					
94	EEG review station, ambulatory	EQ016		20		20		30		30				141	
95	EEG analysis software	EQ013										90		119	
96	PACS Workstation Proxy	ED050										105			

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Work Neutrality (CPT 2016)

October 2018

Intravascular Ultrasound

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 1.80 for CPT code 37252.**

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.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
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)	ZZZ	1.80
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)	ZZZ	1.44

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 37252	Tracking Number	Original Specialty Recommended RVU: 1.80
		Presented Recommended RVU: 1.80
Global Period: ZZZ	Current Work RVU: 1.80	RUC Recommended RVU: 1.80

CPT Descriptor: Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During a lower extremity endovascular arterial revascularization, a 70-year-old male with a complex lesion requires intravascular ultrasound to facilitate treatment of an initial vessel. Note: This is an add-on service. Only consider the additional work related to the intravascular ultrasound of the initial vessel.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is;
Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The risks, benefits, potential complications, and alternatives to the procedure are discussed with the patient and informed consent is obtained.

Description of Intra-Service Work: The patient undergoes lower extremity angiography from a common femoral access for the evaluation and treatment of peripheral arterial disease (reported separately). The intravascular ultrasound catheter is introduced over a guidewire and the area of interest is evaluated. The catheter is advanced, images are taken, color flow is assessed, and plaque morphology is evaluated. After all appropriate data are collected and recorded, the catheter is removed. Endovascular intervention is performed (reported separately), and the catheter is reinserted to assess technical adequacy. The intravascular ultrasound images are reviewed along with any additional information to be dictated into the final operative report.

Description of Post-Service Work: The final operative report is dictated, reviewed, and signed. Results of the procedure are discussed with the patient and the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Matthew Sideman, MD, Francesco Aiello, MD, Michael Hall, MD, Curtis Anderson, MD, John Blebea, MD, Richard Wright, MD, Edward Tuohy, MD and Clifford Kavinsky, MD				
Specialty Society(ies):	SVS, SIR, ACPH, ACC and SCAI				
CPT Code:	37252				
Sample Size:	3350	Resp N:	103	Response: 3.0 %	
Description of Sample:	random samples of the specialty memberships				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	10.00	30.00	250.00
Survey RVW:	0.58	1.80	2.00	2.50	6.00
Pre-Service Evaluation Time:			5.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	4.00	15.00	20.00	30.00	90.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the **pre-service** time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	37252	Recommended Physician Work RVU: 1.80		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	1.00	0.00	1.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	20.00			
Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
ZZZ Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	1.00	0.00	1.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92978	ZZZ	1.80	RUC Time

CPT Descriptor 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)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92979	ZZZ	1.44	RUC Time

CPT Descriptor 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)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64480	ZZZ	1.20	RUC Time	22,183

CPT Descriptor 1 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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99292	ZZZ	2.25	RUC Time	530,403

CPT Descriptor 2 Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 47 **% of respondents:** 45.6 %

Number of respondents who choose 2nd Key Reference Code: 15 **% of respondents:** 14.5 %

TIME ESTIMATES (Median)

	CPT Code: <u>37252</u>	Top Key Reference CPT Code: <u>92978</u>	2nd Key Reference CPT Code: <u>92979</u>
Median Pre-Service Time	1.00	0.00	0.00
Median Intra-Service Time	20.00	25.00	25.00
Median Immediate Post-service Time	1.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	22.00	25.00	25.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	2%	70%	26%	2%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	2%	70%	28%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	9%	76%	15%

Physical effort required	2%	85%	13%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

26%

68%

6%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	7%	73%	13%	7%
------------------------------	----	----	-----	-----	----

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

20%

67%

13%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	7%	80%	13%
--------------------------	----	-----	-----

Physical effort required	0%	87%	13%
--------------------------	----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

20%

73%

7%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

In the NPRM for 2015 MPFS (July 2014), a stakeholder requested that CMS establish non-facility PE RVUs for CPT codes 37250 and 37251. In September 2014, the RUC recommended to refer this issue to CPT. At the October 2014 CPT meeting, CPT codes 37250 and 37251 (and the corresponding S&I codes 75945 and 75946) were deleted and new bundled codes were developed to describe Intravascular Ultrasound (IVUS); 37252 bundled 37250 and 75945; 37253

bundled 37251 and 75946. These recommendations for these newly bundled services represented a reduction in wRVUs compared to how the service was formerly reported with component coding. Future utilization was projected based on available Medicare claims data and estimates of future utilization in the non-facility setting.

In January 2018 the RAW identified these two services as not meeting the work neutrality projections. The specialties agreed to analyze the utilization data for the following RUC/RAW meeting. At the April 2018 RUC meeting, the specialty societies noted that the reported together data indicates that there is not one service or family dominating utilization with these services. The specialties agreed that they underestimated the number of services performed in the non-facility setting.

The RAW recommended at the April 2018 meeting that these services be surveyed for October 2018, noting that there must be something driving the increased utilization. The RAW indicated that the specialty societies should research why there was such an increase in the utilization (possible compelling evidence). Additionally, the RAW believed that the vignette for 37253 may need to be changed based Medicare ICD-10 data that shows the typical diagnosis is venous.

The multispecialty groups conducted a physician work surveys for CPT Codes 37252 and 37253. The specialties revised the vignette for CPT Code 37253 to reflect the ICD10 data in the RUC database.

Vignette Error

The vignettes in the RUC database for 37252 is incorrect.. Code 37252 should say single vessel: *A 70-year-old male undergoes lower extremity endovascular arterial revascularization. He has a complex lesion that requires intravascular ultrasound to facilitate treatment of a single second vessel.* AMA staff have confirmed there is an error in the database and will update it in the next version of the database.

Work Neutrality

Utilization and budget neutrality estimates for the 2015 SORs were made using 2013 Medicare PFS utilization from the RUC database when the service was only provided in the facility. We believe that work neutrality should only have been measured for facility work RVUs and that adding a site of service per CMS request (ie, office) is not part of work neutrality. This was not a case of taking one code and splitting it into multiple codes. Instead, four codes were bundled into two codes and reduced work RVUs were recommended based on the survey 25th percentile and not based on a reduction in work.

Compelling Evidence

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 neutrality. 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. We believe 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.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37252

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty vascular surgery How often? Commonly

Specialty cardiology How often? Commonly

Specialty interventional radiology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. A national estimate is not available

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 32,209

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Current RUC database (2017 utilization data)

Specialty vascular surgery	Frequency 13206	Percentage 41.00 %
Specialty cardiology	Frequency 10307	Percentage 32.00 %
Specialty interventional radiology	Frequency 5154	Percentage 16.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Imaging

BETOS Sub-classification:

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 37252

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 37253	Tracking Number	Original Specialty Recommended RVU: 1.44
		Presented Recommended RVU: 1.44
Global Period: ZZZ	Current Work RVU: 1.44	RUC Recommended RVU: 1.44

CPT Descriptor: 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)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During a venogram, a 40-year-old female with a suspected central venous lesion requires intravascular ultrasound to facilitate treatment of an additional vessel. Note: This is an add-on service. Only consider the additional work related to the intravascular ultrasound of an additional vessel.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: There is no additional preservice work for an additional vessel.

Description of Intra-Service Work: The patient undergoes lower extremity angiography from a common femoral access for the evaluation and treatment of peripheral arterial disease (reported separately). The intravascular ultrasound catheter is introduced over a guidewire and the area of interest in the additional vessel is evaluated. The catheter is advanced, images are taken, color flow is assessed, and plaque morphology is evaluated. After all appropriate data are collected and recorded, the catheter is removed. Endovascular intervention is performed (reported separately), and the catheter is reinserted to assess technical adequacy. The intravascular ultrasound images are reviewed along with any additional information to be dictated into the final operative report.

Description of Post-Service Work: The final operative report is dictated, reviewed, and signed. Results of the procedure are discussed with the patient and the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Matthew Sideman, MD, Francesco Aiello, MD, Michael Hall, MD, Curtis Anderson, MD, John Blebea, MD, Richard Wright, MD, Edward Tuohy, MD and Clifford Kavinsky, MD				
Specialty Society(ies):	SVS, SIR, ACPH, ACC and SCAI				
CPT Code:	37253				
Sample Size:	3350	Resp N:	73	Response: 2.1 %	
Description of Sample:	random samples of the specialty memberships				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	10.00	30.00	200.00
Survey RVW:	0.95	1.44	1.80	2.00	3.00
Pre-Service Evaluation Time:			5.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	3.00	10.00	20.00	30.00	90.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the **pre-service** time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	37253	Recommended Physician Work RVU: 1.44		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	0.00	0.00	0.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	20.00			
Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
ZZZ Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	1.00	0.00	1.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92978	ZZZ	1.80	RUC Time

CPT Descriptor 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)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92979	ZZZ	1.44	RUC Time

CPT Descriptor 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)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64480	ZZZ	1.20	RUC Time	22,183

CPT Descriptor 1 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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99292	ZZZ	2.25	RUC Time	530,403

CPT Descriptor 2 Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 27 **% of respondents:** 36.9 %

Number of respondents who choose 2nd Key Reference Code: 23 **% of respondents:** 31.5 %

TIME ESTIMATES (Median)

	CPT Code: <u>37253</u>	Top Key Reference CPT Code: <u>92978</u>	2nd Key Reference CPT Code: <u>92979</u>
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	20.00	25.00	25.00
Median Immediate Post-service Time	1.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	21.00	25.00	25.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	7%	78%	15%	0%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	4%	74%	22%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	15%	78%	7%

Physical effort required	11%	85%	4%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

22%

70%

7%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	26%	61%	13%	0%
------------------------------	----	-----	-----	-----	----

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

9%

74%

17%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	13%	70%	17%
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Physical effort required	13%	78%	9%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

43%

48%

9%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

In the NPRM for 2015 MPFS (July 2014), a stakeholder requested that CMS establish non-facility PE RVUs for CPT codes 37250 and 37251. In September 2014, the RUC recommended to refer this issue to CPT. At the October 2014 CPT meeting, CPT codes 37250 and 37251 (and the corresponding S&I codes 75945 and 75946) were deleted and new bundled codes were developed to describe Intravascular Ultrasound (IVUS); 37252 bundled 37250 and 75945; 37253

bundled 37251 and 75946. These recommendations for these newly bundled services represented a reduction in wRVUs compared to how the service was formerly reported with component coding. Future utilization was projected based on available Medicare claims data and estimates of future utilization in the non-facility setting.

In January 2018 the RAW identified these two services as not meeting the work neutrality projections. The specialties agreed to analyze the utilization data for the following RUC/RAW meeting. At the April 2018 RUC meeting, the specialty societies noted that the reported together data indicates that there is not one service or family dominating utilization with these services. The specialties agreed that they underestimated the number of services performed in the non-facility setting.

The RAW recommended at the April 2018 meeting that these services be surveyed for October 2018, noting that there must be something driving the increased utilization. The RAW indicated that the specialty societies should research why there was such an increase in the utilization (possible compelling evidence). Additionally, the RAW believed that the vignette for 37253 may need to be changed based Medicare ICD-10 data that shows the typical diagnosis is venous.

The multispecialty groups conducted a physician work surveys for CPT Codes 37252 and 37253. The specialties revised the vignette for CPT Code 37253 to reflect the ICD10 data in the RUC database.

Work Neutrality

Utilization and budget neutrality estimates for the 2015 SORs were made using 2013 Medicare PFS utilization from the RUC database when the service was only provided in the facility. We believe that work neutrality should only have been measured for facility work RVUs and that adding a site of service per CMS request (ie, office) is not part of work neutrality. This was not a case of taking one code and splitting it into multiple codes. Instead, four codes were bundled into two codes and reduced work RVUs were recommended based on the survey 25th percentile and not based on a reduction in work.

Compelling Evidence

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 neutrality. 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. We believe 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.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 37253

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty vascular surgery How often? Commonly

Specialty cardiology How often? Commonly

Specialty interventional radiology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. A national estimate is not available

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 38,310

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Current RUC database (2017 utilization data).

Specialty vascular surgery	Frequency 16857	Percentage 44.00 %
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Specialty cardiology	Frequency 11494	Percentage 30.00 %
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Specialty interventional radiology	Frequency 5747	Percentage 15.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Imaging

BETOS Sub-classification:

Imaging/procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 37253

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR	AS
13	ISSUE: Intravascular Ultrasound																								
14	TAB: 14																								
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
17	1st REF	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)	47	0.072			1.80			25	0					25			0					
18	2nd REF	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)	15	0.058			1.44			25	0					25			0					
19	current	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)		0.088			1.80			22	1					20			1					
20	SVY	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)	103	0.089	0.58	1.80	2.00	2.50	6.00	30	5			4	15	20	30	90	5	0	5	10	30	250
21	REC				0.088	1.80					22	1					20			1					
22																									
23						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
24	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
25	1st REF	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)	27	0.072			1.80			25	0					25			0					
26	2nd REF	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)	23	0.058			1.44			25	0					25			0					
27	CURRENT	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)		0.071			1.44			21	0					20			1					
28	SVY	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)	73	0.079	0.95	1.44	1.80	2.00	3.00	30	5			3	10	20	30	90	5	0	5	10	30	200
29	REC				0.071	1.44					21	0					20			1					

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	
5	ISSUE: Excision of bone																																								
6	TAB: 84																																								
7						RVW					Total	PRE			INTRA					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged						
8	source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	
9	1st REF	11111	xyz	30	0.029			4.25			131	5	5	5			30			5	1					1.0					1										
10	2nd REF	22222	def	15	0.055			5.15			137	10	5	5			35			5						1.0					1					1					
11	CURRENT	55555	abc		0.053			5.00			133	17						27			8	1					1.0					1									
12	SVY	55555	abc	78	0.045	2.00	3.00	5.00	7.00	8.00	146	10	5	10	15	20	30	35	40	10	1					1.0					1										
13	REC	55555	abc		0.020	4.25					142	17	1	3			30			10										1	1.0	1									
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AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

Global Period: ZZZ

Meeting Date: October 2018

CPT Long Descriptor:

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)

37253 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

SVS, SIR, ACC, SCAI and ACPH convened a panel that included a number of experts to evaluate the direct practice expense inputs for these IVUS procedures.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

CPT Codes 37252 and 37253 are existing CPT codes. As such, we included the current direct practice expense inputs on the PE spreadsheet.

**3. Is this code(s) typically billed with an E/M service?
Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)**

Codes not typically billed with E/M

- 37252 – 3%
- 37253 – 5%

Code not typically billed with E/M service in the NF

- 37252 – 5%
- 37243 – 7%

4. **What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different then for the global?
(Please see provided data in PE Subcommittee folder)**

NF (All, global and 26)

- 37252 – 41% Vascular Surgery
- 37253 – 44% Vascular Surgery

NF (Global and TC)

- 37252 – 51% Vascular Surgery
- 37253 – 35% Vascular Surgery

5. **If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:**

N/A

6. **If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.**

N/A

7. **If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:**

N/A

8. **How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code)
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:**

N/A

- 9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time or Perform procedure/service---NOT directly related to physician work time*:**

Clinical staff utilized during the intraservice time are one Angio tech (L041A) and one Nurse (L037D)/Tech (L041A) Blend at (25%/75%). The Angio tech is scrubbed in to the procedure and functions as a hip-to-hip assistant during the entire procedure. The nurse/tech blend performs both imaging duties and assists with retrieving product and plays a supportive role during the procedure. In addition, this staff member monitors and supports the patient.

- 10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.**

Acquire Images (75%) and Circulator (25%) – current interventional model for the second clinical staff. The nurse tech blend performs both imaging duties and assists with retrieving product and plays a supportive role during the procedure.

- 11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:**

N/A

- 12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.**

N/A

- 13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:**

N/A

- 14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:**

N/A

- 15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:**

ES047	IVUS system	Default
EL011	room, angiography	Highly Technical
ED050	Technologist PACS workstation	PACS

- 16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:**

N/A

- 17. If there is any other item on your spreadsheet that needs further explanation please include here:**

N/A

- 18. Please include an explanation of each line item:**

SD173	guidewire, low profile (SpartaCore)	Stiff supportive guidewire required for safe introduction and guidance of IVUS catheter.
SD304	IVUS catheter	Disposable catheter has integrated ultrasound transducer to capture images.
SD305	IVUS Catheter Sterile Cover	Cover for wire exiting IVUS catheter and junction box with IVUS module.

[illegible]

	A	B	O	P
1	RUC Practice Expense Spreadsheet		RECOMMENDED	
2	AtMeeting	Meeting Date: October 2018 Tab: 14 Intravascular Ultrasound Specialty: SVS, SIR, ACC, SCAI, ACPH	37253	
3		RUC Collaboration Website	Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each	
4	Clinical Activity Code	Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment "		
5		LOCATION	Non Fac	Facility
6		GLOBAL PERIOD	ZZZ	ZZZ
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 133.19	\$ -
8		TOTAL CLINICAL STAFF TIME	43	0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0	0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME (L041A)	38	0
11		TOTAL SERVICE PERIOD CLINICAL STAFF TIME (L037D)	5	0
12		TOTAL POST-SERVICE CLINICAL STAFF TIME	0	0
13		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	\$ 17.43	\$ -
14		PRE-SERVICE PERIOD		
31		SERVICE PERIOD		
32		Start: When patient enters office/facility for surgery/procedure:		
33		Pre-Service (of service period)		
49		Intra-service (of service period)		
50	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)	20	
51	CA019	Assist physician or other qualified healthcare professional---directly		
52	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other%)	15	
53	CA020	Assist physician or other qualified healthcare professional---directly	5	
54	CA021	Perform procedure/service---NOT directly related to physician work time		
61		Post-Service (of service period)		
62	CA022	Monitor patient following procedure/service, multitasking 1:4		
63	CA023	Monitor patient following procedure/service, no multitasking		
64	CA024	Clean room/equipment by clinical staff		
65	CA025	Clean scope		
66	CA026	Clean surgical instrument package		
67	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions		
68	CA028	Review/read post-procedure x-ray, lab and pathology reports		
69	CA029	Check dressings, catheters, wounds		
70	CA030	Technologist QC's images in PACS, checking for all images, reformats,	1	
71	CA031	Review examination with interpreting MD/DO	1	
72	CA032	Scan exam documents into PACS. Complete exam in RIS system to	1	
73	CA033	Perform regulatory mandated quality assurance activity (service period)		
74	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry		
75	CA035	Review home care instructions, coordinate visits/prescriptions		
76	CA036	Discharge day management	n/a	
83		End: Patient leaves office		
84		POST-SERVICE PERIOD		
85		Start: Patient leaves office/facility		
86	CA037	Conduct patient communications		
87	CA038	Coordinate post-procedure services		
88		Office visits: List Number and Level of Office Visits	# visits	# visits
94	CA039	Post-operative visits (total time)	0.0	0.0
101		End: with last office visit before end of global period		

	A	B	O	P
1	RUC Practice Expense Spreadsheet		RECOMMENDED	
2	AtMeeting	Meeting Date: October 2018 Tab: 14 Intravascular Ultrasound Specialty: SVS, SIR, ACC, SCAI, ACPH	37253	
3		RUC Collaboration Website	Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each	
4	Clinical Activity Code	Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment "		
5		LOCATION	Non Fac	Facility
6		GLOBAL PERIOD	ZZZ	ZZZ
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 133.19	\$ -
8		TOTAL CLINICAL STAFF TIME	43	0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0	0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME (L041A)	38	0
11		TOTAL SERVICE PERIOD CLINICAL STAFF TIME (L037D)	5	0
12		TOTAL POST-SERVICE CLINICAL STAFF TIME	0	0
102	Supply Code	MEDICAL SUPPLIES		
103		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ -	\$ -
104	SD173	guidewire, low profile (SpartaCore)		
105	SD304	IVUS catheter		
106	SD305	IVUS Catheter Sterile Cover		
110		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A		
112	Equipment Code	EQUIPMENT		
113		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ 115.76	\$ -
114	ES047	IVUS system	20	
115	EL011	room, angiography	20	
116	ED050	Technologist PACS workstation	23	
120		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A		

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS/Other Source – Medicare Utilization Over 30,000

October 2018
X-Ray Exam – Neck (PE Only)

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.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
70360	Radiologic examination; neck, soft tissue	XXX	0.17 (April 2018 RUC Recommendation)

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor:

70360	Radiologic examination; neck, soft tissue
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Global Period: XXX Meeting Date: April 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

The American College of Radiology (ACR), American Society of Neuroradiology (ASNR), American Academy of Family Physicians (AAFP), and American College of Physicians (ACP) convened a consensus panel to finalize the practice expense data for the X-Ray exam neck code, CPT code 70360.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code.** You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

The societies included the existing PE inputs for code 70360 on the spreadsheet to serve as a reference.

3. Is this code(s) typically billed with an E/M service?
Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)

No, this code is not typically billed with an E/M service.
Yes, this code is typically billed with an E/M service in the nonfacility.

4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different than for the global?
(Please see provided data in PE Subcommittee folder)

Nonfacility: Diagnostic Radiology at 20%

Diagnostic Radiology is also the dominant specialty in the global.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
N/A
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.
N/A
7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:

N/A

8. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:
Bring patient into x-ray room and have patient sit/lie on x-ray table or stand as appropriate. Place first cassette behind patient's neck. Position patient's anatomy for the AP view. Step behind shielding to control panel. Set appropriate exposure parameters. Instruct patient to hold still. Take exposure for first view. Step from behind shielding. Take first cassette from behind patient and place second cassette as needed. Position patient's anatomy for lateral view. Step behind shielding to control panel. Set appropriate exposure parameters. Instruct patient to hold still. Take exposure for second view. Step from behind shielding. Take second cassette out behind patient. The above steps are repeated for any additional views to be obtained. All cassettes are then taken to the image reader. Run all cassettes through reader. Check all images for adequate exposure, positioning, coverage, etc. Repeat any views as needed.
9. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
N/A
10. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:
N/A
11. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.
N/A
12. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:
N/A
13. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:
N/A
14. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:
- **Technologist PACS Workstation Proxy (ED050)** –PACS formula; Equals total service period time
 - **Professional PACS Workstation (ED053)** – Equals physician work intra time + 1/2 physician work pre-time
 - **Room, basic radiology (EL012)** – Highly technical formula
15. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:

N/A

16. If there is any other item on your spreadsheet that needs further explanation please include here:

N/A

17. Please include an explanation of each line item:

N/A

	A	B	D	E	F	G	H	I
1	RUC Practice Expense Spreadsheet					REFERENCE CODE	CURRENT	RECOMMENDED
2		<i>Please see other summaries of the standard guidelines in column C. For more complete information about summaries</i>				74018	70360	70360
3		<u>RUC Collaboration Website</u>				Radiologic examination, abdomen; 1 view (Apr 2016)	Radiologic examination; neck, soft tissue (Aug 2003)	Radiologic examination; neck, soft tissue (Apr 2018)
4	Clinical Activity Code	Meeting Date: April 2018 Tab: 17 - X-Ray Neck Specialty: ACR, AAFP, ACP	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute			
5		LOCATION				Non Fac	Non Fac	Non Fac
6		GLOBAL PERIOD						
7		TOTAL COST OF CLINICAL STAFF, SUPPLIES AND EQUIPMENT				\$ 13.95	\$ 15.01	\$ 13.88
8		TOTAL CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	18.0	16.0	18.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	18.0	16.0	18.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	0.0	0.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE				\$ 7.38	\$ 6.56	\$ 7.38
13		PRE-SERVICE PERIOD						
14		Start: Following visit when decision for surgery or procedure made						
19		End: When patient enters office/facility for surgery/procedure						
30		SERVICE PERIOD						
31		Start: When patient enters office/facility for surgery/procedure:						
32		Pre-Service (of service period)						
33	CA009	Greet patient, provide gowning, ensure appropriate medical	L041B	Radiologic	0.41	3	3	
34	CA010	Obtain vital signs						
35	CA011	Provide education/obtain consent						
36	CA012	Review requisition, assess for special needs						
37	CA013	Prepare room, equipment and supplies	L041B	Radiologic	0.41	2	1	2
38	CA014	Confirm order, protocol exam						
39	CA015	Setup scope (nonfacility setting only)						
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of	L041B	Radiologic	0.41	2	1	2
41	CA017	Sedate/apply anesthesia						
48		Intra-service (of service period)						
49	CA018	Assist physician or other qualified healthcare professional--- directly related to physician work time (100%)	L041B	Radiologic Technologist	0.41	3		
50	CA019	Assist physician or other qualified healthcare professional---						
51	CA020	Assist physician or other qualified healthcare professional---						
52	CA021	Perform procedure/service---NOT directly related to physician	L041B	Radiologic	0.41		6	6
59		Post-Service (of service period)						
60	CA022	Monitor patient following procedure/service, multitasking 1:4						
61	CA023	Monitor patient following procedure/service, no multitasking						
62	CA024	Clean room/equipment by clinical staff	L041B	Radiologic	0.41	3	2	3
63	CA025	Clean scope						
64	CA026	Clean surgical instrument package						
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray						
66	CA028	Review/read post-procedure x-ray, lab and pathology reports						
67	CA029	Check dressings, catheters, wounds						
68	CA030	Technologist QC's images in PACS, checking for all images,	L041B	Radiologic	0.41	2	3	2
69	CA031	Review examination with interpreting MD/DO	L041B	Radiologic	0.41	2		2
70	CA032	Scan exam documents into PACS. Complete exam in RIS system	L041B	Radiologic	0.41	1		1
71	CA033	Perform regulatory mandated quality assurance activity (service						
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting,						
73	CA035	Review home care instructions, coordinate visits/prescriptions						
74	CA036	Discharge day management				n/a	n/a	n/a
81		End: Patient leaves office						
82		POST-SERVICE PERIOD						
83		Start: Patient leaves office/facility						
99		End: with last office visit before end of global period						
100	Medical	MEDICAL SUPPLIES	PRICE	UNIT				
101		TOTAL COST OF SUPPLY QUANTITY x PRICE				\$ 0.53	\$ 0.53	\$ -
102	SB026	gown, patient	0.533	item		1	1	
110	Equipment Code	EQUIPMENT	Purchase Price	Equipment Formula	Cost Per Minute			
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE				\$ 6.04	\$ 7.92	\$ 6.50
112	ED050	Technologist PACS workstation	5557	PACS	0.0220179	18	16	18
113	ED053	Professional PACS Workstation	14616.93	Other Formula	0.0579151	4	3	4
114	EL012	room, basic radiology	127750	Highly Technical	0.4840472	12	16	13

RUC Rec April 2018

X-Ray Exam Neck

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS/Other Source – Medicare Utilization Over 30,000

April 2018

X-Ray Exam - Neck

In October 2017, the Relativity Assessment Workgroup 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 crosswalk these services like other recent similar radiology recommendations for April 2018, if approved by the Research Subcommittee.

In February, the Research Subcommittee approved for the specialties to utilize a crosswalk methodology to make physician work and physician time recommendations in lieu of conducting a RUC survey. The Research Subcommittee had reviewed the recommendation made by the specialty societies to crosswalk times and values for these identified codes to other codes performed by the specialty societies. On the Research Subcommittee conference call, the specialty societies explained that when determining an appropriate crosswalk, they tried to find RUC reviewed codes that were similar in service and time, performed on similar anatomical site, required similar number of views and required similar patient positions. The Research Subcommittee agreed that the methodology employed by the specialty was appropriate for these services, noting past precedent of the Research Subcommittee approving a similar request for X-ray codes in April 2017 and in 2010. As part of its discussion, the Subcommittee noted that it would not recommend for the specialty to propose using lower work RVU crosswalks to justify maintaining the value of higher work RVU codes.

The Research Subcommittee approved the crosswalk/reference code methodology as proposed by the specialty societies to be appropriate for codes 70210, 70220, 70250, 70260, 70360, 72170, 72190.

70360 Radiologic examination; neck, soft tissue

CPT code 70360 is an x-ray procedure used to assess the airway and soft tissues of the neck, with potential evaluation of foreign bodies. A 2-view exam is typical. The RUC reviewed the descriptions of work and the expert panel recommendations and agreed on the following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

The RUC agreed with the specialty societies that the current work RVU of 0.17 for CPT code 70360 should be maintained. The RUC compared the code under review to CPT code 74018 *Radiologic examination, abdomen; 1 view* (work RVU = 0.18, 1 minute pre-service time, 3 minutes intra-service time, 1 minute post-service time) and noted that both services should be valued similarly as both studies have identical intra-service and total times. Although the number of views varies with respect to the reference code, the RUC agreed that the magnitude of work is similar and the work RVUs are nearly identical. For additional support, the RUC compared CPT code 70360 to three other radiology codes: CPT code 73080

Radiologic examination, elbow; complete, minimum of 3 views (work RVU = 0.17, 1 minute pre-service time, 3 minutes intra-service time, 1 minute post-service time); *73610 Radiologic examination, ankle; complete, minimum of 3 views* (work RVU = 0.17, 1 minute pre-service time, 3 minutes intra-service time, 1 minute post-service time) and *73630 Radiologic examination, foot; complete, minimum of 3 views* (work RVU = 0.17, 1 minute pre-service time, 3 minutes intra-service time, 1 minute post-service time) and noted that the physician work and times are identical while acknowledging that these codes apply to the extremities unlike CPT code 70360 which is an axillary skeletal radiograph. **The RUC recommends a work RVU of 0.17 for CPT code 70360.**

Practice Expense

The Practice Expense (PE) Subcommittee noted that the non-facility billed together data show that multiple codes are billed on the same day. The specialty societies did not think that the codes billed 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 next PE Subcommittee meeting and remove any staff time, supplies and equipment that is found to be duplicative. The RUC recommends the direct practice expense inputs as submitted by the specialty society. **The RUC recommends that the direct practice expense inputs be accepted as Interim and revisited at the October 2018 RUC meeting.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
70360	Radiologic examination; neck, soft tissue	XXX	0.17 (No Change)

February 19, 2018

Margie Andreae, MD, Chair
 AMA/RUC Research Subcommittee
 American Medical Association
 330 N. Wabash Ave.
 Chicago, IL 60611

Dear Dr. Andreae,

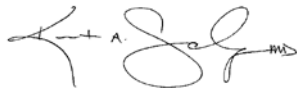
The seven codes listed below were identified by the CMS/Other >30,000 screen. At the January 2018 RUC meeting, the Relativity Assessment Workgroup agreed with the societies' recommendation to use a direct crosswalk methodology to value these codes. The American College of Radiology, American Society of Neuroradiology, American Academy of Orthopaedic Surgeons, and American Academy of Family Physicians believe the existing values for these services are accurate and propose the following crosswalks to existing RUC surveyed codes.

Code	Descriptor	Work RVU	Crosswalk Code	Crosswalk Descriptor	Crosswalk Work RVU
70210	Radiologic examination, sinuses, paranasal, less than 3 views	0.17	74018	Radiologic examination, abdomen; 1 view	0.18
70220	Radiologic examination, sinuses, paranasal, complete, minimum of 3 views	0.25	74019	Radiologic examination, abdomen; 2 views	0.23
70250	Radiologic examination, skull; less than 4 views	0.24	74019	Radiologic examination, abdomen; 2 views	0.23
70260	Radiologic examination, skull; complete, minimum of 4 views	0.34	74022	Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest	0.32
70360	Radiologic examination; neck, soft tissue	0.17	74018	Radiologic examination, abdomen; 1 view	0.18
72170	Radiologic examination, pelvis; 1 or 2 views	0.17	73552	Radiologic examination, femur; minimum 2 views	0.18
72190	Radiologic examination, pelvis; complete, minimum of 3 views	0.21	73502	Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views	0.22


Most of these codes currently lack vignettes and work descriptors. In the accompanying document we provide vignettes and work descriptors for the Committee's consideration.

Should you have any questions, please feel free to contact ACR RUC staff, Stephanie Le, at 800-227-5463, ext. 4584 or via email sle@acr.org.

Sincerely,



Kurt Schoppe, MD
ACR RUC Advisor



William Creevy, MD
AAOS RUC Advisor



Gregory Nicola, MD
ASNR RUC Advisor

/s/

Thomas Kintanar, MD
AAFP RUC Advisor

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 70360	Tracking Number	Original Specialty Recommended RVU: 0.17
		Presented Recommended RVU: 0.17
Global Period: XXX	Current Work RVU: 0.17	RUC Recommended RVU: 0.17

CPT Descriptor: Radiologic examination; neck, soft tissue

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60- year-old woman who swallowed a foreign object presents with globus sensation.

Percentage of Survey Respondents who found Vignette to be Typical:

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the reason for the examination and any pertinent clinical history. Review any prior applicable plain film or imaging studies.

Description of Intra-Service Work: Supervise technologist performing the examination. Interpret the examination and compare the findings to previous studies, if applicable. Interpretation includes evaluation of all soft tissues of the neck including the prevertebral soft tissues and epiglottis. Assess patency of pharynx, larynx and trachea. Evaluate the integrity of the bones. Evaluate for foreign bodies. Dictate report for the medical record.

Description of Post-Service Work: The final report is reviewed and signed, and findings are communicated to the referring physician as needed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2018				
Presenter(s):	Kurt Schoppe, MD; Daniel Wessell, MD; Gregory Nicola, MD; Melissa Chen, MD; Thomas Kintanar, MD; Mary Newman, MD; Tanvir Hussain, MD				
Specialty(s):	American College of Radiology, American Society of Neuroradiology, American Academy of Family Physicians, American College of Physicians				
CPT Code:	70360				
Sample Size:	0	Resp N:	0	Response: 0.0 %	
Description of Sample:					
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate					
Survey RVW:					
Pre-Service Evaluation Time:			0.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:			0.00		
Immediate Post Service-Time:	0.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	70360	Recommended Physician Work RVU: 0.17		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	1.00	0.00	1.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	3.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	1.00	0.00	1.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74018	XXX	0.18	RUC Time

CPT Descriptor Radiologic examination, abdomen; 1 view**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92567	XXX	0.20	RUC Time	856,575

CPT Descriptor 1 Tympanometry (impedance testing)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
96401	XXX	0.21	RUC Time	784,849

CPT Descriptor 2 Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 0 % of respondents: 0.0 %

Number of respondents who choose 2nd Key Reference Code: 0 % of respondents: 0.0 %

TIME ESTIMATES (Median)

	CPT Code: <u>70360</u>	Top Key Reference CPT Code: <u>74018</u>	2nd Key Reference CPT Code:
Median Pre-Service Time	1.00	1.00	0.00
Median Intra-Service Time	3.00	3.00	0.00
Median Immediate Post-service Time	1.00	1.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	5.00	5.00	0.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity					

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required			
Physical effort required			

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity****Mental Effort and Judgment****Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

Physical effort required

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT code for soft tissue x-ray of the neck, 70360 (*Radiologic examination; neck, soft tissue*), was identified by the CMS/Other Source – Utilization over 30,000 screen.

At the January 2018 RUC meeting, the Relativity Assessment Workgroup recommended that the societies use a direct crosswalk methodology to value this code. The specialty societies believe that maintaining value with work RVU of 0.17 is supported by the proposed crosswalk, CPT code 74018 (*Radiologic examination, abdomen; 1 view*).

Recommended Crosswalk

CPT code 70360 (*Radiologic examination; neck, soft tissue*) is an X-ray procedure used to assess the airway and soft tissues of the neck, with potential evaluation of foreign bodies. The specialties propose a crosswalk to CPT code 74018 (*Radiologic examination, abdomen; 1 view*), which has identical total times and a higher wRVU. The magnitude of work is the same despite the different number of views of the exam.

Work RVU Recommendation

The specialties recommend the existing work RVU of 0.17 for CPT code 70360.

Pre, Intra, and Post Service Times

The specialties recommend 1 minute of pre-service time, 3 minutes of intra service time, and 1 minute of post service time for CPT code 70360. The recommended pre-service, intra-service, and post-service times are strongly supported by the crosswalk, CPT code 74018.

Code	Descriptor	RVU	Pre	Intra	Post	Total	IWPUT
70360	X-Ray; neck, soft tissue	0.17	1	3	1	5	0.042
74018	X-Ray, abdomen; 1 view	0.18	1	3	1	5	0.045

MPC Codes

The recommended times and value for 70360 compare well with two other MPC codes:

- 92567 (*Tympanometry (impedance testing)*), and
- 96401 (*Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic*)

Code	Descriptor	RVU	Pre	Intra	Post	Total	IWPUT
70360	X-Ray; neck, soft tissue	0.17	1	3	1	5	0.042
92567	Tympanometry (impedance testing)	0.20	1	4	1	6	0.039
96401	Chemo admin, subcut. or intramusc; non-hormonal anti-neoplastic	0.21	4	3	2	9	0.025

Summary of Recommendation for CPT Code 70360

Our expert panel recommends maintaining the current value of 70360 at 0.17 RVU with service period times of 1, 3, and 1 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.

- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CPT code 70360 may be reported with 70100 (Radiologic examination, mandible; partial, less than 4 views), 72040 (Radiologic examination, spine, cervical; 2 or 3 views), 74230 (Swallowing function, with cineradiography/videoradiography), 74240 (Radiologic examination, gastrointestinal tract, upper; with or without delayed images, without KUB).

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 70360

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Family Medicine How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 216000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The number of services described by CPT code 70360 provided nationally in a one-year period is estimated to be 216,000.

Specialty Diagnostic Radiology Frequency 143159 Percentage 66.27 %

Specialty Family Medicine Frequency 11548 Percentage 5.34 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 72,000

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. CPT code 70360 is estimated to be provided 72,000 times to Medicare patients nationally in a one -year period.

Specialty Diagnostic Radiology Frequency 47720 Percentage 66.27 %

Specialty Family Medicine Frequency 3849 Percentage 5.34 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Imaging

BETOS Sub-classification:
Standard imaging

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 70360

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
13	ISSUE: X-Ray Exam Neck																			
14	TAB: 17																			
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST
17	RUC	74018	Radiologic examination, abdomen: 1 view		0.045			0.18			5	1					3			1
19	Aug-95	70360	Radiologic examination; neck, soft tissue					0.17			5									
24	REC	70360	Radiologic examination; neck, soft tissue		0.042	0.17					5	1				3				1
25																				
26																				
27																				
28																				
29																				
30																				

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	
5	ISSUE: Excision of bone																																								
6	TAB: 84																																								
7						RVW					Total	PRE			INTRA					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged						
8	source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	
9	1st REF	11111	xyz	30	0.029			4.25			131	5	5	5			30			5	1					1.0					1										
10	2nd REF	22222	def	15	0.055			5.15			137	10	5	5			35			5						1.0					1				1						
11	CURRENT	55555	abc		0.053			5.00			133	17						27			8	1					1.0					1									
12	SVY	55555	abc	78	0.045	2.00	3.00	5.00	7.00	8.00	146	10	5	10	15	20	30	35	40	10	1					1.0					1										
13	REC	55555	abc		0.020	4.25					142	17	1	3			30			10									1	1.0	1										
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**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor:

70360	Radiologic examination; neck, soft tissue
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Global Period: XXX Meeting Date: April 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

The American College of Radiology (ACR), American Society of Neuroradiology (ASNR), American Academy of Family Physicians (AAFP), and American College of Physicians (ACP) convened a consensus panel to finalize the practice expense data for the X-Ray exam neck code, CPT code 70360.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code.** You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

The societies included the existing PE inputs for code 70360 on the spreadsheet to serve as a reference.

3. Is this code(s) typically billed with an E/M service?
Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)

No, this code is not typically billed with an E/M service.
Yes, this code is typically billed with an E/M service in the nonfacility.

4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different than for the global?
(Please see provided data in PE Subcommittee folder)

Nonfacility: Diagnostic Radiology at 20%

Diagnostic Radiology is also the dominant specialty in the global.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
N/A
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.
N/A
7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:

N/A

8. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:
Bring patient into x-ray room and have patient sit/lie on x-ray table or stand as appropriate. Place first cassette behind patient's neck. Position patient's anatomy for the AP view. Step behind shielding to control panel. Set appropriate exposure parameters. Instruct patient to hold still. Take exposure for first view. Step from behind shielding. Take first cassette from behind patient and place second cassette as needed. Position patient's anatomy for lateral view. Step behind shielding to control panel. Set appropriate exposure parameters. Instruct patient to hold still. Take exposure for second view. Step from behind shielding. Take second cassette out behind patient. The above steps are repeated for any additional views to be obtained. All cassettes are then taken to the image reader. Run all cassettes through reader. Check all images for adequate exposure, positioning, coverage, etc. Repeat any views as needed.
9. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
N/A
10. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:
N/A
11. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.
N/A
12. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:
N/A
13. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:
N/A
14. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:
 - **Technologist PACS Workstation Proxy (ED050)** –PACS formula; Equals total service period time
 - **Professional PACS Workstation (ED053)** – Equals physician work intra time + 1/2 physician work pre-time
 - **Room, basic radiology (EL012)** – Highly technical formula
15. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:

N/A

16. If there is any other item on your spreadsheet that needs further explanation please include here:

N/A

17. Please include an explanation of each line item:

N/A

	A	B	D	E	F	G	H	I
1	RUC Practice Expense Spreadsheet					REFERENCE CODE	CURRENT	RECOMMENDED
2		<i>Please see other summaries of the standard guidelines in column C. For more complete information about summaries</i>				74018	70360	70360
3		<u>RUC Collaboration Website</u>				Radiologic examination, abdomen; 1 view (Apr 2016)	Radiologic examination; neck, soft tissue (Aug 2003)	Radiologic examination; neck, soft tissue (Apr 2018)
4	Clinical Activity Code	Meeting Date: April 2018 Tab: 17 - X-Ray Neck Specialty: ACR, AAFP, ACP	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute			
5		LOCATION				Non Fac	Non Fac	Non Fac
6		GLOBAL PERIOD						
7		TOTAL COST OF CLINICAL STAFF, SUPPLIES AND EQUIPMENT				\$ 13.95	\$ 15.01	\$ 13.88
8		TOTAL CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	18.0	16.0	18.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	18.0	16.0	18.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	0.0	0.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE				\$ 7.38	\$ 6.56	\$ 7.38
13		PRE-SERVICE PERIOD						
14		Start: Following visit when decision for surgery or procedure made						
19		End: When patient enters office/facility for surgery/procedure						
30		SERVICE PERIOD						
31		Start: When patient enters office/facility for surgery/procedure:						
32		Pre-Service (of service period)						
33	CA009	Greet patient, provide gowning, ensure appropriate medical	L041B	Radiologic	0.41	3	3	
34	CA010	Obtain vital signs						
35	CA011	Provide education/obtain consent						
36	CA012	Review requisition, assess for special needs						
37	CA013	Prepare room, equipment and supplies	L041B	Radiologic	0.41	2	1	2
38	CA014	Confirm order, protocol exam						
39	CA015	Setup scope (nonfacility setting only)						
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of	L041B	Radiologic	0.41	2	1	2
41	CA017	Sedate/apply anesthesia						
48		Intra-service (of service period)						
49	CA018	Assist physician or other qualified healthcare professional--- directly related to physician work time (100%)	L041B	Radiologic Technologist	0.41	3		
50	CA019	Assist physician or other qualified healthcare professional---						
51	CA020	Assist physician or other qualified healthcare professional---						
52	CA021	Perform procedure/service---NOT directly related to physician	L041B	Radiologic	0.41		6	6
59		Post-Service (of service period)						
60	CA022	Monitor patient following procedure/service, multitasking 1:4						
61	CA023	Monitor patient following procedure/service, no multitasking						
62	CA024	Clean room/equipment by clinical staff	L041B	Radiologic	0.41	3	2	3
63	CA025	Clean scope						
64	CA026	Clean surgical instrument package						
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray						
66	CA028	Review/read post-procedure x-ray, lab and pathology reports						
67	CA029	Check dressings, catheters, wounds						
68	CA030	Technologist QC's images in PACS, checking for all images,	L041B	Radiologic	0.41	2	3	2
69	CA031	Review examination with interpreting MD/DO	L041B	Radiologic	0.41	2		2
70	CA032	Scan exam documents into PACS. Complete exam in RIS system	L041B	Radiologic	0.41	1		1
71	CA033	Perform regulatory mandated quality assurance activity (service						
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting,						
73	CA035	Review home care instructions, coordinate visits/prescriptions						
74	CA036	Discharge day management				n/a	n/a	n/a
81		End: Patient leaves office						
82		POST-SERVICE PERIOD						
83		Start: Patient leaves office/facility						
99		End: with last office visit before end of global period						
100	Medical	MEDICAL SUPPLIES	PRICE	UNIT				
101		TOTAL COST OF SUPPLY QUANTITY x PRICE				\$ 0.53	\$ 0.53	\$ -
102	SB026	gown, patient	0.533	item		1	1	
110	Equipment Code	EQUIPMENT	Purchase Price	Equipment Formula	Cost Per Minute			
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE				\$ 6.04	\$ 7.92	\$ 6.50
112	ED050	Technologist PACS workstation	5557	PACS	0.0220179	18	16	18
113	ED053	Professional PACS Workstation	14616.93	Other Formula	0.0579151	4	3	4
114	EL012	room, basic radiology	127750	Highly Technical	0.4840472	12	16	13

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS/Other Source – Medicare Utilization Over 30,000

October 2018

CT – Orbit/Ear/Fossa

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 IWP/UT. 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 IWP/UT in comparison to the survey code. The intensity/complexity survey results support the IWP/UT 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 IWP/UT. CPT code 70480 is more intense with more complex anatomic structures to evaluate compared to code 70470, which accounts for the differences in IWP/UT.

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.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
70480	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material	XXX	1.28 (No change)
(f)70481	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)	XXX	1.13
(f)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	XXX	1.27

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 70480	Tracking Number	Original Specialty Recommended RVU: 1.28
		Presented Recommended RVU: 1.28
Global Period: XXX	Current Work RVU: 1.28	RUC Recommended RVU: 1.28

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 76-year-old woman presents with conductive hearing loss.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the reason for the examination and any pertinent clinical history. Review any prior imaging studies. Determine the appropriate CT protocol for the examination, confirm that noncontrast-only images are indicated, and determine the need for additional 2D reconstructions. Communicate protocol to the CT technologists.

Description of Intra-Service Work: Determine whether contrast-enhanced sequences are necessary. Interpret detailed thin section slices through the temporal bones, evaluating the integrity of the horizontal, superior, and posterior semicircular canals, cochlea, modiolus, vestibular aqueduct, inner auditory canals, and course of the facial nerve. Assess the mineralization of the temporal bone. Assess the epitympanum and hypotympanum and the integrity and positioning of the ossicles. Evaluate the orbits (globe, lens, lacrimal glands, optic nerves, extraocular muscles, intraconal fat). Assess the facial soft tissues including the retromaxillary fat. Assess the cavernous, precavernous spaces, infraorbital foramen, supraorbital foramen, optic canal, and pterygopalatine fossa. Assess the bony structures including the facial bones and skull base. Evaluate the visualized brain/brainstem. Assess for bony erosion and fractures in the case of trauma. Evaluate the paranasal sinuses and mastoid air cells. Compare the current imaging to all pertinent available prior studies. Dictate a report.

Description of Post-Service Work: Review, edit, and sign report for the medical record. Communicate the findings with referring provider and/or patient as needed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Kurt Schoppe, MD; Daniel Wessell, MD; Lauren Golding, MD; Gregory Nicola, MD; Melissa Chen, MD				
Specialty(s):	American College of Radiology, American Society of Neuroradiology				
CPT Code:	70480				
Sample Size:	2562	Resp N:	42	Response: 1.6 %	
Description of Sample:	The ACR surveyed a total of 750 members (a random sample of 375 members and a separate random sample of 375 members who perform CT and neuro imaging procedures). The ASNR performed a random sample of 1812 of its membership.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	10.00	31.00	78.00	200.00	1500.00
Survey RVW:	1.07	1.28	1.39	1.62	2.00
Pre-Service Evaluation Time:			4.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	5.00	10.00	15.00	15.00	25.00
Immediate Post Service-Time:	3.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	70480	Recommended Physician Work RVU: 1.28		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	4.00	0.00	4.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	15.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	3.00	0.00	3.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
70542	XXX	1.62	RUC Time

CPT Descriptor Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
70490	XXX	1.28	RUC Time

CPT Descriptor Computed tomography, soft tissue neck; without contrast material**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
70460	XXX	1.13	RUC Time	32,094

CPT Descriptor 1 Computed tomography, head or brain; with contrast material(s)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
70470	XXX	1.27	RUC Time	110,713

CPT Descriptor 2 Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 9 % of respondents: 21.4 %

Number of respondents who choose 2nd Key Reference Code: 7 % of respondents: 16.6 %

TIME ESTIMATES (Median)

	CPT Code: <u>70480</u>	Top Key Reference CPT Code: <u>70542</u>	2nd Key Reference CPT Code: <u>70490</u>
Median Pre-Service Time	4.00	5.00	5.00
Median Intra-Service Time	15.00	20.00	15.00
Median Immediate Post-service Time	3.00	5.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	22.00	30.00	25.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	11%	44%	33%	11%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
11%	44%	44%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	11%	56%	33%
Physical effort required	0%	56%	44%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%

44%

56%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

0%

43%

57%

0%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

0%

71%

29%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

0%

57%

43%

Physical effort required

0%

100%

0%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

14%

57%

29%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

CPT code 70480 was identified on the screen for CMS/Other codes with utilization over 30,000. 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. The descriptors for these three codes are shown below.

- **70480** (*Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material*),
- **70481** (*Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)*),
- **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*)

This family of CT codes will not have the normal step-up in times and work RVU as other family of codes that is typical of radiology because of the different anatomy, and therefore type of work that is typical for the 70480 code compared to the 70481 and 70482 codes. The without IV contrast code, 70480, is fundamentally different work than the with IV contrast codes, 70481 and 70482. This is supported by the claims database where the most commonly billed diagnosis for 70480 is hearing loss, while the most commonly billed diagnosis for both 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 70481 and 70482.

Survey Process

The specialties surveyed a total of 2,562 members. The ACR surveyed a total of 750 members (a random sample of 375 members and a separate random sample of 375 members who perform CT and neuro imaging procedures). The ASNR performed a random sample of 1,812 of its membership.

Although these codes have been previously valued under flawed methodology of CMS/Other, we will not be seeking compelling evidence argument.

CPT code 70480 is an invaluable tool in investigating diverse causes for hearing loss and vertigo. It is an important tool 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 70480 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. A combination of its utility (as a positive and negative predictor of pathology), intensity, and the amount of technical training necessary to accurately interpret leads us to believe that this procedure would be appropriately valued at 1.28 work RVU.

Work RVU Recommendation:

The expert panel recommends a work RVU of 1.28 for CPT code 70480, which is the 25th percentile survey value and equal to the current CMS/Other value.

Time Recommendation:

The expert panel recommends the following median survey times: 4 minutes of pre-service time, 15 minutes of intra-service time, and 3 minutes of post-service time. This is a total time of 22 minutes.

Key Reference Services

The most commonly chosen reference codes by survey participants include an MRI of a similar region of the surveyed code (orbit, face, and/or neck) with contrast and a CT soft tissue neck without contrast procedure.

- **70542** (*Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)*), chosen by 21% of respondents, and
- **70490** (*Computed tomography, soft tissue neck; without contrast material*), chosen by 17% of respondents.

Our recommendation compares well to the most commonly chosen key reference service, 70542, which has a higher intra service time and work RVU, with a slightly lower IWPUT. This is supported by the intensity/complexity survey results in which respondents felt that 70480 was identical or more complex than 70542. Although magnetic resonance imaging is a technically challenging modality, specialized anatomic knowledge is needed to evaluate the compact and complex area in 70480.

The second key reference code, 70490, has the same intraservice time, identical wRVU, and slightly lower IWPUT in comparison to the surveyed code. The intensity/complexity survey results support the IWPUT differential as most respondents felt that 70480 was slightly more intense and complex than 70490. Although the neck anatomy is complex, the lack of intravenous contrast in 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.

The relationships are summarized in the following table:

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWPUT	% chosen
70480	CT, orbit, sella, posterior fossa or ear; w/o contrast	1.28	22	4	15	3	0.075	
70490	CT, soft tissue neck; w/o contrast	1.28	25	5	15	5	0.070	17%
70542	MRI, orbit, face, and/or neck; w/contrast	1.62	30	5	20	5	0.070	21%

MPC Codes

Our recommendation compares favorably to two radiology MPC codes 70460 (*Computed tomography, head or brain; with contrast material(s)*) and 70470 (*Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections*). 70470 has identical intraservice times, nearly identical RVUs, and a lower IWPUT. CPT code 70480 is more intense with more complex anatomic structures to evaluate compared to 70470, which accounts for the differences in IWPUT. 70460 has lower total times and nearly proportionate lower RVU in comparison to 70480.

The relationships are summarized in the following table:

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWPUT
70460	CT, head or brain; w/contrast	1.13	22	5	12	5	0.076
70470	CT, head or brain; w/o and w/contrast	1.27	25	5	15	5	0.070
70480	CT, orbit, sella, posterior fossa or ear; w/o contrast	1.28	22	4	15	3	0.075

Summary

In summary, our expert panel recommends maintaining the current value of **70480** at 1.28 RVUs, with median service period times of 4, 15, and 3 minutes. We believe this compares favorably with the most commonly chosen key reference service, 70542, as well as MPC code 70470. Relativity is maintained across the family of RUC-reviewed CT and Neuro imaging codes.

CPT Code	Descriptor	wRVU	Pre Time	Intra Time	Post Time	TOTAL Time	IWPUT	Source	RUC Mtg Date
70450	Computed tomography, head or brain; without contrast material	0.85	4	10	5	19	0.065	RUC	Oct-12
72192	Computed tomography, pelvis; without contrast material	1.09	3	10	5	18	0.091	RUC	Aug-05
70460	Computed tomography, head or brain; with contrast material(s)	1.13	5	12	5	22	0.076	RUC	Oct-12
70481	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material	1.13	4	13	3	20	0.075		Oct 2018
71250	Computed tomography, thorax; without contrast material	1.16	5	15	5	25	0.062	RUC	Apr-16
72193	Computed tomography, pelvis; with contrast material(s)	1.16	3	10	5	18	0.098	RUC	Aug-05
74150	Computed tomography, abdomen; without contrast material	1.19	3	12	5	20	0.084	RUC	Aug-05
71260	Computed tomography, thorax; with contrast material(s)	1.24	5	16	5	26	0.064	RUC	Apr-16
70470	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections	1.27	5	15	5	25	0.070	RUC	Apr-11
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	1.27	4	15	4	23	0.073		Oct 2018
74160	Computed tomography, abdomen; with contrast material(s)	1.27	3	15	5	23	0.073	RUC	Aug-05
70480	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material	1.28	4	15	3	22	0.075		Oct 2018
70490	Computed tomography, soft tissue neck; without contrast material	1.28	5	15	5	25	0.070	RUC	Jan-17
70540	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)	1.35	5	19	5	29	0.059	RUC	Jan-16
70491	Computed tomography, soft tissue neck; with contrast material(s)	1.38	5	17	5	27	0.068	RUC	Jan-17

74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	1.40	5	18	5	28	0.065	RUC	Apr-12
70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material	1.48	5	18	5	28	0.070	RUC	Jan-13
70492	Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections	1.62	5	20	5	30	0.070	RUC	Jan-17
70542	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)	1.62	5	20	5	30	0.070	RUC	Jan-16
74176	Computed tomography, abdomen and pelvis; without contrast material	1.74	5	22	5	32	0.069	RUC	Feb-10
70498	Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing	1.75	5	20	5	30	0.076	RUC	Apr-14
70552	Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)	1.78	5	20	7	32	0.076	RUC	Jan-13
72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)	1.78	5	23	5	33	0.068	RUC	Apr-13
74177	Computed tomography, abdomen and pelvis; with contrast material(s)	1.82	5	25	5	35	0.064	RUC	Feb-10
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	2.01	5	30	5	40	0.060	RUC	Feb-10

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 70480

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 162150

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 70480 is estimated to be provided 162,150 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 143795 Percentage 88.68 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 54,050

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 70480 is estimated to be provided 54,050 times nationally in a one-year period to Medicare patients.

Specialty Diagnostic Radiology Frequency 47932 Percentage 88.68 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Imaging

BETOS Sub-classification:
Advanced imaging

BETOS Sub-classification Level II:
CAT/CT/CTA: Brain/Head/Neck

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 70480

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 70481	Tracking Number	Original Specialty Recommended RVU: 1.13
		Presented Recommended RVU: 1.13
Global Period: XXX	Current Work RVU: 1.38	RUC Recommended RVU: 1.13

CPT Descriptor: Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old woman presents with eye swelling.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the reason for the examination and any pertinent clinical history. Review any prior imaging studies. Determine the appropriate CT protocol for the examination, confirm that contrast administration is indicated, and determine the need for additional 2D reconstructions. Communicate protocol to the CT technologists.

Description of Intra-Service Work: Interpret the images, which are optimized for evaluation of the orbits (globe, lens, lacrimal glands, optic nerves, extraocular muscles, intraconal fat). Assess the facial soft tissues including the retromaxillary fat. Assess the cavernous, precavernous spaces, infraorbital foramen, supraorbital foramen, optic canal, and pterygopalatine fossa. Evaluate the integrity of the horizontal, superior, and posterior semicircular canals, cochlea, modiolus, vestibular aqueduct, inner auditory canals, and course of the facial nerve. Assess the mineralization of the temporal bone. Assess the epitympanum and hypotympanum and the integrity and positioning of the ossicles. Assess the bony structures including the facial bones and skull base. Evaluate the visualized brain/brainstem. Assess for bony erosion and fractures in the case of trauma. Evaluate the paranasal sinuses and mastoid air cells. Assess for rim-enhancing fluid collections including periosteal abscess, masses, and perineural enhancement. Compare the current imaging to all pertinent available prior studies. Dictate a report.

Description of Post-Service Work: Review, edit, and sign report for the medical record. Communicate the findings with referring provider and/or patient as needed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Kurt Schoppe, MD; Daniel Wessell, MD; Lauren Golding, MD; Gregory Nicola, MD; Melissa Chen, MD				
Specialty(s):	American College of Radiology, American Society of Neuroradiology				
CPT Code:	70481				
Sample Size:	2562	Resp N:	42	Response: 1.6 %	
Description of Sample:	The ACR surveyed a total of 750 members (a random sample of 375 members and a separate random sample of 375 members who perform CT and neuro imaging procedures). The ASNR performed a random sample of 1812 of its membership.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	25.00	50.00	100.00	600.00
Survey RVW:	1.04	1.32	1.40	1.60	2.10
Pre-Service Evaluation Time:			4.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	5.00	10.00	13.00	15.00	30.00
Immediate Post Service-Time:	3.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	70481	Recommended Physician Work RVU: 1.13		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	4.00	0.00	4.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	13.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	3.00	0.00	3.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
70491	XXX	1.38	RUC Time

CPT Descriptor Computed tomography, soft tissue neck; with contrast material(s)**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
70487	XXX	1.13	RUC Time

CPT Descriptor Computed tomography, maxillofacial area; with contrast material(s)**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
70460	XXX	1.13	RUC Time	32,094

CPT Descriptor 1 Computed tomography, head or brain; with contrast material(s)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 12 % of respondents: 28.5 %

Number of respondents who choose 2nd Key Reference Code: 11 % of respondents: 26.1 %

TIME ESTIMATES (Median)

	CPT Code: <u>70481</u>	Top Key Reference CPT Code: <u>70491</u>	2nd Key Reference CPT Code: <u>70487</u>
Median Pre-Service Time	4.00	5.00	5.00
Median Intra-Service Time	13.00	17.00	12.00
Median Immediate Post-service Time	3.00	5.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	20.00	27.00	22.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	67%	25%	8%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
8%	58%	33%

Technical Skill/Physical Effort

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	8%	67%	25%
Physical effort required	0%	92%	8%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%

58%

42%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

0%

36%

55%

9%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

9%

36%

55%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

0%

55%

45%

Physical effort required

0%

64%

36%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%

45%

55%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

CPT code 70480 was identified on the screen for CMS/Other codes with utilization over 30,000. 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. The descriptors for these three codes are shown below.

- **70480** (*Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material*),
- **70481** (*Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)*),
- **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*)

This family of CT codes will not have the normal step-up in times and work RVU as other family of codes that is typical of radiology because of the different anatomy, and therefore type of work that is typical for the 70480 code compared to the 70481 and 70482 codes. The without IV contrast code, 70480, is fundamentally different work than the with IV contrast codes, 70481 and 70482. This is supported by the claims database where the most commonly billed diagnosis for 70480 is hearing loss, while the most commonly billed diagnosis for both 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 70481 and 70482.

Survey Process

The specialties surveyed a total of 2,562 members. The ACR surveyed a total of 750 members (a random sample of 375 members and a separate random sample of 375 members who perform CT and neuro imaging procedures). The ASNR performed a random sample of 1,812 of its membership.

Although these codes have been previously valued under flawed methodology of CMS/Other, we will not be seeking compelling evidence argument.

After pre-facilitation meeting, we are recommending to crosswalk the 70481 code to CPT code 70487 (*Computed tomography, maxillofacial area; with contrast material(s)*).

Unlike the 70480 code, 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. 70481 is an important tool in investigating diverse causes for visual changes, eye pain, and orbital swelling, as well as the extent of involvement of known infectious/inflammatory/neoplastic processes of the eye. Additionally, it is also important to assess subtle enhancement in the adjacent skull base foramen and spaces which may be a potential route of disease spread into the intracranial compartment. For 70481, 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. Not only is a positive result significant, a negative result is also pertinent in patient management, in relieving patient anxiety, and in providing assurance to the ordering physician. A combination of its utility (as a positive and negative predictor of pathology), intensity, and the amount of technical training necessary to accurately interpret leads us to believe that this procedure would be appropriately valued at 1.13 work RVU.

Work RVU Recommendation:

After pre-facilitation, the expert panel recommends a work RVU of 1.13 for CPT code 70481 which has been cross-walked to 70487, (*Computed tomography, maxillofacial area; with contrast material(s)*), one of the commonly chosen key reference services.

Time Recommendation:

The expert panel recommends the following median survey times: 4 minutes of pre-service time, 13 minutes of intra-service time, and 3 minute of post-service time. This is a total time of 20 minutes.

Key Reference Services

The most commonly chosen reference codes by survey participants include a CT of soft tissue neck with contrast and a CT of maxillofacial area with contrast procedure.

- **70491** (*Computed tomography, soft tissue neck; with contrast material(s)*), chosen by 29% of respondents, and
- **70487** (*Computed tomography, maxillofacial area; with contrast material(s)*), chosen by 26% of respondents.

Our recommendation is supported by both of the key reference services. 70491 (CT soft tissue neck without contrast) has slightly higher intraservice time and wRVU. CPT code 70481 is performed in the ER and inpatient setting at a higher percentage of time compared to 70491, and therefore, the patient population is more complex, which justifies the slightly higher IWPUR.

The second most commonly chosen KRS, 70487, was last reviewed by the RUC in April 2014. 70481 is similarly intense work with clinical concern for orbital pathology compared to 70487, which typically involves evaluation of a patient with facial cellulitis or dental infection. This is why 70487 was selected as an appropriate crosswalk for the recommend RVU.

The relationships are summarized in the following table:

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWPUR	% chosen
70481	CT, orbit, sella, posterior fossa or ear; w/contrast	1.13	20	4	13	3	0.075	
70487	CT, maxillofacial; w/contrast	1.13	22	5	12	5	0.076	26%
70491	CT, soft tissue neck; w/contrast	1.38	27	5	17	5	0.068	29%

MPC Codes

The surveyed code compares well with MPC code 70460 (*Computed tomography, head or brain; with contrast material(s)*) with similar times, work RVU's and IWPUR.

The relationship is summarized in the following table:

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWPUT
70460	CT, head or brain; w/contrast	1.13	22	5	12	5	0.076
70481	CT, orbit, sella, posterior fossa or ear; w/contrast	1.13	20	4	13	3	0.075

Summary

The recommended value of 1.13 for **70481** (*Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)*) is below the 25th percentile survey value, and supported by the KRS and MPC code comparisons.

CPT Code	Descriptor	wRVU	Pre Time	Intra Time	Post Time	TOTAL Time	IWPUT	Source	RUC Mtg Date
70450	Computed tomography, head or brain; without contrast material	0.85	4	10	5	19	0.065	RUC	Oct-12
72192	Computed tomography, pelvis; without contrast material	1.09	3	10	5	18	0.091	RUC	Aug-05
70460	Computed tomography, head or brain; with contrast material(s)	1.13	5	12	5	22	0.076	RUC	Oct-12
70481	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material	1.13	4	13	3	20	0.075		Oct 2018
71250	Computed tomography, thorax; without contrast material	1.16	5	15	5	25	0.062	RUC	Apr-16
72193	Computed tomography, pelvis; with contrast material(s)	1.16	3	10	5	18	0.098	RUC	Aug-05
74150	Computed tomography, abdomen; without contrast material	1.19	3	12	5	20	0.084	RUC	Aug-05
71260	Computed tomography, thorax; with contrast material(s)	1.24	5	16	5	26	0.064	RUC	Apr-16
70470	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections	1.27	5	15	5	25	0.070	RUC	Apr-11
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	1.27	4	15	4	23	0.073		Oct 2018
74160	Computed tomography, abdomen; with contrast material(s)	1.27	3	15	5	23	0.073	RUC	Aug-05
70480	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material	1.28	4	15	3	22	0.075		Oct 2018
70490	Computed tomography, soft tissue neck; without contrast material	1.28	5	15	5	25	0.070	RUC	Jan-17
70540	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)	1.35	5	19	5	29	0.059	RUC	Jan-16
70491	Computed tomography, soft tissue neck; with contrast material(s)	1.38	5	17	5	27	0.068	RUC	Jan-17
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	1.40	5	18	5	28	0.065	RUC	Apr-12

70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material	1.48	5	18	5	28	0.070	RUC	Jan-13
70492	Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections	1.62	5	20	5	30	0.070	RUC	Jan-17
70542	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)	1.62	5	20	5	30	0.070	RUC	Jan-16
74176	Computed tomography, abdomen and pelvis; without contrast material	1.74	5	22	5	32	0.069	RUC	Feb-10
70498	Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing	1.75	5	20	5	30	0.076	RUC	Apr-14
70552	Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)	1.78	5	20	7	32	0.076	RUC	Jan-13
72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)	1.78	5	23	5	33	0.068	RUC	Apr-13
74177	Computed tomography, abdomen and pelvis; with contrast material(s)	1.82	5	25	5	35	0.064	RUC	Feb-10
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	2.01	5	30	5	40	0.060	RUC	Feb-10

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 70481

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 29943

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 70481 is estimated to be provided 29,943 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 28730 Percentage 95.94 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 9,981

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 70481 is estimated to be provided 9,981 times nationally in a one-year period to Medicare patients.

Specialty Diagnostic Radiology Frequency 9577 Percentage 95.95 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Imaging

BETOS Sub-classification:

Advanced imaging

BETOS Sub-classification Level II:

CAT/CT/CTA: Brain/Head/Neck

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 70481

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 70482	Tracking Number	Original Specialty Recommended RVU: 1.27
		Presented Recommended RVU: 1.27
Global Period: XXX	Current Work RVU: 1.45	RUC Recommended RVU: 1.27

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 78-year-old woman presents with an orbital mass.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the reason for the examination and any pertinent clinical history. Review any prior imaging studies. Determine the appropriate CT protocol for the examination, confirm that imaging before and after contrast administration is indicated, and determine the need for additional 2D reconstructions. Communicate protocol to the CT technologists.

Description of Intra-Service Work: Interpret the images, which are optimized for evaluation of the orbits (globe, lens, lacrimal glands, optic nerves, extraocular muscles, intraconal fat). Assess the facial soft tissues including the retromaxillary fat. Assess the cavernous, precavernous spaces, infraorbital foramen, supraorbital foramen, optic canal, and pterygopalatine fossa. Evaluate the integrity of the horizontal, superior, and posterior semicircular canals, cochlea, modiolus, vestibular aqueduct, inner auditory canals, and course of the facial nerve. Assess the mineralization of the temporal bone. Assess the epitympanum and hypotympanum and the integrity and positioning of the ossicles. Assess the bony structures including the facial bones and skull base. Evaluate the visualized brain/brainstem. Assess for bony erosion and fractures in the case of trauma. Evaluate the paranasal sinuses and mastoid air cells. Assess for rim-enhancing fluid collections including periosteal abscess, masses, and perineural enhancement. Compare the current imaging to all pertinent available prior studies. Dictate a report.

Description of Post-Service Work: Review, edit, and sign report for the medical record. Communicate the findings with referring provider and/or patient as needed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Kurt Schoppe, MD; Daniel Wessell, MD; Lauren Golding, MD; Gregory Nicola, MD; Melissa Chen, MD				
Specialty(s):	American College of Radiology, American Society of Neuroradiology				
CPT Code:	70482				
Sample Size:	2562	Resp N:	42	Response: 1.6 %	
Description of Sample:	The ACR surveyed a total of 750 members (a random sample of 375 members and a separate random sample of 375 members who perform CT and neuro imaging procedures). The ASNR performed a random sample of 1812 of its membership.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	15.00	25.00	50.00	600.00
Survey RVW:	1.15	1.46	1.62	1.67	2.40
Pre-Service Evaluation Time:			4.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	5.00	11.00	15.00	20.00	40.00
Immediate Post Service-Time:	4.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	70482	Recommended Physician Work RVU: 1.27		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	4.00	0.00	4.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	15.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	4.00	0.00	4.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
70492	XXX	1.62	RUC Time

CPT Descriptor Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
70488	XXX	1.27	RUC Time

CPT Descriptor Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
74170	XXX	1.40	RUC Time	104,828

CPT Descriptor 1 Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 13 % of respondents: 30.9 %

Number of respondents who choose 2nd Key Reference Code: 10 % of respondents: 23.8 %

TIME ESTIMATES (Median)

	CPT Code: <u>70482</u>	Top Key Reference CPT Code: <u>70492</u>	2nd Key Reference CPT Code: <u>70488</u>
Median Pre-Service Time	4.00	5.00	5.00
Median Intra-Service Time	15.00	20.00	15.00
Median Immediate Post-service Time	4.00	5.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	23.00	30.00	25.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	8%	69%	23%	0%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
8%	69%	23%

Technical Skill/Physical Effort

<u>Less</u>	<u>Identical</u>	<u>More</u>
8%	69%	23%

Physical effort required	0%	92%	8%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

8%	69%	23%
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2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	0%	40%	60%	0%
------------------------------	----	----	-----	-----	----

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

20%	40%	40%
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Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	10%	60%	30%
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Physical effort required	0%	70%	30%
--------------------------	----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%	60%	40%
----	-----	-----

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

CPT code 70480 was identified on the screen for CMS/Other codes with utilization over 30,000. 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. The descriptors for these three codes are shown below.

- **70480** (*Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material*),
- **70481** (*Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)*),
- **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*)

This family of CT codes will not have the normal step-up in times and work RVU as other family of codes that is typical of radiology because of the different anatomy, and therefore type of work that is typical for the 70480 code compared to the 70481 and 70482 codes. This is supported by the claims database where the most commonly billed diagnosis for 70480 is hearing loss, while the most commonly billed diagnosis for both 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 70481 and 70482.

Survey Process

The specialties surveyed a total of 2,562 members. The ACR surveyed a total of 750 members (a random sample of 375 members and a separate random sample of 375 members who perform CT and neuro imaging procedures). The ASNR performed a random sample of 1,812 of its membership.

Although these codes have been previously valued under flawed methodology of CMS/Other, we will not be seeking compelling evidence argument.

After pre-facilitation meeting, we are recommending to crosswalk the 70482 code to CPT code 70488 (*Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections*).

CPT code 70482 is an important tool in investigating diverse causes for visual changes, eye pain, and orbital swelling, as well as the extent of involvement of known infectious/inflammatory/ neoplastic processes of the eye. Similarly to 70481, 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. Not only is a positive result significant, a negative result is also pertinent in patient management in relieving patient anxiety, and in providing assurance to ordering physicians. A combination of its utility (as a positive and negative predictor of pathology), intensity, and the amount of technical training necessary to accurately interpret leads us to believe that this procedure would be appropriately valued at 1.27 work RVU.

Work RVU Recommendation:

The expert panel recommends a work RVU of 1.27 for CPT code 70482, which is cross-walked to CPT code 70488 and is one of the commonly chosen Key Reference Services.

Time Recommendation:

The expert panel recommends the following median survey times: 4 minutes of pre-service time, 15 minutes of intra-service time, and 4 minutes of post-service time. This is a total time of 23 minutes.

Key Reference Services

The most commonly chosen reference codes by survey participants include a CT of soft tissue neck without and with contrast and a CT of maxillofacial area without and with contrast procedure.

- **70492** (*Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections*), chosen by 31% of respondents, and
- **70488** (*Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections*), chosen by 24% of respondents.

Our recommendation is comparable to both of the most commonly chosen KRS. The second most commonly chosen KRS, 70488 has the same intraservice time and covers similar anatomic regions compared to 70482, which is why it was selected as a crosswalk. While survey respondents indicated 70482 has more complexity and intensity than 70488, the latter code has similar times and remains an appropriate comparison.

The relationships are summarized in the following table:

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWPUT	% chosen
70482	CT, orbit, sella, posterior fossa or ear; w/o and w/contrast	1.27	23	4	15	4	0.073	
70488	CT, maxillofacial; w/o and w/contrast	1.27	25	5	15	5	0.070	24%
70492	CT, soft tissue neck; w/o & w/contrast	1.62	30	5	20	5	0.070	31%

MPC Code

The surveyed code compares well with MPC code 74170 (*Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections*). The surveyed code and the MPC have similar intra-service times, but the surveyed 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 relationships are summarized in the following table:

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWPUT
70482	CT, orbit, sella, posterior fossa or ear; w/o and w/contrast	1.27	23	4	15	4	0.073
74170	CT abd w/o & w/contrast	1.40	28	5	18	5	0.065

Summary

The cross-walked value and comparison with applicable codes support 1.27, which is below the 25th percentile for **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). Relativity within the contrast codes of this family is maintained, and across the family of RUC-reviewed CT codes.

CPT Code	Descriptor	wRVU	Pre Time	Intra Time	Post Time	TOTAL Time	IWPUT	Source	RUC Mtg Date
70450	Computed tomography, head or brain; without contrast material	0.85	4	10	5	19	0.065	RUC	Oct-12
72192	Computed tomography, pelvis; without contrast material	1.09	3	10	5	18	0.091	RUC	Aug-05
70460	Computed tomography, head or brain; with contrast material(s)	1.13	5	12	5	22	0.076	RUC	Oct-12
70481	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material	1.13	4	13	3	20	0.075		Oct 2018
71250	Computed tomography, thorax; without contrast material	1.16	5	15	5	25	0.062	RUC	Apr-16
72193	Computed tomography, pelvis; with contrast material(s)	1.16	3	10	5	18	0.098	RUC	Aug-05
74150	Computed tomography, abdomen; without contrast material	1.19	3	12	5	20	0.084	RUC	Aug-05
71260	Computed tomography, thorax; with contrast material(s)	1.24	5	16	5	26	0.064	RUC	Apr-16
70470	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections	1.27	5	15	5	25	0.070	RUC	Apr-11
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	1.27	4	15	4	23	0.073		Oct 2018
74160	Computed tomography, abdomen; with contrast material(s)	1.27	3	15	5	23	0.073	RUC	Aug-05
70480	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material	1.28	4	15	3	22	0.075		Oct 2018
70490	Computed tomography, soft tissue neck; without contrast material	1.28	5	15	5	25	0.070	RUC	Jan-17
70540	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)	1.35	5	19	5	29	0.059	RUC	Jan-16
70491	Computed tomography, soft tissue neck; with contrast material(s)	1.38	5	17	5	27	0.068	RUC	Jan-17

74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	1.40	5	18	5	28	0.065	RUC	Apr-12
70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material	1.48	5	18	5	28	0.070	RUC	Jan-13
70492	Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections	1.62	5	20	5	30	0.070	RUC	Jan-17
70542	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)	1.62	5	20	5	30	0.070	RUC	Jan-16
74176	Computed tomography, abdomen and pelvis; without contrast material	1.74	5	22	5	32	0.069	RUC	Feb-10
70498	Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing	1.75	5	20	5	30	0.076	RUC	Apr-14
70552	Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)	1.78	5	20	7	32	0.076	RUC	Jan-13
72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)	1.78	5	23	5	33	0.068	RUC	Apr-13
74177	Computed tomography, abdomen and pelvis; with contrast material(s)	1.82	5	25	5	35	0.064	RUC	Feb-10
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	2.01	5	30	5	40	0.060	RUC	Feb-10

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 70482

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 15600

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 70482 is estimated to be provided 15,600 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 15087 Percentage 96.71 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,200

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 70482 is estimated to be provided 5,200 times nationally in a one-year period to Medicare patients.

Specialty Diagnostic Radiology Frequency 5029 Percentage 96.71 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Imaging

BETOS Sub-classification:

Advanced imaging

BETOS Sub-classification Level II:

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 70482

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR	AS
13	ISSUE: CT Orbit/Sella/Ear/Fossa																								
14	TAB: 16																								
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
17	1st REF	70542	Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)	9	0.070			1.62			30	5					20			5					
18	2nd REF	70490	Computed tomography, soft tissue neck; without contrast material	7	0.070			1.28			25	5					15			5					
19	CMS/Other	70480	Computed tomography, orbit, sella, or		0.000			1.28			25														
20	SVY	70480	Computed tomography, orbit, sella, or	42	0.082	1.07	1.28	1.39	1.62	2.00	22	4			5	10	15	15	25	3	10	31	78	200	1500
21	ACK	70480	Computed tomography, orbit, sella, or	16	0.096	1.07	1.32	1.50	1.64	2.00	18	3			5	10	15	15	25		20	29	50	100	500
22	ACK	70480	Computed tomography, orbit, sella, or	10	0.087	1.07	1.27	1.38	1.62	2.00	21	3			7	11	14	15	21	4	20	39	88	100	500
23	ACK	70480	Computed tomography, orbit, sella, or	6	0.095	1.29	1.43	1.60	1.68	1.90	23	4			5	11	15	15	25	4	25	26	30	45	85
24	ASNR	70480	Computed tomography, orbit, sella, or	26	0.080	1.17	1.28	1.35	1.60	2.00	22	4			6	11	15	15	25	3	10	46	100	250	1500
25	REC	70480	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material		0.075			1.28			22	4					15			3					
26																									
27						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
28	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
29	1st REF	70491	Computed tomography, soft tissue neck; with contrast material(s)	12	0.068			1.38			27	5					17			5					
30	2nd REF	70487	Computed tomography, maxillofacial area; with contrast material(s)	11	0.076			1.13			22	5					12			5					
31	CMS/Other	70481	Computed tomography, orbit, sella, or		#DIV/0!			1.38			26														
32	SVY	70481	Computed tomography, orbit, sella, or	42	0.096	1.04	1.32	1.40	1.60	2.10	20	4			5	10	13	15	30	3	0	25	50	100	600
33	ACK	70481	Computed tomography, orbit, sella, or	16	0.083	1.13	1.38	1.42	1.61	2.10	23	4			5	10	15	19	30	4	0	14	25	100	500
34	ACK	70481	Computed tomography, orbit, sella, or	10	0.081	1.13	1.38	1.40	1.50	2.00	23	4			7	13	15	16	30	4	0	21	63	100	500
35	ACK	70481	Computed tomography, orbit, sella, or	6	0.091	1.38	1.41	1.55	1.62	2.10	23	4			5	11	15	20	28	4	5	10	20	44	80
36	ASNR	70481	Computed tomography, orbit, sella, or	26	0.102	1.04	1.26	1.38	1.59	1.90	19	4			6	10	12	15	25	3	10	31	55	100	600
37	REC	70481	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)		0.075			1.13			20	4					13			3					
38																									
39						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
40	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
41	1st REF	70492	Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections	13	0.070			1.62			30	5					20			5					
42	2nd REF	70488	Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections	10	0.070			1.27			25	5					15			5					
43	CMS/Other	70482	Computed tomography, orbit, sella, or		#DIV/0!			1.45			27														
44	SVY	70482	Computed tomography, orbit, sella, or	42	0.096	1.15	1.46	1.62	1.67	2.40	23	4			5	11	15	20	40	4	0	15	25	50	600
45	ACK	70482	Computed tomography, orbit, sella, or	16	0.087	1.19	1.57	1.62	1.71	2.40	26	5			5	14	16	22	40	5	2	12	24	63	500
46	ACK	70482	Computed tomography, orbit, sella, or	10	0.090	1.19	1.61	1.64	1.74	2.00	25	4			7	15	16	20	40	5	2	16	38	100	500
47	ACK	70482	Computed tomography, orbit, sella, or	6	0.069	1.55	1.56	1.59	1.62	2.40	29	5			5	13	20	25	30	4	5	11	17	24	50
48	ASNR	70482	Computed tomography, orbit, sella, or	26	0.104	1.15	1.31	1.61	1.64	2.00	21	4			8	11	14	19	35	3	0	20	28	50	600
49	REC	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		0.073			1.27			23	4					15			4					

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor:

70480	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material
70481	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)
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

Global Period: XXX Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

The American College of Radiology (ACR) and the American Society of Neuroradiology (ASNR) convened a consensus panel to finalize the practice expense data for the CT orbit/sella/fossa/ear code family, CPT codes 70480, 70481, and 70482.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

The society included the existing PE inputs for codes 70480, 70481, and 70482 on the spreadsheet to serve as a reference.

3. Is this code(s) typically billed with an E/M service?
Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)

These codes are not typically billed with an E/M service.
These codes are not typically billed with an E/M service in the nonfacility.

4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different then for the global?
(Please see provided data in PE Subcommittee folder)

Diagnostic radiology is the dominant provider in the nonfacility for this code family and has the following time percentages for each code:

70480: 60%

70481: 76%

70482: 74%

Diagnostic radiology is also the dominant provider in the global for this code family.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
 - **Prepare room, equipment, supplies (CA013)** – 2 minutes is the standard for most exams; however, we are requesting 4 minutes for 70481 and 70482 to allow additional time for the technologist to set up the contrast injector and prepare the contrast materials for injection. This is consistent with the recently reviewed codes, CT neck and CT chest.
 - **Prepare, set up and start IV, initial positioning and monitoring of patient (CA016)** - 2 minutes is standard for non-contrast codes and consistent with prior CT exams. We recommended 5 minutes for the codes involving contrast (70481 and 70482) to allow for time for positioning the patient with the IV, connecting the patient to the contrast injector, and ensuring there are no impediments to table motion during the exam. This is consistent with the recently reviewed codes, CT neck and CT chest.
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.
N/A
7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:
N/A
8. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:
Bring patient into CT room and assist patient onto CT table. Position patient's anatomy for anatomic coverage and comfort. If contrast is required, prepare injector, perform a test injection if needed, and ensure free movement of IV tubing with CT gantry motion. Step behind shielding to control panel. Set appropriate exposure parameters. Instruct patient to hold still. Obtain scout image. Confirm appropriate patient positioning to ensure adequate coverage of anatomic region and potential pathology. Adjust patient positioning if needed. Set acquisition parameters. Instruct patient to hold still. Obtain axial images. Confirm appropriate imaging coverage. For the without followed by with contrast material examination, the process above is repeated to obtain axial images with contrast. The images are checked for quality and above steps are repeated for any additional covered needed. Special reformatted images are performed by the technologist for these sets of codes. In addition to the typical coronal and sagittal reformations that are performed, additional reformatted planes are created. For the 70480 code, the technologist selects the plane that is parallel to the axis of the petrous bone to create reconstructions. Then the technologist creates an additional reformat that is orthogonal to this plane. This has to be performed for both sides of the temporal bone. For the 70481 and 70482 codes, the technologist creates sagittal reformats along the axis of the optic nerve on both sides. Send the images from the console to the image archive.
9. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
N/A
10. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:
N/A

11. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.
N/A
12. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:
N/A
13. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:
14. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:
 - **Technologist PACS Workstation Proxy (ED050)** –PACS formula; Equals total service period time
 - **Professional PACS Workstation (ED053)** – Equals physician work intra time + 1/2 physician work pre-time
 - **Room, CT (EL007)** – Highly technical formula
15. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:
N/A
16. If there is any other item on your spreadsheet that needs further explanation please include here:
N/A
17. Please include an explanation of each line item:
N/A

	A	B	D	E	I	K	O	Q	U	W
1	RUC Practice Expense Spreadsheet				CURRENT	RECOMMENDED	CURRENT	RECOMMENDED	CURRENT	RECOMMENDED
2		<i>standards/guidelines in column C. For more</i>			70480	70480	70481	70481	70482	70482
3		<i>RUC Collaboration Website</i>			Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material (Aug. 2003)	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material (Oct. 2018)	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s) (Aug. 2003)	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s) (Oct. 2018)	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections (Aug. 2003)	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections (Oct. 2018)
4	Clinical Activity Code	Meeting Date: October 2018 Tab: CT Orbit/Ear/Fossa Specialty: ACR, ASNR	Clinical Staff Type Code	Clinical Staff Type						
5		LOCATION			Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac
6		GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME			\$ 244.76	\$ 153.15	\$ 294.74	\$ 197.08	\$ 337.58	\$ 245.32
8		TOTAL CLINICAL STAFF TIME	L046A	CT Technologist	51.0	42.0	60.0	50.0	68.0	59.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L046A	CT Technologist	6.0	3.0	7.0	3.0	7.0	3.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L046A	CT Technologist	45.0	39.0	53.0	47.0	61.0	56.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L046A	CT Technologist	0.0	0.0	0.0	0.0	0.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE			\$ 23.46	\$ 19.32	\$ 27.60	\$ 23.00	\$ 31.28	\$ 27.14
13	PRE-SERVICE PERIOD									
14	Start: Following visit when decision for surgery or procedure made									
20	CA006	Confirm availability of prior images/studies	L046A	CT Technologist	6	2	7	2	7	2
21	CA007	Review patient clinical extant information and questionnaire	L046A	CT Technologist		1		1		1
22	CA008	Perform regulatory mandated quality assurance								
29	End: When patient enters office/facility for surgery/procedure									
30	SERVICE PERIOD									
31	Start: When patient enters office/facility for surgery/procedure:									
32	Pre-Service (of service period)									
33	CA009	Greet patient, provide gowning, ensure	L046A	CT	3	3	3	3	3	3
34	CA010	Obtain vital signs								
35	CA011	Provide education/obtain consent	L046A	CT Technologist	2	2	3	3	3	3
36	CA012	Review requisition, assess for special needs								
37	CA013	Prepare room, equipment and supplies	L046A	CT Technologist	2	2	4	4	4	4
38	CA014	Confirm order, protocol exam	L046A	CT Technologist		1		1		1
39	CA015	Setup scope (nonfacility setting only)								
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L046A	CT Technologist	4	2	7	5	7	5
41	CA017	Sedate/apply anesthesia								
48	Intra-service (of service period)									
49	CA018	Assist physician or other qualified healthcare								
50	CA019	Assist physician or other qualified healthcare								
51	CA020	Assist physician or other qualified healthcare								
52	CA021	Perform procedure/service---NOT directly related to physician work time	L046A	CT Technologist	20	20	22	22	26	31
59	Post-Service (of service period)									
60	CA022	Monitor patient following procedure/service,								
61	CA023	Monitor patient following procedure/service, no								
62	CA024	Clean room/equipment by clinical staff	L046A	CT	3	3	3	3	3	3
63	CA025	Clean scope								
64	CA026	Clean surgical instrument package								
65	CA027	Complete post-procedure diagnostic forms, lab								
66	CA028	Review/read post-procedure x-ray, lab and								
67	CA029	Check dressings, catheters, wounds								

	A	B	D	E	I	K	O	Q	U	W
1		RUC Practice Expense Spreadsheet			CURRENT	RECOMMENDED	CURRENT	RECOMMENDED	CURRENT	RECOMMENDED
2		standards/guidelines in column C. For more			70480	70480	70481	70481	70482	70482
3		RUC Collaboration Website			Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material (Aug. 2003)	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material (Oct. 2018)	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s) (Aug. 2003)	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s) (Oct. 2018)	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections (Aug. 2003)	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections (Oct. 2018)
4		Clinical Activity Code Meeting Date: October 2018 Tab: CT Orbit/Ear/Fossa Specialty: ACR, ASNR	Clinical Staff Type Code	Clinical Staff Type						
5		LOCATION			Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac
6		GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME			\$ 244.76	\$ 153.15	\$ 294.74	\$ 197.08	\$ 337.58	\$ 245.32
8		TOTAL CLINICAL STAFF TIME	L046A	CT Technolo	51.0	42.0	60.0	50.0	68.0	59.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L046A	CT Technolo	6.0	3.0	7.0	3.0	7.0	3.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L046A	CT Technolo	45.0	39.0	53.0	47.0	61.0	56.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L046A	CT Technolo	0.0	0.0	0.0	0.0	0.0	0.0
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page	L046A	CT Technolo gist	11	3	11	3	15	3
69	CA031	Review examination with interpreting MD/DO	L046A	CT		2		2		2
70	CA032	Scan exam documents into PACS. Complete	L046A	CT		1		1		1
71	CA033	Perform regulatory mandated quality assurance								
81		End: Patient leaves office								
82		POST-SERVICE PERIOD								
83		Start: Patient leaves office/facility								
99		End: with last office visit before end of global								
100	Supply	MEDICAL SUPPLIES	PRICE	UNIT						
101		TOTAL COST OF SUPPLY QUANTITY x PRICE			\$ 0.63	\$ 0.63	\$ 7.37	\$ 6.77	\$ 7.37	\$ 6.77
103	SA019	kit, iv starter	1.6	kit			1	1	1	1
104		1 tourniquet								
105		1 alcohol prep pad								
106		1 PVP ointment								
107		1 PVP prep pad								
108		2 gauze sponges (2"x2")								
109		1 bandage (1"x3")								
110		1 sm roll surgical tape								
111		1 pr gloves								
112		1 underpad 2ft x 3ft (Chux)								
113	SB006	drape, non-sterile, sheet 40in x 60in	0.222	item			1	1	1	1
114	SB022	gloves, non-sterile	0.084	pair			1		1	
115	SB026	gown, patient	0.533	item	1	1	1	1	1	1
116	SB036	paper, exam table	0.014	foot	7	7	7	7	7	7
117	SC001	angiocatheter 14g-24g	1.505	item			1	1	1	1
118	SC012	heparin lock	0.917	item			1	1	1	1
119	SC019	iv tubing (extension)	0.53	foot			1	1	1	1
120	SC029	needle, 18-27g	0.089	item			1	1	1	1
121	SC053	syringe 20ml	0.558	item			1	1	1	1
122	SG021	bandage, strip 0.75in x 3in (Bandaid)	0.043	item			1		1	
123	SG053	gauze, sterile 2in x 2in	0.057	item			1		1	
124	SG079	tape, surgical paper 1in (Micropore)	0.002	inch			6		6	
125	SH068	sodium chloride 0.9% inj bacteriostatic (30ml uou)	0.7	item			1	1	1	1
126	SJ043	povidone swabsticks (3 pack uou)	0.409	item			1	0	1	0
127	SJ053	swab-pad, alcohol	0.013	item			1	1	1	1
129										
130	Equipme nt Code	EQUIPMENT	Purchase Price	Equipme nt Formula						
131		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE			\$ 220.67	\$ 133.20	\$ 259.77	\$ 167.32	\$ 298.93	\$ 211.42
132	ED050	Technologist PACS workstation	5557	PACS	45	39	53	47	61	56
133	ED053	Professional PACS Workstation	14616.93	Other Formula	13	17	13	15	14	17
134	EL007	room, CT	1284000	Highly Technica l	45	27	53	34	61	43

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS/Other Source – Medicare Utilization Over 30,000

October 2018

X-Ray Exam – Clavicle/Shoulder (PE Only)

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.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
73000	Radiologic examination; clavicle, complete	XXX	0.16 (April 2018 RUC Recommendation)
73010	Radiologic examination; scapula, complete	XXX	0.17 (April 2018 RUC Recommendation)
73020	Radiologic examination, shoulder; 1 view	XXX	0.15 (April 2018 RUC Recommendation)
(f)73030	Radiologic examination, shoulder; complete, minimum of 2 views	XXX	0.18 (April 2018 RUC Recommendation).
(f)73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	XXX	0.18 (April 2018 RUC Recommendation)

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor:

73000	Radiologic examination; clavicle, complete
73010	Radiologic examination; scapula, complete
73020	Radiologic examination, shoulder; 1 view
73030	Radiologic examination, shoulder; complete, minimum of 2 views
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction

Global Period: XXX Meeting Date: April 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

The American College of Radiology (ACR) and American Academy of Orthopaedic Society (AAOS) convened a consensus panel to finalize the practice expense data for the X-Ray exam of the clavicle and shoulder code family, CPT codes 73000, 73010, 73020, 73030, and 73050.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code.** You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

The societies included the existing PE inputs for codes 73000, 73010, 73020, 73030, and 73050 on the spreadsheet to serve as a reference.

3. Is this code(s) typically billed with an E/M service?

Codes 73010 and 73050 are typically billed with an E/M service; 54% and 64%, respectively. Codes 73000, 73020 and 73030 are not; 27%, 22% and 36%, respectively.

Is this code(s) typically billed with the E/M service in the nonfacility?

Codes 73010, 73020, 73030 and 73050 are typically billed with the E/M service in the nonfacility; 77%, 56%, 64% and 76%, respectively. Code 73000 is not typically billed at 49%.

At the October 2018 RUC meeting, duplicative time for clinical activities, CA013 Prepare room, equipment and supplies and CA024 Clean room/equipment by clinical staff was removed.

4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different then for the global?
(Please see provided data in PE Subcommittee folder)

Orthopedic Surgery is the dominant provider in the nonfacility for all codes in this family.

73000: 56%

73010: 72%

73020: 52%

73030: 55%

73050: 65%

Diagnostic Radiology is the dominant provider for the global for CPT codes 73000, 73020, and 73030. Orthopedic Surgery is the dominant provider for the global for CPT codes 73010 and 73050.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
N/A
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

For CPT code 73030 (*Radiologic examination, shoulder; complete, minimum of 2 views*), we are requesting 2 additional minutes for the technologist to perform the examination (CA021: Perform procedure/service---NOT directly related to physician work time). While this is a minimum 2 view code, typical clinical practice currently is a three view exam (AP, Grashey plus a transscapular-Y or axillary view). The two additional minutes (6 minutes total) is consistent with the 2 minutes per view that we have typically recommended for extremity codes

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:
8. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

Bring patient into x-ray room and have patient sit/lie on x-ray table or stand as appropriate. Place first cassette behind patient's clavicle, shoulder or acromioclavicular joint. Position patient's anatomy for the first view. Step behind shielding to control panel. Set appropriate exposure parameters. Instruct patient to hold still. Take exposure for first view. Step from behind shielding. Take first cassette from behind patient and place second cassette as needed. Position patient's anatomy for second view. Step behind shielding to control panel. Set appropriate exposure parameters. Instruct patient to hold still. Take exposure for second view. Step from behind shielding. Take second cassette out behind patient. The above steps are repeated for any additional views to be obtained. All cassettes are then taken to the image reader. Run all three cassettes through reader. Check all images for adequate exposure, positioning, coverage, etc. Repeat any views as needed. Typical number of views for 73000 would be 2 (AP and up-angled), for 73010 would be 2 (AP and Lateral), for 73020 would be 1 (AP), for 73030 would be 3 (AP, Grashey and trans-scapular Y or axillary) and for 73050 would be 3 (AP and up-angled of affected side with AP contralateral comparison view).

9. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
N/A
10. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

N/A

11. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.

N/A

12. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:

N/A

13. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:

N/A

14. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

- **Technologist PACS Workstation Proxy (ED050)** –PACS formula; Equals total service period time
- **Professional PACS Workstation (ED053)** – Equals physician work intra time + 1/2 physician work pre-time
- **Room, basic radiology (EL012)** – Highly technical formula

15. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:

N/A

16. If there is any other item on your spreadsheet that needs further explanation please include here:

N/A

17. Please include an explanation of each line item:

N/A

	A	B	D	E	F	G	H	I	J	K	L	M						
1	RUC Practice Expense Spreadsheet - REVISED AT RUC					CURRENT	RECOMMENDED	CURRENT	RECOMMENDED	CURRENT	RECOMMENDED	CURRENT						
2		standards/guidelines in column C. For more				73000	73000	73010	73010	73020	73020	73030						
3		RUC Collaboration Website				Radiologic examination; clavicle, complete (Aug 2003)	Radiologic examination; clavicle, complete (Oct 2018)	Radiologic examination; scapula, complete (Aug 2003)	Radiologic examination; scapula, complete (Oct 2018)	Radiologic examination, shoulder; 1 view (Aug 2003)	Radiologic examination, shoulder; 1 view (Oct 2018)	Radiologic examination, shoulder; complete, minimum of 2 views (Aug 2003)						
4	Clinical Activity Code	Meeting Date: October 2018 - REVISED Tab: 20 - X-Ray Clavicle/Shoulder Specialty: ACR, AAOS	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute													
5		LOCATION											Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac
6		GLOBAL PERIOD																
7		TOTAL COST OF CLINICAL STAFF, SUPPLIES AND EQUIPMENT				\$ 13.22	\$ 13.85	\$ 13.22	\$ 7.62	\$ 10.54	\$ 8.51	\$ 11.89						
8		TOTAL CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	14.0	19.0	14.0	11.0	11.0	12.0	14.0						
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	0.0	0.0	0.0	0.0	0.0	0.0	0.0						
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	14.0	19.0	14.0	11.0	11.0	12.0	14.0						
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	0.0	0.0	0.0	0.0	0.0	0.0	0.0						
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE				\$ 5.74	\$ 7.79	\$ 5.74	\$ 4.51	\$ 4.51	\$ 4.92	\$ 5.74						
13	PRE-SERVICE PERIOD																	
14	Start: Following visit when decision for surgery or procedure made																	
29	End: When patient enters office/facility for surgery/procedure																	
30	SERVICE PERIOD																	
31	Start: When patient enters office/facility for surgery/procedure:																	
32	Pre-Service (of service period)																	
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	L041B	Radiologic Technologist	0.41	3	3	3		3		3						
34	CA010	Obtain vital signs																
35	CA011	Provide education/obtain consent																
36	CA012	Review requisition, assess for special needs																
37	CA013	Prepare room, equipment and supplies	L041B	Radiologic Technologist	0.41	1	2	1	0	1	1	1						
38	CA014	Confirm order, protocol exam																
39	CA015	Setup scope (nonfacility setting only)																
40	CA016	Prepare, set-up and start IV, initial positioning and	L041B	Radiologic Technologist	0.41	1	2	1	2	1	1	1						
41	CA017	Sedate/apply anesthesia																
48	Intra-service (of service period)																	
49	CA018	Assist physician or other qualified healthcare																
50	CA019	Assist physician or other qualified healthcare																
51	CA020	Assist physician or other qualified healthcare																
52	CA021	Perform procedure/service---NOT directly related to physician work time	L041B	Radiologic Technologist	0.41	4	4	4	4	2	2	4						
59	Post-Service (of service period)																	
60	CA022	Monitor patient following procedure/service,																
61	CA023	Monitor patient following procedure/service, no																
62	CA024	Clean room/equipment by clinical staff	L041B	Radiologic Technologist	0.41	2	3	2	0	2	3	2						
63	CA025	Clean scope																
64	CA026	Clean surgical instrument package																
65	CA027	Complete post-procedure diagnostic forms, lab and																
66	CA028	Review/read post-procedure x-ray, lab and																
67	CA029	Check dressings, catheters, wounds																
68	CA030	Technologist QC's images in PACS, checking for all	L041B	Radiologic Technologist	0.41	3	2	3	2	2	2	3						
69	CA031	Review examination with interpreting MD/DO	L041B	Radiologic Technologist	0.41		2		2		2							
70	CA032	Scan exam documents into PACS. Complete exam	L041B	Radiologic Technologist	0.41		1		1		1							
71	CA033	Perform regulatory mandated quality assurance																
72	CA034	Document procedure (nonPACS) (e.g. mandated																
73	CA035	Review home care instructions, coordinate																
74	CA036	Discharge day management				n/a	n/a	n/a	n/a	n/a	n/a	n/a						
81	End: Patient leaves office																	
82	POST-SERVICE PERIOD																	
83	Start: Patient leaves office/facility																	
99	End: with last office visit before end of global																	

	A	B	D	E	F	G	H	I	J	K	L	M
1	RUC Practice Expense Spreadsheet - REVISED AT RUC					CURRENT	RECOMMENDED	CURRENT	RECOMMENDED	CURRENT	RECOMMENDED	CURRENT
2		standards/guidelines in column C. For more				73000	73000	73010	73010	73020	73020	73030
3		RUC Collaboration Website				Radiologic examination; clavicle, complete (Aug 2003)	Radiologic examination; clavicle, complete (Oct 2018)	Radiologic examination; scapula, complete (Aug 2003)	Radiologic examination; scapula, complete (Oct 2018)	Radiologic examination, shoulder; 1 view (Aug 2003)	Radiologic examination, shoulder; 1 view (Oct 2018)	Radiologic examination, shoulder; complete, minimum of 2 views (Aug 2003)
4	Clinical Activity Code	Meeting Date: October 2018 - REVISED Tab: 20 - X-Ray Clavicle/Shoulder Specialty: ACR, AAOS	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute							
5		LOCATION				Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac
6		GLOBAL PERIOD										
7		TOTAL COST OF CLINICAL STAFF, SUPPLIES AND EQUIPMENT				\$ 13.22	\$ 13.85	\$ 13.22	\$ 7.62	\$ 10.54	\$ 8.51	\$ 11.89
8		TOTAL CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	14.0	19.0	14.0	11.0	11.0	12.0	14.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	14.0	19.0	14.0	11.0	11.0	12.0	14.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	0.0	0.0	0.0	0.0	0.0	0.0	0.0
100	Medical	MEDICAL SUPPLIES	PRICE	UNIT								
101		TOTAL COST OF SUPPLY QUANTITY x PRICE				\$ 0.53	\$ 0.53	\$ 0.53	\$ -	\$ 0.53	\$ -	\$ 0.53
102	SB026	gown, patient	0.533	item		1	1	1		1		1
103												
110	Equipment Code	EQUIPMENT	Purchase Price	Equipment Formula	Cost Per Minute							
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE				\$ 6.95	\$ 5.53	\$ 6.95	\$ 3.11	\$ 5.50	\$ 3.59	\$ 5.61
112	ED050	Technologist PACS workstation	5557	PACS	0.022017924	14	19	14	11	11	12	17
113	ED053	Professional PACS Workstation	14616.93	Other Formula	0.057915145	3	4	3	4	3	4	5
114	EL012	room, basic radiology	127750	Highly Technical	0.484047196	14	11	14	6	11	7	11

	A	B	N	O	P
1	RUC Practice Expense Spreadsheet - REVISED AT RUC		RECOMMENDED	CURRENT	RECOMMENDED
2		<i>standards/guidelines in column C. For more</i>	73030	73050	73050
3		RUC Collaboration Website	Radiologic examination, shoulder; complete, minimum of 2 views (Oct 2018)	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction (Aug 2003)	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction (Oct 2018)
4	Clinical Activity Code	Meeting Date: October 2018 - REVISED Tab: 20 - X-Ray Clavicle/Shoulder Specialty: ACR, AAOS			
5		LOCATION	Non Fac	Non Fac	Non Fac
6		GLOBAL PERIOD			
7		TOTAL COST OF CLINICAL STAFF, SUPPLIES AND EQUIPMENT	\$ 13.93	\$ 15.01	\$ 9.46
8		TOTAL CLINICAL STAFF TIME	18.0	16.0	13.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	18.0	16.0	13.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	\$ 7.38	\$ 6.56	\$ 5.33
13		PRE-SERVICE PERIOD			
14		Start: Following visit when decision for surgery or			
29		End: When patient enters office/facility for surgery.			
30		SERVICE PERIOD			
31		Start: When patient enters office/facility for surgery			
32		Pre-Service (of service period)			
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available		3	
34	CA010	Obtain vital signs			
35	CA011	Provide education/obtain consent			
36	CA012	Review requisition, assess for special needs			
37	CA013	Prepare room, equipment and supplies	2	1	0
38	CA014	Confirm order, protocol exam			
39	CA015	Setup scope (nonfacility setting only)			
40	CA016	Prepare, set-up and start IV, initial positioning and	2	1	2
41	CA017	Sedate/apply anesthesia			
48		Intra-service (of service period)			
49	CA018	Assist physician or other qualified healthcare			
50	CA019	Assist physician or other qualified healthcare			
51	CA020	Assist physician or other qualified healthcare			
52	CA021	Perform procedure/service---NOT directly related to physician work time	6	6	6
59		Post-Service (of service period)			
60	CA022	Monitor patient following procedure/service,			
61	CA023	Monitor patient following procedure/service, no			
62	CA024	Clean room/equipment by clinical staff	3	2	0
63	CA025	Clean scope			
64	CA026	Clean surgical instrument package			
65	CA027	Complete post-procedure diagnostic forms, lab and			
66	CA028	Review/read post-procedure x-ray, lab and			
67	CA029	Check dressings, catheters, wounds			
68	CA030	Technologist QC's images in PACS, checking for all	2	3	2
69	CA031	Review examination with interpreting MD/DO	2		2
70	CA032	Scan exam documents into PACS. Complete exam	1		1
71	CA033	Perform regulatory mandated quality assurance			
72	CA034	Document procedure (nonPACS) (e.g. mandated			
73	CA035	Review home care instructions, coordinate			
74	CA036	Discharge day management	n/a	n/a	n/a
81		End: Patient leaves office			
82		POST-SERVICE PERIOD			
83		Start: Patient leaves office/facility			
99		End: with last office visit before end of global			

	A	B	N	O	P
1	RUC Practice Expense Spreadsheet - REVISED AT RUC		RECOMMENDED	CURRENT	RECOMMENDED
2		<i>standards/guidelines in column C. For more</i>	73030	73050	73050
3		RUC Collaboration Website	Radiologic examination, shoulder; complete, minimum of 2 views (Oct 2018)	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction (Aug 2003)	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction (Oct 2018)
4	Clinical Activity Code	Meeting Date: October 2018 - REVISED Tab: 20 - X-Ray Clavicle/Shoulder Specialty: ACR, AAOS			
5		LOCATION	Non Fac	Non Fac	Non Fac
6		GLOBAL PERIOD			
7		TOTAL COST OF CLINICAL STAFF, SUPPLIES AND EQUIPMENT	\$ 13.93	\$ 15.01	\$ 9.46
8		TOTAL CLINICAL STAFF TIME	18.0	16.0	13.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	18.0	16.0	13.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0
100	Medical	MEDICAL SUPPLIES			
101		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ -	\$ 0.53	\$ -
102	SB026	gown, patient		1	
103					
110	Equipment Code	EQUIPMENT			
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ 6.55	\$ 7.92	\$ 4.13
112	ED050	Technologist PACS workstation	18	16	13
113	ED053	Professional PACS Workstation	5	3	5
114	EL012	room, basic radiology	13	16	8

April RUC Rec
X-Ray Exam Clavicle-
Shoulder (PE Only)

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS/Other Source – Medicare Utilization Over 30,000

April 2018

X-Ray Exam – Clavicle/ Shoulder

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 April 2018.

73000 Radiologic examination; clavicle, complete

The RUC reviewed the survey results from 82 physicians and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute, for a combined total of 5 minutes. The RUC determined that the current work RVU of 0.16, which is also the survey 25th percentile, appropriately accounts for the physician work involved to perform this service. The RUC noted that codes 73000, 73010, and 73020 require the same physician time, however, they are recommending slight differences in work values based on intensity and complexity. To justify the work RVU of 0.16, the RUC reviewed the top key reference code *73060 Radiologic examination; humerus, minimum of 2 views* (work RVU= 0.16, pre-service time of 1 minute, intra-service time of 3 minutes, and post-service time of 1 minute), and noted that both services require identical times, as well as the same amount of physician work, and therefore should be valued identically. To further justify a recommended work RVU of 0.16, the RUC reviewed the second key MPC comparison code *73120 Radiologic examination, hand; 2 views* (work RVU= 0.16, pre-service time of 1 minute, intra-service time of 4 minutes, and post-service time of 1 minute), and found that the survey code is appropriately valued because both codes require similar physician work and time, and should therefore be valued similarly. **The RUC recommends a work RVU of 0.16 for CPT code 73000.**

73010 Radiologic examination; scapula, complete

The RUC reviewed the survey results from 82 physicians and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute, for a combined total of 5 minutes. The RUC determined that the current work RVU of 0.17, which is also the survey 25th percentile, appropriately accounts for the physician work involved to perform this service. The RUC noted that codes 73000, 73010, and 73020 require the same physician time, however, they are recommending slight differences in work values based on intensity and complexity. To justify the work RVU of 0.17, the RUC reviewed the top key reference service code *73610 Radiologic examination, ankle; complete, minimum of 3 views* (work RVU= 0.17, pre-service time of 1 minute, intra-service time of 3 minutes, and post-service time of 1 minute), and noted that both services require an identical amount of work and times and should be valued similarly. To further justify a work RVU of 0.17, the RUC reviewed the second key reference code *73060 Radiologic examination; humerus, minimum of 2 views* (work RVU= 0.16, pre-service time of 1 minute, intra-service time of 3 minutes, and post-service time of 1 minute), and found that the survey

code is appropriately valued because it is more intense and complex to perform as indicated by 100% of the survey respondents, and should therefore be valued similarly due to both requiring the same physician time to perform. **The RUC recommends a work RVU of 0.17 for CPT code 73010.**

73020 Radiologic examination, shoulder; 1 view

The RUC reviewed the survey results from 82 physicians and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute, for a combined total of 5 minutes. The RUC determined that a work RVU of 0.15, which is the current value and below the survey 25th percentile, appropriately accounts for the physician work involved to perform this service. The RUC noted that codes 73000, 73010, and 73020 require the same physician time, however, they are recommending slight differences in work values based on intensity and complexity. To justify the work RVU of 0.15, the RUC reviewed top key reference code 73060 *Radiologic examination; humerus, minimum of 2 views* (work RVU= 0.16, pre-service time of 1 minute, intra-service time of 3 minutes, and post-service time of 1 minute), and noted that both services require identical time and should be valued similarly. To further justify a work RVU of 0.15, the RUC reviewed MPC code 93042 *Rhythm ECG, 1-3 leads; interpretation and report only* (work RVU= 0.15, pre-service time of 2 minutes, intra-service time of 3 minutes, and post-service time of 2 minutes), and found that the survey code is appropriately valued because both codes require an identical amount of physician work and identical intra-service times, further justifying a work RVU of 0.15 for the survey code. **The RUC recommends a work RVU of 0.15 for CPT code 73020.**

73030 Radiologic examination, shoulder; complete, minimum of 2 views

The RUC reviewed the survey results from 82 physicians and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute, for a combined total of 6 minutes. The RUC determined that a work RVU of 0.18, which is the current value and at the survey 25th percentile, appropriately accounts for the physician work involved to perform this service. To justify the work RVU of 0.18, the RUC compared the survey code to the top key reference code 73562 *Radiologic examination, knee; 3 views* (work RVU= 0.18, pre-service time of 1 minute, intra-service time of 4 minutes, and post-service time of 1 minute), and noted that both services require identical times and should be valued identically. To further justify a work RVU of 0.18, the RUC reviewed code 73552 *Radiologic examination, femur; minimum 2 views* (work RVU= 0.18, pre-service time of 1 minute, intra-service time of 4 minutes, and post-service time of 1 minute), and found that the survey code is appropriately valued because it requires identical intra-service and total times, further supporting a work value of 0.18 for the survey code. **The RUC recommends a work RVU of 0.18 for CPT code 73030.**

73050 Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction

The RUC reviewed the survey results from 75 physicians and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute, for a combined total of 6 minutes. The RUC determined that a work RVU of 0.18, which is below the current value and at the survey 25th percentile, appropriately accounts for the physician work involved to perform this service. To justify the work RVU of 0.18, the RUC compared the survey code to code 73562 *Radiologic examination, knee; 3 views* (work RVU= 0.18, pre-service time of 1 minute, intra-service time of 4 minutes, and post-service time of 1 minute), and noted that both services require

identical times and should be valued identically. To further justify a work RVU of 0.18, the RUC reviewed code 73552 *Radiologic examination, femur; minimum 2 views* (work RVU= 0.18, pre-service time of 1 minute, intra-service time of 4 minutes, and post-service time of 1 minute), and found that the survey code is appropriately valued because it requires identical intra-service and total times, which further supports a recommended work value of 0.18 for the survey code. **The RUC recommends a work RVU of 0.18 for CPT code 73050.**

Practice Expense

The Practice Expense (PE) Subcommittee removed 1 minute of clinical staff time for clinical activity, prepare, set-up and start IV, initial positioning and monitoring of patient (CA016). The PE Subcommittee noted that the non-facility billed together data show that multiple codes are billed on the same day. The specialty societies did not think that the codes billed 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 next PE Subcommittee meeting and remove any staff time, supplies and equipment that is found to be duplicative. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee. **The RUC recommends that the direct practice expense inputs be accepted as Interim and revisited at the October 2018 RUC meeting.**

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.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
73000	Radiologic examination; clavicle, complete	XXX	0.16 (No Change)
73010	Radiologic examination; scapula, complete	XXX	0.17 (No Change)
73020	Radiologic examination, shoulder; 1 view	XXX	0.15 (No Change)

73030(f)	Radiologic examination, shoulder; complete, minimum of 2 views	XXX	0.18 (No Change)
73050(f)	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	XXX	0.18

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 73000	Tracking Number	Original Specialty Recommended RVU: 0.16
		Presented Recommended RVU: 0.16
Global Period: XXX	Current Work RVU: 0.16	RUC Recommended RVU: 0.16

CPT Descriptor: Radiologic examination; clavicle, complete

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old woman has clavicular pain after a fall. A radiological examination is performed to evaluate for clavicle fracture.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the provided clinical history. Review any prior applicable imaging studies.

Description of Intra-Service Work: Supervise the technologist performing the examination, evaluating the quality of the exam and obtaining additional views as necessary. Assess the clavicle and the surrounding soft tissue and osseous structures. Interpret the examination with comparison to relevant prior imaging if available. Dictate report for the medical record.

Description of Post-Service Work: The final report is reviewed and signed, and findings are communicated to the referring physician as needed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2018				
Presenter(s):	Kurt Schoppe, MD; Daniel Wessell, MD; Andrew Moriarity, MD; William Creevy, MD; Hussein Elkousy, MD				
Specialty(s):	American College of Radiology, American Academy of Orthopaedic Surgeons				
CPT Code:	73000				
Sample Size:	2000	Resp N:	82	Response: 4.1 %	
Description of Sample:	The ACR surveyed a total of 1750 members (a random sample of 875 members and a separate random sample of 875 members who perform radiography, emergency/trauma, or musculoskeletal procedures). The AAOS performed a random sample of 250 individuals from their membership.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	42.00	74.00	750.00
Survey RVW:	0.13	0.16	0.17	0.18	0.27
Pre-Service Evaluation Time:			1.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	2.00	2.00	3.00	5.00	11.00
Immediate Post Service-Time:	2.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	73000	Recommended Physician Work RVU: 0.16		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	1.00	0.00	1.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	3.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	1.00	0.00	1.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
73060	XXX	0.16	RUC Time

CPT Descriptor Radiologic examination; humerus, minimum of 2 views**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
73562	XXX	0.18	RUC Time

CPT Descriptor Radiologic examination, knee; 3 views**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
90970	XXX	0.14	RUC Time	1,133,290

CPT Descriptor 1 End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
73120	XXX	0.16	RUC Time	280,566

CPT Descriptor 2 Radiologic examination, hand; 2 views

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99211	XXX	0.18	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 33 % of respondents: 40.2 %

Number of respondents who choose 2nd Key Reference Code: 10 % of respondents: 12.1 %

TIME ESTIMATES (Median)

	CPT Code: <u>73000</u>	Top Key Reference CPT Code: <u>73060</u>	2nd Key Reference CPT Code: <u>73562</u>
Median Pre-Service Time	1.00	1.00	1.00
Median Intra-Service Time	3.00	3.00	4.00
Median Immediate Post-service Time	1.00	1.00	1.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	5.00	5.00	6.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	85%	15%	0%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	3%	85%	12%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	0%	85%	15%

Physical effort required	3%	91%	6%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

3%	82%	15%
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2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	10%	70%	20%	0%
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Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

20%	70%	10%
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Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	0%	80%	20%
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Physical effort required	0%	90%	10%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

10%	80%	10%
-----	-----	-----

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

CPT codes 73000 [Radiologic examination; clavicle, complete], 73010 [Radiologic examination; scapula, complete], and 73020 [Radiologic examination, shoulder; 1 view] were identified for CMS-Other utilization

over 30,000. The American College of Radiology (ACR) and the American Academy of Orthopaedic Society (AAOS) agreed to survey the codes for the April 2018 RUC meeting and expanded the family to include CPT codes 73030 [*Radiologic examination; shoulder, complete, minimum of 2 views*] and 73050 [*Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction*]. The societies convened an expert panel of physicians familiar with the services to review the survey data and provide the following recommendations.

Survey Process

The ACR surveyed a total of 1,750 members (a random sample of 875 from the entire membership and a separate random sample of 875 members who perform radiography, emergency/trauma, or musculoskeletal procedures). The AAOS surveyed a total random sample of 250 members.

Work RVU Recommendation:

The expert panel recommends a work RVU of 0.16 for CPT code 73000 which is the 25th percentile of the survey and the current value.

Time Recommendation:

The expert panel recommends the following median survey times: 1 minute of pre-service time, 3 minutes of intra-service time, and 1 minute of post-service time. This is a total time of 5 minutes which, is the same as the existing CMS/Other total time of 5 minutes.

Key Reference Services

The most commonly chosen reference code by survey participants, 73060 (*Radiologic examination; humerus, minimum of 2 views*), has the same service times and identical wRVU as the surveyed code and is also an examination requiring at least two radiographic views to evaluate a bone and the adjacent joints. The second most commonly chosen code, 73562 (*Radiologic examination, knee; 3 views*), has a higher wRVU and an additional one minute of intra-service time needed to evaluate the knee, which focuses on the joint and articulation between two bones.

CPT	Descriptor	RVU	Total Time	Pre	Intra	Post	IWPUT	% chosen
73000	Radiologic examination; clavicle, complete	0.16	5	1	3	1	0.038	
73060	Radiologic examination; humerus, minimum of 2 views	0.16	5	1	3	1	0.038	40%
73562	Radiologic examination, knee; 3 views	0.18	6	1	4	1	0.034	12%

MPC Codes

The surveyed code compares well with three other MPC codes, only one of which is performed by radiology:

- **90970** - *End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older*
- **73120** - *Radiologic examination, hand; 2 views*

- **99211** - Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

The surveyed code wRVU is the same as MPC code 73120 and closely bracketed by the MPC codes 90970 and 99211. Code 90970 has similar intra-service time and 2.5 minutes less of total time, supporting the 0.02 lower wRVU. Code 73120 is a radiology code with 1 minute more intra-service time and the same wRVU. 73120 involves the evaluation of multiple bones and joints in the hand in two views, compared to the surveyed code, which involves fewer bones and joints, although it typically has three or more views for the complete examination. Code 99211 has 2 minutes more intra-service time and correspondingly has 0.02 more wRVU compared to the surveyed code. These three MPC codes are included in the following table for comparison and confirm the appropriateness of the recommended wRVU and times within the larger RBRVS.

CPT	Descriptor	RVU	Total Time	Pre	Intra	Post	IWPUT
90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	0.14	2.5		2.5		0.056
73000	Radiologic examination; clavicle, complete	0.16	5	1	3	1	0.038
73120	Radiologic examination, hand; 2 views	0.16	6	1	4	1	0.029
99211	Outpatient visit, established, level 1	0.18	7		5	2	0.027

Conclusion

The survey results, along with the applicable comparison codes, support the recommended value for 73000 [*Radiologic examination; clavicle, complete*] at the current value. Relativity within the X-ray clavicle/shoulder family is also maintained.

CPT	Descriptor	RVU	Total Time	Pre	Intra	Post	IWPUT
73020	Radiologic examination, shoulder; 1 view	0.15	5	1	3	1	0.035
73000	Radiologic examination; clavicle, complete	0.16	5	1	3	1	0.038
73010	Radiologic examination; scapula, complete	0.17	5	1	3	1	0.042
73030	Radiologic examination, shoulder; complete, minimum of 2 views	0.18	6	1	4	1	0.034
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	0.18	6	1	4	1	0.034

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 73000

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Orthopedic Surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 295389

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by code 73000 provided nationally in a one-year period is estimated to be 295,389.

Specialty Diagnostic Radiology	Frequency 149291	Percentage 50.54 %
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Specialty Orthopedic Surgery	Frequency 93122	Percentage 31.52 %
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Specialty	Frequency 0	Percentage 0.00 %
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 98,463

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The ACR estimates that CPT code 73000 will be provided 98,463 times to Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology	Frequency 49764	Percentage 50.54 %
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Specialty Orthopedic Surgery	Frequency 31041	Percentage 31.52 %
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Imaging

BETOS Sub-classification:

Standard imaging

BETOS Sub-classification Level II:

Musculoskeletal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 73000

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 73010	Tracking Number	Original Specialty Recommended RVU: 0.17
		Presented Recommended RVU: 0.17
Global Period: XXX	Current Work RVU: 0.17	RUC Recommended RVU: 0.17

CPT Descriptor: Radiologic examination; scapula, complete

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old woman has scapular pain after a motor vehicle collision. A radiological examination is performed to evaluate for scapular fracture.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the provided clinical history. Review any prior applicable imaging studies.

Description of Intra-Service Work: Supervise the technologist performing the examination, evaluating the quality of the exam and obtaining additional views as necessary. Assess the scapula and the surrounding soft tissue and osseous structures. Interpret the examination with comparison to relevant prior imaging if available. Dictate report for the medical record.

Description of Post-Service Work: The final report is reviewed and signed, and findings are communicated to the referring physician as needed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2018				
Presenter(s):	Kurt Schoppe, MD; Daniel Wessell, MD; Andrew Moriarity, MD; William Creevy, MD; Hussein Elkousy, MD				
Specialty(s):	American College of Radiology, American Academy of Orthopaedic Surgeons				
CPT Code:	73010				
Sample Size:	2000	Resp N:	82	Response: 4.1 %	
Description of Sample:	The ACR surveyed a total of 1750 members (a random sample of 875 members and a separate random sample of 875 members who perform radiography, emergency/trauma, or musculoskeletal procedures). The AAOS performed a random sample of 250 individuals from their membership.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	20.00	39.00	250.00
Survey RVW:	0.13	0.17	0.18	0.22	0.30
Pre-Service Evaluation Time:			1.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	1.00	3.00	3.00	5.00	11.00
Immediate Post Service-Time:	2.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	73010	Recommended Physician Work RVU: 0.17		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	1.00	0.00	1.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	3.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	1.00	0.00	1.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
73610	XXX	0.17	RUC Time

CPT Descriptor Radiologic examination, ankle; complete, minimum of 3 views**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
73060	XXX	0.16	RUC Time

CPT Descriptor Radiologic examination; humerus, minimum of 2 views**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
90970	XXX	0.14	RUC Time	1,133,290

CPT Descriptor 1 End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99211	XXX	0.18	RUC Time	4,365,183

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
96401	XXX	0.21	RUC Time

CPT Descriptor Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 17 **% of respondents:** 20.7 %

Number of respondents who choose 2nd Key Reference Code: 12 **% of respondents:** 14.6 %

TIME ESTIMATES (Median)

	CPT Code: <u>73010</u>	Top Key Reference CPT Code: <u>73610</u>	2nd Key Reference CPT Code: <u>73060</u>
Median Pre-Service Time	1.00	1.00	1.00
Median Intra-Service Time	3.00	3.00	3.00
Median Immediate Post-service Time	1.00	1.00	1.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	5.00	5.00	5.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	59%	41%	0%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
6%	59%	35%

Technical Skill/Physical Effort

<u>Less</u>	<u>Identical</u>	<u>More</u>
6%	65%	29%

Physical effort required	6%	82%	12%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

6%	76%	18%
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2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	0%	50%	50%	0%
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Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

0%	58%	42%
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Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	0%	75%	25%
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Physical effort required	0%	92%	8%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%	50%	50%
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Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

CPT codes 73000 [Radiologic examination; clavicle, complete], 73010 [Radiologic examination; scapula, complete], and 73020 [Radiologic examination, shoulder; 1 view] were identified for CMS-Other utilization

over 30,000. The American College of Radiology (ACR) and the American Academy of Orthopaedic Society (AAOS) agreed to survey the codes for the April 2018 RUC meeting and expanded the family to include CPT codes 73030 [*Radiologic examination; shoulder, complete, minimum of 2 views*] and 73050 [*Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction*]. The societies convened an expert panel of physicians familiar with the services to review the survey data and provide the following recommendations.

Survey Process

The ACR surveyed a total of 1,750 members (a random sample of 875 from the entire membership and a separate random sample of 875 members who perform radiography, emergency/trauma, or musculoskeletal procedures). The AAOS surveyed a total random sample of 250 members.

Work RVU Recommendation:

The expert panel recommends a work RVU of 0.17 for CPT code 73010, which is the 25th percentile of the survey and the current value.

Time Recommendation:

The expert panel recommends the following median survey times: 1 minute of pre-service time, 3 minutes of intra-service time, and 1 minute of post-service time. This is a total time of 5 minutes, which is the same as the existing CMS/Other total time of 5 minutes.

Key Reference Services

The most commonly chosen reference code by survey participants, 73610 (*Radiologic examination, ankle; complete, minimum of 3 views*), has the same service times and identical wRVU as the surveyed code and is also a complete radiographic examination requiring at least three views. The second most commonly chosen code, 73060 (*Radiologic examination; humerus, minimum of 2 views*), has the same service times and 0.01 lower wRVU because it is a two-view examination of one bone and the adjacent joints, compared to at least three views for the surveyed code.

CPT	Descriptor	RVU	Total Time	Pre	Intra	Post	IWPUT	% chosen
73060	Radiologic examination; humerus, minimum of 2 views	0.16	5	1	3	1	0.038	15%
73010	Radiologic examination; scapula, complete	0.17	5	1	3	1	0.042	
73610	Radiologic examination, ankle; complete, minimum of 3 views	0.17	5	1	3	1	0.042	21%

MPC Codes

The surveyed code compares well with three other MPC codes, none of which are performed by radiology:

- **90970** - *End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older*

- **99211** - Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
- **96401** - Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic

The surveyed code wRVU is closely bracketed by the MPC codes 90970, 99211, and 96401. Code 90970 has the same intra-service time and 2 minutes less of total time supporting the 0.03 lower wRVU. Code 99211 has 2 minutes more intra-service time and supports the 0.01 higher wRVU. Code 96401 has the same intra-service time although 4 minutes more total time which supports the 0.04 higher wRVU. These three MPC codes are included in the following table for comparison and confirm the appropriateness of the recommended wRVU and times within the larger RBRVS.

CPT	Descriptor	RVU	Total Time	Pre	Intra	Post	IWPUT
90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	0.14	2.5		2.5		0.056
73010	Radiologic examination; scapula, complete	0.17	5	1	3	1	0.042
99211	Outpatient visit, established, level 1	0.18	7		5	2	0.027
96401	Chemotherapy admin., SC or IM, non-hormonal anti-neoplastic	0.21	9	4	3	2	0.025

Conclusion

The survey results and comparison with applicable codes support the recommended value for 73010 [*Radiologic examination; scapula, complete*] at the current value. Relativity within the X-ray clavicle/shoulder family is also maintained.

CPT	Descriptor	RVU	Total Time	Pre	Intra	Post	IWPUT
73020	Radiologic examination, shoulder; 1 view	0.15	5	1	3	1	0.035
73000	Radiologic examination; clavicle, complete	0.16	5	1	3	1	0.038
73010	Radiologic examination; scapula, complete	0.17	5	1	3	1	0.042
73030	Radiologic examination, shoulder; complete, minimum of 2 views	0.18	6	1	4	1	0.034
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	0.18	6	1	4	1	0.034

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
☐ Multiple codes are used to maintain consistency with similar codes.
☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CPT code 73010 is typically reported on the same date with CPT code 73030 (Radiologic examination, shoulder; complete, minimum of 2 views).
-

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 73010

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
 If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Orthopedic Surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 159999

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by code 73010 provided nationally in a one-year period is estimated to be 159,999.

Specialty Diagnostic Radiology	Frequency 51833	Percentage 32.39 %
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Specialty Orthopedic Surgery	Frequency 81103	Percentage 50.68 %
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Specialty	Frequency 0	Percentage 0.00 %
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 53,333

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The ACR estimates that CPT code 73010 will be provided 53,333 times to Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology	Frequency 17278	Percentage 32.39 %
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Specialty Orthopedic Surgery

Frequency 27034

Percentage 50.68 %

Specialty

Frequency 0

Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Imaging

BETOS Sub-classification:

Standard imaging

BETOS Sub-classification Level II:

Musculoskeletal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 73010

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 73020	Tracking Number	Original Specialty Recommended RVU: 0.15
		Presented Recommended RVU: 0.15
Global Period: XXX	Current Work RVU: 0.15	RUC Recommended RVU: 0.15

CPT Descriptor: Radiologic examination, shoulder; 1 view

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old woman presents after shoulder dislocation. A single view radiological examination is performed to evaluate glenohumeral joint alignment.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the provided clinical history. Review any prior applicable imaging studies.

Description of Intra-Service Work: Supervise the technologist performing the examination, evaluating the quality of the exam and obtaining additional views as necessary. Assess the shoulder joint and the surrounding soft tissue and osseous structures. Interpret the examination with comparison to relevant prior imaging if available. Dictate report for the medical record.

Description of Post-Service Work: The final report is reviewed and signed, and findings are communicated to the referring physician as needed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2018				
Presenter(s):	Kurt Schoppe, MD; Daniel Wessell, MD; Andrew Moriarity, MD; William Creevy, MD; Hussein Elkousy, MD				
Specialty(s):	American College of Radiology, American Academy of Orthopaedic Surgeons				
CPT Code:	73020				
Sample Size:	2000	Resp N:	82	Response: 4.1 %	
Description of Sample:	The ACR surveyed a total of 1750 members (a random sample of 875 members and a separate random sample of 875 members who perform radiography, emergency/trauma, or musculoskeletal procedures). The AAOS performed a random sample of 250 individuals from their membership.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	14.00	30.00	100.00	800.00
Survey RVW:	0.10	0.16	0.16	0.18	0.31
Pre-Service Evaluation Time:			1.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	1.00	2.00	3.00	4.00	11.00
Immediate Post Service-Time:	1.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	73020	Recommended Physician Work RVU: 0.15		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	1.00	0.00	1.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	3.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	1.00	0.00	1.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0 99239x 0.0 99217x 0.00
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
73060	XXX	0.16	RUC Time

CPT Descriptor Radiologic examination; humerus, minimum of 2 views**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
71045	XXX	0.18	RUC Time

CPT Descriptor Radiologic examination, chest; single view**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
90970	XXX	0.14	RUC Time	1,133,290

CPT Descriptor 1 End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93042	XXX	0.15	RUC Time	443,031

CPT Descriptor 2 Rhythm ECG, 1-3 leads; interpretation and report only

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
73120	XXX	0.16	RUC Time

CPT Descriptor Radiologic examination, hand; 2 views**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 29 % of respondents: 35.3 %

Number of respondents who choose 2nd Key Reference Code: 10 % of respondents: 12.1 %

TIME ESTIMATES (Median)

	CPT Code: <u>73020</u>	Top Key Reference CPT Code: <u>73060</u>	2nd Key Reference CPT Code: <u>71045</u>
Median Pre-Service Time	1.00	1.00	1.00
Median Intra-Service Time	3.00	3.00	3.00
Median Immediate Post-service Time	1.00	1.00	1.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	5.00	5.00	5.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	3%	17%	76%	3%	0%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	28%	62%	10%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	21%	72%	7%

Physical effort required	24%	72%	3%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

10%

76%

14%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	20%	80%	0%	0%
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Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

20%

80%

0%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	10%	70%	20%
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Physical effort required	10%	80%	10%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

40%

50%

10%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

CPT codes 73000 [*Radiologic examination; clavicle, complete*], 73010 [*Radiologic examination; scapula, complete*], and 73020 [*Radiologic examination, shoulder; 1 view*] were identified for CMS-Other utilization over 30,000. The American College of Radiology (ACR) and the American Academy of Orthopaedic Society (AAOS) agreed to survey the codes for the April 2018 RUC meeting and expanded the family to include CPT codes 73030 [*Radiologic examination; shoulder, complete, minimum of 2 views*] and 73050 [*Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction*]. The societies convened an expert panel of physicians familiar with the services to review the survey data and provide the following recommendations.

Survey Process

The ACR surveyed a total of 1,750 members (a random sample of 875 from the entire membership and a separate random sample of 875 members who perform radiography, emergency/trauma, or musculoskeletal procedures). The AAOS surveyed a total random sample of 250 members.

Work RVU Recommendation:

The expert panel recommends a work RVU of 0.15 for CPT code 73020, which is the current value of this code.

Time Recommendation:

The expert panel recommends the following median survey times: 1 minute of pre-service time, 3 minutes of intra-service time, and 1 minute of post-service time. This is a total time of 5 minutes, which is the same as the existing CMS/Other total time of 5 minutes.

Key Reference Services

The most commonly chosen reference code by survey participants, 73060 (*Radiologic examination; humerus, minimum of 2 views*), has the same service times and 0.01 higher wRVU compared to the surveyed code which requires evaluation of a single bone and the adjacent joints while the surveyed code is a single-view examination focused on a joint and the included bones. The second most commonly chosen reference code, 71045 (*Radiologic examination, chest; single view*), has the same service times and 0.03 higher wRVU because it is a two-view examination of a more complex area, the chest, compared to the single view of one joint for the surveyed code.

CPT	Descriptor	RVU	Total Time	Pre	Intra	Post	IWPUT	% chosen
73020	Radiologic examination, shoulder; 1 view	0.15	5	1	3	1	0.035	
73060	Radiologic examination; humerus, minimum of 2 views	0.16	5	1	3	1	0.038	35%
71045	Radiologic examination, chest; single view	0.18	5	1	3	1	0.045	12%

MPC Codes

The surveyed code compares well with three other MPC codes, only one of which is performed by radiology:

- **90970** - *End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older*
- **93042** - *Rhythm ECG, 1-3 leads; interpretation and report only*
- **73120** - *Radiologic examination, hand; 2 views*

Code 93042 has an identical wRVU and intra-service time compared to the surveyed code. Additionally, the surveyed code is closely bracketed by the MPC codes 90970 and 73120. Code 90970 has 2.5 minutes less of total time and has a wRVU that is lower by 0.01. Code 73120 is a radiology code with 1 minute more intra-service time and 0.01 higher wRVU, which involves evaluation of multiple bones and joints in the hand with two views compared to the surveyed code, which involves fewer bones and joints and a single view of the shoulder. These three MPC codes are included in the following table for comparison and confirm the appropriateness of the recommended wRVU and times within the larger RBRVS.

CPT	Descriptor	RVU	Total Time	Pre	Intra	Post	IWPUT
90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	0.14	2.5		2.5		0.056
73020	Radiologic examination, shoulder; 1 view	0.15	5	1	3	1	0.035
93042	Rhythm ECG, 1-3 leads; interpretation and report only	0.15	7	2	3	2	0.020
73120	Radiologic examination, hand; 2 views	0.16	6	1	4	1	0.289

Conclusion

The survey results and comparison with applicable codes support the recommended value for 73020 [*Radiologic examination, shoulder; 1 view*] at the current value. Relativity within the X-ray clavicle/shoulder family is also maintained.

CPT	Descriptor	RVU	Total Time	Pre	Intra	Post	IWPUT
73020	Radiologic examination, shoulder; 1 view	0.15	5	1	3	1	0.035
73000	Radiologic examination; clavicle, complete	0.16	5	1	3	1	0.038
73010	Radiologic examination; scapula, complete	0.17	5	1	3	1	0.042
73030	Radiologic examination, shoulder; complete, minimum of 2 views	0.18	6	1	4	1	0.034
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	0.18	6	1	4	1	0.034

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 73020

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Orthopedic Surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 413151

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by code 73020 provided nationally in a one-year period is estimated to be 413,151.

Specialty Diagnostic Radiology Frequency 225081 Percentage 54.47 %

Specialty Orthopedic Surgery Frequency 92187 Percentage 22.31 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 137,717 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The ACR estimates that CPT code 73020 will be provided 137,717 times to Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 75027 Percentage 54.47 %

Specialty Orthopedic Surgery Frequency 30729 Percentage 22.31 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Imaging

BETOS Sub-classification:

Standard imaging

BETOS Sub-classification Level II:

Musculoskeletal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 73020

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 73030	Tracking Number	Original Specialty Recommended RVU: 0.18
		Presented Recommended RVU: 0.18
Global Period: XXX	Current Work RVU: 0.18	RUC Recommended RVU: 0.18

CPT Descriptor: Radiologic examination, shoulder; complete, minimum of 2 views

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old woman has severe pain with overhead activities and cannot raise her left arm at the shoulder. A radiological examination is performed to evaluate for arthritis of the shoulder.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the provided clinical history. Review any prior applicable imaging studies.

Description of Intra-Service Work: Supervise the technologist performing the examination, evaluating the quality of the exam and obtaining additional views as necessary. Assess the shoulder joint and the surrounding soft tissue and osseous structures. Interpret the examination with comparison to relevant prior imaging if available. Dictate report for the medical record.

Description of Post-Service Work: The final report is reviewed and signed, and findings are communicated to the referring physician as needed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2018				
Presenter(s):	Kurt Schoppe, MD; Daniel Wessell, MD; Andrew Moriarity, MD; William Creevy, MD; Hussein Elkousy, MD				
Specialty(s):	American College of Radiology, American Academy of Orthopaedic Surgeons				
CPT Code:	73030				
Sample Size:	2000	Resp N:	82	Response: 4.1 %	
Description of Sample:	The ACR surveyed a total of 1750 members (a random sample of 875 members and a separate random sample of 875 members who perform radiography, emergency/trauma, or musculoskeletal procedures). The AAOS performed a random sample of 250 individuals from their membership.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	100.00	200.00	438.00	4565.00
Survey RVW:	0.15	0.18	0.20	0.22	0.40
Pre-Service Evaluation Time:			1.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	1.00	3.00	4.00	5.00	17.00
Immediate Post Service-Time:	2.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	73030	Recommended Physician Work RVU: 0.18		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	1.00	0.00	1.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	4.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	1.00	0.00	1.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
73562	XXX	0.18	RUC Time

CPT Descriptor Radiologic examination, knee; 3 views**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
73564	XXX	0.22	RUC Time

CPT Descriptor Radiologic examination, knee; complete, 4 or more views**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93042	XXX	0.15	RUC Time	443,031

CPT Descriptor 1 Rhythm ECG, 1-3 leads; interpretation and report only

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
70355	XXX	0.20	RUC Time	34,289

CPT Descriptor 2 Orthopantogram (eg, panoramic x-ray)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
96401	XXX	0.21	RUC Time

CPT Descriptor Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 24 % of respondents: 29.2 %

Number of respondents who choose 2nd Key Reference Code: 11 % of respondents: 13.4 %

TIME ESTIMATES (Median)

	CPT Code: <u>73030</u>	Top Key Reference CPT Code: <u>73562</u>	2nd Key Reference CPT Code: <u>73564</u>
Median Pre-Service Time	1.00	1.00	1.00
Median Intra-Service Time	4.00	4.00	5.00
Median Immediate Post-service Time	1.00	1.00	1.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	6.00	6.00	7.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	83%	17%	0%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
0%	75%	25%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	4%	75%	21%
Physical effort required	0%	88%	13%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%

79%

21%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

0%

100%

0%

0%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

18%

73%

9%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

0%

64%

36%

Physical effort required

0%

91%

9%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%

91%

9%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

CPT codes 73000 [*Radiologic examination; clavicle, complete*], 73010 [*Radiologic examination; scapula, complete*], and 73020 [*Radiologic examination, shoulder; 1 view*] were identified for CMS-Other utilization over 30,000. The American College of Radiology (ACR) and the American Academy of Orthopaedic Society (AAOS) agreed to survey the codes for the April 2018 RUC meeting and expanded the family to include CPT codes 73030 [*Radiologic examination; shoulder, complete, minimum of 2 views*] and 73050 [*Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction*]. The societies convened an expert panel of physicians familiar with the services to review the survey data and provide the following recommendations.

Survey Process

The ACR surveyed a total of 1,750 members (a random sample of 875 from the entire membership and a separate random sample of 875 members who perform radiography, emergency/trauma, or musculoskeletal procedures). The AAOS surveyed a total random sample of 250 members.

Work RVU Recommendation:

The expert panel recommends a work RVU of 0.18 for CPT code 73030, which is the 25th percentile of the survey and the current value.

Time Recommendation:

The expert panel recommends the following median survey times: 1 minute of pre-service time, 4 minutes of intra-service time, and 1 minute of post-service time. This is a total time of 6 minutes which is 1 minute less than the existing total time of 7 minutes.

Key Reference Services

The most commonly chosen reference code by survey participants, 73562 (*Radiologic examination, knee; 3 views*), has identical service times as well as wRVU compared to the surveyed code. Both examinations review multiple views of a complex articulating joint and the adjacent bones. The second most commonly chosen code, 73564 (*Radiologic examination, knee; complete, 4 or more views*), has one minute more of intra-service time and 0.04 higher wRVU to account for the additional time and intensity of intra-service work required for the additional view for that particular examination.

CPT	Descriptor	RVU	Total Time	Pre	Intra	Post	IWPUT	% chosen
73030	Radiologic examination, shoulder; complete, minimum of 2 views	0.18	6	1	4	1	0.034	
73562	Radiologic examination, knee; 3 views	0.18	6	1	4	1	0.034	29%
73564	Radiologic examination, knee; complete, 4 or more views	0.22	7	1	5	1	0.035	13%

MPC Codes

The surveyed code compares well with three other MPC codes, only one of which is performed by radiology:

- **93042** - *Rhythm ECG, 1-3 leads; interpretation and report only*
- **70355** - *Orthopantomogram (eg, panoramic x-ray)*
- **96401** - *Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic*

The surveyed code wRVU is closely bracketed by the MPC codes 93042, 70355, and 96401. Code 93042 has one minute less intra-service time which supports the 0.03 lower wRVU. Code 70355 is a radiology code that

involves evaluation of the oral cavity and has one minute more of intra-service time. The identical total times for 70355 and the surveyed code support the 0.02 higher wRVU for 70355. Code 96401 has 1 minute less intra-service time, although 3 additional minutes is allocated to total time for the procedure which supports the slightly higher wRVU. These three MPC codes are included in the following table for comparison and confirm the appropriateness of the recommended wRVU and times within the larger RBRVS.

CPT	Descriptor	RVU	Total Time	Pre	Intra	Post	IWPUT
93402	Rhythm ECG, 1-3 leads; interpretation and report only	0.15	7	2	3	2	0.020
73030	Radiologic examination, shoulder; complete, minimum of 2 views	0.18	6	1	4	1	0.034
70355	Orthopantomogram (eg, panoramic x-ray)	0.20	6		5	1	0.036
96401	Chemotherapy admin., SC or IM, non-hormonal anti-neoplastic	0.21	9	4	3	2	0.025

Conclusion

The survey results and comparison with applicable codes support the recommended value for 73030 [*Radiologic examination; shoulder, complete, minimum of 2 views*] at the current value. Relativity within the X-ray clavicle/shoulder family is also maintained.

CPT	Descriptor	RVU	Total Time	Pre	Intra	Post	IWPUT
73020	Radiologic examination, shoulder; 1 view	0.15	5	1	3	1	0.035
73000	Radiologic examination; clavicle, complete	0.16	5	1	3	1	0.038
73010	Radiologic examination; scapula, complete	0.17	5	1	3	1	0.042
73030	Radiologic examination, shoulder; complete, minimum of 2 views	0.18	6	1	4	1	0.034
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	0.18	6	1	4	1	0.034

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 73030

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Orthopedic Surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 7721139

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by code 73030 provided nationally in a one-year period is estimated to be 7,721,139.

Specialty Diagnostic Radiology	Frequency 3882509	Percentage 50.28 %
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Specialty Orthopedic Surgery	Frequency 2496242	Percentage 32.32 %
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Specialty	Frequency 0	Percentage 0.00 %
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,573,713 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The ACR estimates that CPT code 73030 will be provided 2,573,713 times to Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology	Frequency 1294170	Percentage 50.28 %
--------------------------------	-------------------	--------------------

Specialty Orthopedic Surgery	Frequency 832081	Percentage 32.32 %
------------------------------	------------------	--------------------

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Imaging

BETOS Sub-classification:

Standard imaging

BETOS Sub-classification Level II:

Musculoskeletal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 73030

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 73050	Tracking Number	Original Specialty Recommended RVU: 0.18
		Presented Recommended RVU: 0.18
Global Period: XXX	Current Work RVU: 0.20	RUC Recommended RVU: 0.18

CPT Descriptor: Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old woman has acromioclavicular joint pain after a fall. A radiological examination is performed to evaluate for acromioclavicular joint separation.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the provided clinical history. Review any prior applicable imaging studies.

Description of Intra-Service Work: Supervise the technologist performing the examination, evaluating the quality of the exam and obtaining additional views as necessary. Assess the acromioclavicular joints and the surrounding soft tissue and osseous structures. Interpret the examination with comparison to relevant prior imaging if available. Dictate report for the medical record.

Description of Post-Service Work: The final report is reviewed and signed, and findings are communicated to the referring physician as needed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2018				
Presenter(s):	Kurt Schoppe, MD; Daniel Wessell, MD; Andrew Moriarity, MD; William Creevy, MD; Hussein Elkousy, MD				
Specialty(s):	American College of Radiology, American Academy of Orthopaedic Surgeons				
CPT Code:	73050				
Sample Size:	2000	Resp N:	75	Response: 3.7 %	
Description of Sample:	The ACR surveyed a total of 1750 members (a random sample of 875 members and a separate random sample of 875 members who perform radiography, emergency/trauma, or musculoskeletal procedures). The AAOS performed a random sample of 250 individuals from their membership.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	9.00	15.00	33.00	500.00
Survey RVW:	0.14	0.18	0.20	0.25	0.35
Pre-Service Evaluation Time:			2.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	2.00	3.00	4.00	5.00	11.00
Immediate Post Service-Time:	<u>2.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	<u>0.00</u>	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	<u>0.00</u>	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	<u>0.00</u>	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	73050	Recommended Physician Work RVU: 0.18		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	1.00	0.00	1.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	4.00			
Please, pick the <u>post</u> -service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	1.00	0.00	1.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
73521	XXX	0.22	RUC Time

CPT Descriptor Radiologic examination, hips, bilateral, with pelvis when performed; 2 views**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
73565	XXX	0.16	RUC Time

CPT Descriptor Radiologic examination, knee; both knees, standing, anteroposterior**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93042	XXX	0.15	RUC Time	443,031

CPT Descriptor 1 Rhythm ECG, 1-3 leads; interpretation and report only

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
70355	XXX	0.20	RUC Time	34,289

CPT Descriptor 2 Orthopantogram (eg, panoramic x-ray)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
96401	XXX	0.21	RUC Time

CPT Descriptor Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 16 % of respondents: 21.3 %

Number of respondents who choose 2nd Key Reference Code: 11 % of respondents: 14.6 %

TIME ESTIMATES (Median)

	CPT Code: <u>73050</u>	Top Key Reference CPT Code: <u>73521</u>	2nd Key Reference CPT Code: <u>73565</u>
Median Pre-Service Time	1.00	1.00	1.00
Median Intra-Service Time	4.00	4.00	3.00
Median Immediate Post-service Time	1.00	1.00	1.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	6.00	6.00	5.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	6%	6%	63%	25%	0%

Mental Effort and Judgment

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

<u>Less</u>	<u>Identical</u>	<u>More</u>
6%	69%	25%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	6%	56%	38%
Physical effort required	6%	75%	19%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

19%

63%

19%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

9%

55%

36%

0%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

9%

64%

27%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

9%

73%

18%

Physical effort required

0%

82%

18%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

9%

73%

18%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

CPT codes 73000 [*Radiologic examination; clavicle, complete*], 73010 [*Radiologic examination; scapula, complete*], and 73020 [*Radiologic examination, shoulder; 1 view*] were identified for CMS-Other utilization over 30,000. The American College of Radiology (ACR) and the American Academy of Orthopaedic Society (AAOS) agreed to survey the codes for the April 2018 RUC meeting and expanded the family to include CPT codes 73030 [*Radiologic examination; shoulder, complete, minimum of 2 views*] and 73050 [*Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction*]. The societies convened an expert panel of physicians familiar with the services to review the survey data and provide the following recommendations.

Survey Process

The ACR surveyed a total of 1,750 members (a random sample of 875 from the entire membership and a separate random sample of 875 members who perform radiography, emergency/trauma, or musculoskeletal procedures). The AAOS surveyed a total random sample of 250 members.

Work RVU Recommendation:

The expert panel recommends a work RVU of 0.18 for CPT code 73050, which is the 25th percentile of the survey and below the current value of 0.20.

Time Recommendation:

The expert panel recommends the following median survey times: 1 minute of pre-service time, 4 minutes of intra-service time, and 1 minute of post-service time. This is a total time of 6 minutes which is the same as the existing CMS/Other total time.

Key Reference Services

The most commonly chosen reference code by survey participants, 73521 (*Radiologic examination, hips, bilateral, with pelvis when performed; 2 views*), has identical service times compared to the surveyed code. Both examinations review multiple views of joints and the adjacent bones; however, the hip joint is slightly more complex which requires greater intensity during the intra-service period. The second most commonly chosen code, 73565 (*Radiologic examination, knee; both knees, standing, anteroposterior*), has one minute less of intra-service time and correspondingly 0.02 lower wRVU. Both examinations compare bilateral joints, however, the reference code is a single view examination examining one joint while the surveyed code includes additional joints in the same field of view and may require weighted distraction which increases the time and intensity of intra-service evaluation.

CPT	Descriptor	RVU	Total Time	Pre	Intra	Post	IWPUT	% chosen
73565	Radiologic examination, knee; both knees, standing, anteroposterior	0.16	5	1	3	1	0.038	15%
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	0.18	6	1	4	1	0.034	
73521	Radiologic examination, hips, bilateral, with pelvis when performed; 2 views	0.22	6	1	4	1	0.044	21%

MPC Codes

The surveyed code compares well with three other MPC codes, only one of which is performed by radiology:

- **93042** - *Rhythm ECG, 1-3 leads; interpretation and report only*
- **70355** - *Orthopantomogram (eg, panoramic x-ray)*
- **96401** - *Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic*

Code 93042 has one minute less intra-service time which supports the 0.03 lower wRVU. Code 70355 is a radiology code that involves evaluation of the oral cavity and has one minute more of intra-service time and same total time which supports the 0.02 higher wRVU. Code 96401 has 1 minute less intra-service time although 3 minutes more of total time for the procedure which supports the slightly higher wRVU. These three MPC codes are included in the following table for comparison and confirm the appropriateness of the recommended wRVU and times within the larger RBRVS.

CPT	Descriptor	RVU	Total Time	Pre	Intra	Post	IWPUT
93042	Rhythm ECG, 1-3 leads; interpretation and report only	0.15	7	2	3	2	0.020
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	0.18	6	1	4	1	0.034
70355	Orthopantomogram (eg, panoramic x-ray)	0.20	6		5	1	0.036
96401	Chemotherapy admin., SC or IM, non-hormonal anti-neoplastic	0.21	9	4	3	2	0.025

Conclusion

The survey results and comparison with applicable codes support the recommended value for 73050 [*Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction*] at the survey 25th percentile value. Relativity within the X-ray clavicle/shoulder family is also maintained.

CPT	Descriptor	RVU	Total Time	Pre	Intra	Post	IWPUT
73020	Radiologic examination, shoulder; 1 view	0.15	5	1	3	1	0.035
73000	Radiologic examination; clavicle, complete	0.16	5	1	3	1	0.038
73010	Radiologic examination; scapula, complete	0.17	5	1	3	1	0.042
73030	Radiologic examination, shoulder; complete, minimum of 2 views	0.18	6	1	4	1	0.034
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	0.18	6	1	4	1	0.034

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CPT code 73050 is typically reported on the same date as CPT code 73030 (Radiologic examination, shoulder; complete, minimum of 2 views)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 73050

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Orthopedic Surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 30999

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by code 73050 provided nationally in a one-year period is estimated to be 30,999.

Specialty Diagnostic Radiology	Frequency 7098	Percentage 22.89 %
Specialty Orthopedic Surgery	Frequency 17682	Percentage 57.04 %
Specialty	Frequency 0	Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 10,333

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The ACR estimates that CPT code 73050 will be provided 10,333 times to Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology	Frequency 2366	Percentage 22.89 %
Specialty Orthopedic Surgery	Frequency 5894	Percentage 57.04 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Imaging

BETOS Sub-classification:

Standard imaging

BETOS Sub-classification Level II:

Musculoskeletal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 73050

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR	AS
12																									
13	ISSUE: X-Ray Clavicle/Shoulder																								
14	TAB: 20																								
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
17	1st REF	73060	Radiologic examination; humerus, minimum of 2 views	33	0.038			0.16			5	1					3			1					
18	2nd REF	73562	Radiologic examination, knee; 3 views	10	0.034			0.18			6	1					4			1					
19	CMS/ Other	73000	Radiologic examination; clavicle, complete		0.000			0.16			5														
20	SVY	73000	Radiologic examination; clavicle, complete	82	0.034	0.13	0.16	0.17	0.18	0.27	6	1			2	2	3	5	11	2	0	20	42	74	750
21	ACR Combined	73000	Radiologic examination; clavicle, complete	75	0.038	0.13	0.16	0.16	0.18	0.27	5	1			2	2	3	5	10	1	0	20	43	85	750
22	ACR - Subset	73000	Radiologic examination; clavicle, complete	55	0.031	0.15	0.16	0.16	0.18	0.27	6	1			2	3	3	5	10	2	0	20	43	58	200
23	ACR - Random	73000	Radiologic examination; clavicle, complete	20	0.042	0.13	0.16	0.17	0.20	0.27	5	1			2	2	3	5	10	1	0	20	40	100	750
24	AAOS	73000	Radiologic examination; clavicle, complete	7	0.017	0.15	0.16	0.18	0.19	0.22	9	2			3	4	4	7	11	3	6	9	18	63	100
25	REC	73000	Radiologic examination; clavicle, complete		0.038	0.16					5	1				3				1					
26																									
27						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
28	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
29	1st REF	73610	Radiologic examination, ankle; complete, minimum of 3 views	17	0.042			0.17			5	1					3			1					
30	2nd REF	73060	Radiologic examination; humerus, minimum of 2 views	12	0.038			0.16			5	1					3			1					
31	CMS/ Other	73010	Radiologic examination; scapula, complete		0.000			0.17			5														
32	SVY	73010	Radiologic examination; scapula, complete	82	0.038	0.13	0.17	0.18	0.22	0.30	6	1			1	3	3	5	11	2	0	10	20	39	250
33	ACR Combined	73010	Radiologic examination; scapula, complete	75	0.045	0.13	0.17	0.18	0.22	0.30	5	1			1	3	3	5	10	1	0	10	20	42	250
34	ACR - Subset	73010	Radiologic examination; scapula, complete	55	0.038	0.16	0.17	0.18	0.22	0.30	6	1			2	3	3	5	10	2	0	10	20	30	180
35	ACR - Random	73010	Radiologic examination; scapula, complete	20	0.045	0.13	0.17	0.18	0.22	0.29	5	1			1	2	3	5	10	1	0	10	23	50	250
36	AAOS	73010	Radiologic examination; scapula, complete	7	0.018	0.16	0.18	0.20	0.20	0.22	10	2			3	4	5	7	11	3	0	2	10	23	50
37	REC	73010	Radiologic examination; scapula, complete		0.042	0.17					5	1				3				1					
38																									
39						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
40	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
41	1st REF	73060	Radiologic examination; humerus, minimum of 2 views	29	0.038			0.16			5	1					3			1					
42	2nd REF	71045	Radiologic examination, chest; single view	10	0.045			0.18			5	1					3			1					
43	CMS/ Other	73020	Radiologic examination, shoulder; 1 view		0.000			0.15			5														
44	SVY	73020	Radiologic examination, shoulder; 1 view	82	0.038	0.10	0.16	0.16	0.18	0.31	5	1			1	2	3	4	11	1	0	14	30	100	800
45	ACR Combined	73020	Radiologic examination, shoulder; 1 view	75	0.038	0.12	0.16	0.16	0.18	0.31	5	1			1	2	3	4	10	1	0	15	40	100	800
46	ACR - Subset	73020	Radiologic examination, shoulder; 1 view	55	0.031	0.12	0.16	0.16	0.18	0.31	6	1			2	2	3	4	10	2	0	15	30	100	500
47	ACR - Random	73020	Radiologic examination, shoulder; 1 view	20	0.058	0.13	0.15	0.16	0.18	0.20	4	1			1	2	2	3	5	1	0	18	55	100	800
48	AAOS	73020	Radiologic examination, shoulder; 1 view	7	0.015	0.10	0.16	0.17	0.18	0.20	9	2			2	3	4	7	11	3	0	5	5	8	25
49	REC	73020	Radiologic examination, shoulder; 1 view		0.035	0.15					5	1				3				1					
50																									

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR	AS
13	ISSUE: X-Ray Clavicle/Shoulder																								
14	TAB: 20																								
51						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
52	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
53	1st REF	73562	Radiologic examination, knee; 3 views	24	0.034			0.18			6	1					4			1					
54	2nd REF	73564	Radiologic examination, knee; complete, 4 or more views	11	0.035			0.22			7	1					5			1					
55	Apr-11	73030	Radiologic examination, shoulder; complete, minimum of 2 views		0.028			0.18			7	1					4			2					
56	SVY	73030	Radiologic examination, shoulder; complete, minimum of 2 views	82	0.033	0.15	0.18	0.20	0.22	0.40	7	1			1	3	4	5	17	2	0	100	200	438	4565
57	ACR Combined	73030	Radiologic examination, shoulder; complete, minimum of 2 views	75	0.039	0.15	0.18	0.20	0.22	0.40	6	1			1	3	4	5	10	1	0	97	200	469	465
58	ACR - Subset	73030	Radiologic examination, shoulder; complete, minimum of 2 views	55	0.033	0.15	0.18	0.20	0.22	0.31	7	1			2	3	4	5	10	2	0	87	200	425	1000
59	ACR - Random	73030	Radiologic examination, shoulder; complete, minimum of 2 views	20	0.052	0.16	0.18	0.20	0.22	0.40	5	1			1	2	3	5	7	1	0	100	269	550	4565
60	AAOS	73030	Radiologic examination, shoulder; complete, minimum of 2 views	7	0.022	0.18	0.18	0.22	0.22	0.35	10	2			3	4	5	9	17	3	45	100	200	325	500
61	REC	73030	Radiologic examination, shoulder; complete, minimum of 2 views		0.034	0.18					6	1					4			1					
62																									
63						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
64	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
65	1st REF	73521	Radiologic examination, hips, bilateral, with pelvis when performed; 2 views	16	0.044			0.22			6	1					4			1					
66	2nd REF	73565	Radiologic examination, knee; both knees, standing, anteroposterior	11	0.038			0.16			5	1					3			1					
67	CMS/ Other	73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction		0.000			0.20			6														
68	SVY	73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	75	0.028	0.14	0.18	0.20	0.25	0.35	8	2			2	3	4	5	11	2	0	9	15	33	500
69	ACR Combined	73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	68	0.036	0.14	0.18	0.21	0.26	0.35	7	1			2	3	4	5	10	2	0	10	18	36	500
70	ACR - Subset	73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	51	0.028	0.14	0.18	0.20	0.26	0.35	8	2			2	3	4	5	10	2	0	10	15	33	300
71	ACR - Random	73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	17	0.058	0.16	0.18	0.22	0.24	0.30	5	1			2	3	3	5	7	1	1	7	20	40	500
72	AAOS	73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	7	0.014	0.16	0.18	0.18	0.23	0.30	10	2			3	4	5	9	11	3	0	2	5	20	100
73	REC	73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction		0.034	0.18					6	1					4			1					
74																									
75																									

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	
5	ISSUE: Excision of bone																																								
6	TAB: 84																																								
7	source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE			INTRA					IMMD	FAC-inpt/same day					FAC-obs				Office					Prolonged						
8						MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX		POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57
9	1st REF	11111	xyz	30	0.029			4.25			131	5	5	5			30			5	1					1.0				1											
10	2nd REF	22222	def	15	0.055			5.15			137	10	5	5			35			5						1.0				1				1							
11	CURRENT	55555	abc		0.053			5.00			133	17						27			8	1					1.0				1										
12	SVY	55555	abc	78	0.045	2.00	3.00	5.00	7.00	8.00	146	10	5	10	15	20	30	35	40	10	1					1.0				1											
13	REC	55555	abc		0.020	4.25					142	17	1	3			30			10									1	1.0	1										
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**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor:

73000	Radiologic examination; clavicle, complete
73010	Radiologic examination; scapula, complete
73020	Radiologic examination, shoulder; 1 view
73030	Radiologic examination, shoulder; complete, minimum of 2 views
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction

Global Period: XXX Meeting Date: April 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

The American College of Radiology (ACR) and American Academy of Orthopaedic Society (AAOS) convened a consensus panel to finalize the practice expense data for the X-Ray exam of the clavicle and shoulder code family, CPT codes 73000, 73010, 73020, 73030, and 73050.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code.** You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

The societies included the existing PE inputs for codes 73000, 73010, 73020, 73030, and 73050 on the spreadsheet to serve as a reference.

3. Is this code(s) typically billed with an E/M service?

Codes 73010 and 73050 are typically billed with an E/M service; 54% and 64%, respectively. Codes 73000, 73020 and 73030 are not; 27%, 22% and 36%, respectively.

Is this code(s) typically billed with the E/M service in the nonfacility?

Codes 73010, 73020, 73030 and 73050 are typically billed with the E/M service in the nonfacility; 77%, 56%, 64% and 76%, respectively. Code 73000 is not typically billed at 49%.

4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different then for the global?
(Please see provided data in PE Subcommittee folder)

Orthopedic Surgery is the dominant provider in the nonfacility for all codes in this family.

73000: 56%

73010: 72%

73020: 52%

73030: 55%

73050: 65%

Diagnostic Radiology is the dominant provider for the global for CPT codes 73000, 73020, and 73030. Orthopedic Surgery is the dominant provider for the global for CPT codes 73010 and 73050.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

For CPT code 73030 (*Radiologic examination, shoulder; complete, minimum of 2 views*), we are requesting 2 additional minutes for the technologist to perform the examination (CA021: Perform procedure/service---NOT directly related to physician work time). While this is a minimum 2 view code, typical clinical practice currently is a three view exam (AP, Grashey plus a transscapular-Y or axillary view). The two additional minutes (6 minutes total) is consistent with the 2 minutes per view that we have typically recommended for extremity codes

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:
8. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

Bring patient into x-ray room and have patient sit/lie on x-ray table or stand as appropriate. Place first cassette behind patient's clavicle, shoulder or acromioclavicular joint. Position patient's anatomy for the first view. Step behind shielding to control panel. Set appropriate exposure parameters. Instruct patient to hold still. Take exposure for first view. Step from behind shielding. Take first cassette from behind patient and place second cassette as needed. Position patient's anatomy for second view. Step behind shielding to control panel. Set appropriate exposure parameters. Instruct patient to hold still. Take exposure for second view. Step from behind shielding. Take second cassette out behind patient. The above steps are repeated for any additional views to be obtained. All cassettes are then taken to the image reader. Run all three cassettes through reader. Check all images for adequate exposure, positioning, coverage, etc. Repeat any views as needed. Typical number of views for 73000 would be 2 (AP and up-angled), for 73010 would be 2 (AP and Lateral), for 73020 would be 1 (AP), for 73030 would be 3 (AP, Grashey and trans-scapular Y or axillary) and for 73050 would be 3 (AP and up-angled of affected side with AP contralateral comparison view).

9. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

10. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

N/A

11. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.
N/A
12. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:
N/A
13. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:
N/A
14. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:
 - **Technologist PACS Workstation Proxy (ED050)** –PACS formula; Equals total service period time
 - **Professional PACS Workstation (ED053)** – Equals physician work intra time + 1/2 physician work pre-time
 - **Room, basic radiology (EL012)** – Highly technical formula
15. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:
N/A
16. If there is any other item on your spreadsheet that needs further explanation please include here:
N/A
17. Please include an explanation of each line item:
N/A

	A	B	D	E	F	G	H	I	J	K	L	M							
1	RUC Practice Expense Spreadsheet					CURRENT	RECOMMENDED	CURRENT	RECOMMENDED	CURRENT	RECOMMENDED	CURRENT							
2		standards/guidelines in column C. For more				73000	73000	73010	73010	73020	73020	73030							
3		RUC Collaboration Website				Radiologic examination; clavicle, complete (Aug 2003)	Radiologic examination; clavicle, complete (Apr 2018)	Radiologic examination; scapula, complete (Aug 2003)	Radiologic examination; scapula, complete (Apr 2018)	Radiologic examination, shoulder; 1 view (Aug 2003)	Radiologic examination, shoulder; 1 view (Apr 2018)	Radiologic examination, shoulder; complete, minimum of 2 views (Aug 2003)							
4	Clinical Activity Code	Meeting Date: April 2018 - REVISED AT RUC Tab: 20 - X-Ray Clavicle/Shoulder Specialty: ACR, AAOS	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute														
5		LOCATION											Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	
6		GLOBAL PERIOD																	
7		TOTAL COST OF CLINICAL STAFF, SUPPLIES AND EQUIPMENT											\$ 13.22	\$ 13.85	\$ 13.22	\$ 12.09	\$ 10.54	\$ 8.51	\$ 11.89
8		TOTAL CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41								14.0	19.0	14.0	16.0	11.0	12.0	14.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	0.0	0.0	0.0	0.0	0.0	0.0	0.0							
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	14.0	19.0	14.0	16.0	11.0	12.0	14.0							
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	0.0	0.0	0.0	0.0	0.0	0.0	0.0							
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE				\$ 5.74	\$ 7.79	\$ 5.74	\$ 6.56	\$ 4.51	\$ 4.92	\$ 5.74							
13	PRE-SERVICE PERIOD																		
14	Start: Following visit when decision for surgery or procedure made																		
29	End: When patient enters office/facility for surgery/procedure																		
30	SERVICE PERIOD																		
31	Start: When patient enters office/facility for surgery/procedure:																		
32	Pre-Service (of service period)																		
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	L041B	Radiologic Technologist	0.41	3	3	3		3		3							
34	CA010	Obtain vital signs																	
35	CA011	Provide education/obtain consent																	
36	CA012	Review requisition, assess for special needs																	
37	CA013	Prepare room, equipment and supplies	L041B	Radiologic Technologist	0.41	1	2	1	2	1	1	1							
38	CA014	Confirm order, protocol exam																	
39	CA015	Setup scope (nonfacility setting only)																	
40	CA016	Prepare, set-up and start IV, initial positioning and	L041B	Radiologic Technologist	0.41	1	2	1	2	1	1	1							
41	CA017	Sedate/apply anesthesia																	
48	Intra-service (of service period)																		
49	CA018	Assist physician or other qualified healthcare																	
50	CA019	Assist physician or other qualified healthcare																	
51	CA020	Assist physician or other qualified healthcare																	
52	CA021	Perform procedure/service---NOT directly related to physician work time	L041B	Radiologic Technologist	0.41	4	4	4	4	2	2	4							
59	Post-Service (of service period)																		
60	CA022	Monitor patient following procedure/service,																	
61	CA023	Monitor patient following procedure/service, no																	
62	CA024	Clean room/equipment by clinical staff	L041B	Radiologic Technologist	0.41	2	3	2	3	2	3	2							
63	CA025	Clean scope																	
64	CA026	Clean surgical instrument package																	
65	CA027	Complete post-procedure diagnostic forms, lab and																	
66	CA028	Review/read post-procedure x-ray, lab and																	
67	CA029	Check dressings, catheters, wounds																	
68	CA030	Technologist QC's images in PACS, checking for all	L041B	Radiologic Technologist	0.41	3	2	3	2	2	2	3							
69	CA031	Review examination with interpreting MD/DO	L041B	Radiologic Technologist	0.41		2		2										
70	CA032	Scan exam documents into PACS. Complete exam	L041B	Radiologic Technologist	0.41		1		1										
71	CA033	Perform regulatory mandated quality assurance																	
72	CA034	Document procedure (nonPACS) (e.g. mandated																	
73	CA035	Review home care instructions, coordinate				n/a	n/a	n/a	n/a	n/a	n/a	n/a							
74	CA036	Discharge day management																	
81	End: Patient leaves office																		
82	POST-SERVICE PERIOD																		
83	Start: Patient leaves office/facility																		
99	End: with last office visit before end of global																		

	A	B	D	E	F	G	H	I	J	K	L	M
1	RUC Practice Expense Spreadsheet					CURRENT	RECOMMENDED	CURRENT	RECOMMENDED	CURRENT	RECOMMENDED	CURRENT
2		standards/guidelines in column C. For more				73000	73000	73010	73010	73020	73020	73030
3		RUC Collaboration Website				Radiologic examination; clavicle, complete (Aug 2003)	Radiologic examination; clavicle, complete (Apr 2018)	Radiologic examination; scapula, complete (Aug 2003)	Radiologic examination; scapula, complete (Apr 2018)	Radiologic examination, shoulder; 1 view (Aug 2003)	Radiologic examination, shoulder; 1 view (Apr 2018)	Radiologic examination, shoulder; complete, minimum of 2 views (Aug 2003)
4	Clinical Activity Code	Meeting Date: April 2018 - REVISED AT RUC Tab: 20 - X-Ray Clavicle/Shoulder Specialty: ACR, AAOS	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute							
5		LOCATION				Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac	Non Fac
6		GLOBAL PERIOD										
7		TOTAL COST OF CLINICAL STAFF, SUPPLIES AND EQUIPMENT				\$ 13.22	\$ 13.85	\$ 13.22	\$ 12.09	\$ 10.54	\$ 8.51	\$ 11.89
8		TOTAL CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	14.0	19.0	14.0	16.0	11.0	12.0	14.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	14.0	19.0	14.0	16.0	11.0	12.0	14.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L041B	Radiologic Technologist	0.41	0.0	0.0	0.0	0.0	0.0	0.0	0.0
100	Medical	MEDICAL SUPPLIES	PRICE	UNIT								
101		TOTAL COST OF SUPPLY QUANTITY x PRICE				\$ 0.53	\$ 0.53	\$ 0.53	\$ -	\$ 0.53	\$ -	\$ 0.53
102	SB026	gown, patient	0.533	item		1	1	1		1		1
103												
110	Equipment Code	EQUIPMENT	Purchase Price	Equipment Formula	Cost Per Minute							
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE				\$ 6.95	\$ 5.53	\$ 6.95	\$ 5.53	\$ 5.50	\$ 3.59	\$ 5.61
112	ED050	Technologist PACS workstation	5557	PACS	0.022017924	14	19	14	16	11	12	17
113	ED053	Professional PACS Workstation	14616.93	Other Formula	0.057915145	3	4	3	4	3	4	5
114	EL012	room, basic radiology	127750	Highly Technical	0.484047196	14	11	14	11	11	7	11

	A	B	N	O	P
1	RUC Practice Expense Spreadsheet		RECOMMENDED	CURRENT	RECOMMENDED
2		<i>standards/guidelines in column C. For more</i>	73030	73050	73050
3		RUC Collaboration Website	Radiologic examination, shoulder; complete, minimum of 2 views (Apr 2018)	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction (Aug 2003)	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction (Apr 2018)
4	Clinical Activity Code	Meeting Date: April 2018 - REVISED AT RUC Tab: 20 - X-Ray Clavicle/Shoulder Specialty: ACR, AAOS			
5		LOCATION	Non Fac	Non Fac	Non Fac
6		GLOBAL PERIOD			
7		TOTAL COST OF CLINICAL STAFF, SUPPLIES AND EQUIPMENT	\$ 13.93	\$ 15.01	\$ 13.93
8		TOTAL CLINICAL STAFF TIME	18.0	16.0	18.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	18.0	16.0	18.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	\$ 7.38	\$ 6.56	\$ 7.38
13		PRE-SERVICE PERIOD			
14		Start: Following visit when decision for surgery or			
29		End: When patient enters office/facility for surgery.			
30		SERVICE PERIOD			
31		Start: When patient enters office/facility for surgery			
32		Pre-Service (of service period)			
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available		3	
34	CA010	Obtain vital signs			
35	CA011	Provide education/obtain consent			
36	CA012	Review requisition, assess for special needs			
37	CA013	Prepare room, equipment and supplies	2	1	2
38	CA014	Confirm order, protocol exam			
39	CA015	Setup scope (nonfacility setting only)			
40	CA016	Prepare, set-up and start IV, initial positioning and	2	1	2
41	CA017	Sedate/apply anesthesia			
48		Intra-service (of service period)			
49	CA018	Assist physician or other qualified healthcare			
50	CA019	Assist physician or other qualified healthcare			
51	CA020	Assist physician or other qualified healthcare			
52	CA021	Perform procedure/service---NOT directly related to physician work time	6	6	6
59		Post-Service (of service period)			
60	CA022	Monitor patient following procedure/service,			
61	CA023	Monitor patient following procedure/service, no			
62	CA024	Clean room/equipment by clinical staff	3	2	3
63	CA025	Clean scope			
64	CA026	Clean surgical instrument package			
65	CA027	Complete post-procedure diagnostic forms, lab and			
66	CA028	Review/read post-procedure x-ray, lab and			
67	CA029	Check dressings, catheters, wounds			
68	CA030	Technologist QC's images in PACS, checking for all	2	3	2
69	CA031	Review examination with interpreting MD/DO	2		2
70	CA032	Scan exam documents into PACS. Complete exam	1		1
71	CA033	Perform regulatory mandated quality assurance			
72	CA034	Document procedure (nonPACS) (e.g. mandated			
73	CA035	Review home care instructions, coordinate			
74	CA036	Discharge day management	n/a	n/a	n/a
81		End: Patient leaves office			
82		POST-SERVICE PERIOD			
83		Start: Patient leaves office/facility			
99		End: with last office visit before end of global			

	A	B	N	O	P
1	RUC Practice Expense Spreadsheet		RECOMMENDED	CURRENT	RECOMMENDED
2		standards/guidelines in column C. For more	73030	73050	73050
3		RUC Collaboration Website	Radiologic examination, shoulder; complete, minimum of 2 views (Apr 2018)	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction (Aug 2003)	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction (Apr 2018)
4	Clinical Activity Code	Meeting Date: April 2018 - REVISED AT RUC Tab: 20 - X-Ray Clavicle/Shoulder Specialty: ACR, AAOS			
5		LOCATION	Non Fac	Non Fac	Non Fac
6		GLOBAL PERIOD			
7		TOTAL COST OF CLINICAL STAFF, SUPPLIES AND EQUIPMENT	\$ 13.93	\$ 15.01	\$ 13.93
8		TOTAL CLINICAL STAFF TIME	18.0	16.0	18.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	18.0	16.0	18.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0
100	Medical	MEDICAL SUPPLIES			
101		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ -	\$ 0.53	\$ -
102	SB026	gown, patient		1	
103					
110	Equipment Code	EQUIPMENT			
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ 6.55	\$ 7.92	\$ 6.55
112	ED050	Technologist PACS workstation	18	16	18
113	ED053	Professional PACS Workstation	5	3	5
114	EL012	room, basic radiology	13	16	13

AMA/Specialty Society RVS Update Committee Summary of Recommendations
****Codes Reported Together 75% or More****

October 2018

Urography

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.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
74425	Urography, antegrade (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation	XXX	0.51

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 74425	Tracking Number	Original Specialty Recommended RVU: 0.51
		Presented Recommended RVU: 0.51
Global Period: XXX	Current Work RVU: 0.36	RUC Recommended RVU: 0.51

CPT Descriptor: Urography, antegrade (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old male with history of bladder cancer has had a cystectomy and bilateral uretero-ileal diversion with ileostomy. After the procedure, the patient has worsening abdominal pain with new intraabdominal fluid collections. Antegrade urography is performed to assess the integrity of the ureteral anastomoses and determine whether a urine leak is present.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Current patient symptoms are discussed. Pertinent labs, operative notes, clinic notes, and previous imaging are reviewed. Procedure discussed with patient and family.

Description of Intra-Service Work: Existing retrograde nephroureteral are examined. Fluoroscopic images of the abdomen and pelvis are obtained. Contrast is injected into the existing tubes under real time fluoroscopy. Spot and loop images are obtained in the supine position. Patient is moved into left and right oblique position, additional contrast is injected, and further imaging is obtained. All imaging is reviewed, compared to prior studies, and further imaging obtained as needed. The final report is created.

Description of Post-Service Work: Results are discussed with other involved physicians. Plans for further care and follow-up are discussed. Results and recommendations are discussed with the patient and family

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Michael Hall, MD, Curtis Anderson, MD, Kurt Schoppe, MD, Andy Moriarity, MD, Daniel Wessell, MD, Thomas Turk, MD, Kyle Richards, MD and Andrew Peterson, MD				
Specialty Society(ies):	SIR, ACR and AUA				
CPT Code:	74425				
Sample Size:	7500	Resp N:	107	Response: 1.4 %	
Description of Sample:	SIR: surveyed 750 random SIR members ACR: surveyed a total of 750 members (a random sample of 375 members and a separate random sample of 375 members who perform genitourinary and interventional radiology procedures) AUA: surveyed 6000 random AUA members				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	8.00	16.00	150.00
Survey RVW:	0.50	0.51	0.65	1.00	25.00
Pre-Service Evaluation Time:			10.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	5.00	10.00	14.00	20.00	90.00
Immediate Post Service-Time:	10.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	74425	Recommended Physician Work RVU: 0.51		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time
Pre-Service Evaluation Time:		5.00	0.00	5.00
Pre-Service Positioning Time:		0.00	0.00	0.00
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00
Intra-Service Time:		14.00		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	5.00	0.00	5.00

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00
Discharge Day Mgmt:	0.00	99238x 0.0 99239x 0.0 99217x 0.00
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
74400	XXX	0.49	RUC Time

CPT Descriptor Urography (pyelography), intravenous, with or without KUB, with or without tomography

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
76942	XXX	0.67	RUC Time

CPT Descriptor Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92083	XXX	0.50	RUC Time	2,943,051

CPT Descriptor 1 Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93224	XXX	0.52	RUC Time	347,714

CPT Descriptor 2 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

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 57 % of respondents: 53.2 %

Number of respondents who choose 2nd Key Reference Code: 10 % of respondents: 9.3 %

TIME ESTIMATES (Median)

	CPT Code: <u>74425</u>	Top Key Reference CPT Code: <u>74400</u>	2nd Key Reference CPT Code: <u>76942</u>
Median Pre-Service Time	5.00	5.00	7.00
Median Intra-Service Time	14.00	15.00	15.00
Median Immediate Post-service Time	5.00	5.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	24.00	25.00	27.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	3%	25%	58%	14%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or 	5%	30%	65%

- | |
|--|
| other information that must be reviewed and analyzed
• Urgency of medical decision making |
|--|

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

3%

30%

67%

Physical effort required

2%

35%

63%

Psychological Stress**Less****Identical****More**

- | |
|---|
| • The risk of significant complications, morbidity and/or mortality
• Outcome depends on the skill and judgment of physician
• Estimated risk of malpractice suit with poor outcome |
|---|

4%

26%

70%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More****Overall intensity/complexity**

0%

20%

20%

30%

30%

Mental Effort and Judgment**Less****Identical****More**

- | |
|--|
| • The number of possible diagnosis and/or the number of management options that must be considered
• The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
• Urgency of medical decision making |
|--|

10%

30%

60%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

40%

0%

60%

Physical effort required

30%

20%

50%

Psychological Stress**Less****Identical****More**

- | |
|---|
| • The risk of significant complications, morbidity and/or mortality
• Outcome depends on the skill and judgment of physician
• Estimated risk of malpractice suit with poor outcome |
|---|

20%

20%

60%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The societies are recommending an increase in wRVU compared to current based on the following compelling evidence. First, incorrect assumptions were made in the CMS/Other valuation of this code that currently lacks a vignette and typical patient. Second, 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 has markedly decreased and the patient population is now different. Based on claims data the societies believe that 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. A multisociety survey resulted in 107 responses with a median intra-service time of 14 minutes, pre-service time of 5 minutes, and post-service time of 5 minutes. Based on a survey total time of 24 minutes (compared to 9 currently, or roughly 2.7 times current), the societies recommend an RVU of 0.51 (current RVU 0.39) based on 25th percentile of survey for code 74425.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 74425

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Radiology (IR) How often? Commonly

Specialty Urology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. A national frequency number is not known.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,300

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Current RUC database reports 4295 Medicare claims for 2017.

Specialty Radiology (IR)	Frequency 2925	Percentage 68.02 %
--------------------------	----------------	--------------------

Specialty Urology	Frequency 1335	Percentage 31.04 %
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Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Imaging

BETOS Sub-classification:

Standard imaging

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 74425

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR	AS
13	ISSUE: Urography																								
14	TAB: 18																								
15	Source	CPT	DESC	Resp	IWPUT	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16						MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
17	1st REF	74400	Urography (pyelography), intravenous, with or v	57	0.018			0.49			25	5				15				5					
18	2nd REF	76942	Ultrasonic guidance for needle placement (eg, b	10	0.027			0.67			27	7				15				5					
19	CURREN T	74425	Urography, antegrade (pyelostogram, nephrostogram	#DIV/0!				0.36			9														
20	SVY	74425	Urography, antegrade (pyelostogram, nephrost	107	0.014	0.50	0.51	0.65	1.00	25.00	34	10			5	10	14	20	90	10	0	3	8	16	150
21	SVY	74425	SIR	25	0.015	0.49	0.60	0.85	1.50	5.00	45	15			8	10	20	30	90	10	8	10	20	30	150
22	SVY	74425	ACR	15	0.043	0.49	0.51	0.65	0.91	1.50	20	5			5	5	10	16	30	5	0	1	4	18	150
23	SVY	74425	AUA	67	0.012	0.50	0.50	0.61	0.96	25.00	33	10			6	10	13	17	60	10	2	2	6	10	100
24	REC				0.020	0.51					24	5				14				5					

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

Global Period: XXX

REVISED at MEETING

Meeting Date: October 2018

CPT Long Descriptor(s):

77445: Urography, antegrade (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

SIR, ACR and AUA convened a panel that included a number of experts familiar with these services to evaluate the direct practice expense inputs for this urography procedure.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

We included the direct practice expense inputs for CPT Code 74400 *Urography (pyelography), intravenous, with or without KUB, with or without tomography* on the PE spreadsheet. This code was selected as the work reference code.

**3. Is this code(s) typically billed with an E/M service?
Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)**

Code not typically billed with E/M (5%)
Code not typically billed with E/M service in the NF (32%)

**4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different then for the global?
(Please see provided data in PE Subcommittee folder)**

NF (All, global and 26) – Radiology (59%)
NF (Global and TC) – Urology (84%)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

This CPT code was not previously priced in the nonfacility setting. The specialty societies feel that it is appropriate to develop clinical staff, supply and equipment inputs for the nonfacility setting due to a change in patient population that this CPT code will be utilized with. With the bundling of the genitourinary interventional code family, this CPT code should be utilized primarily in conjunction with diagnostic imaging of the postoperative genitourinary system without concomitant intervention. With this new expected utilization pattern, we feel it is appropriate to add inputs for the use of this code in an office setting where it may be appropriately utilized.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:

CPT Code 74400 currently has 10 minutes for “*Process films, hang films and review study with interpreting MD prior to patient discharge*”. We broke that up in the following way on the PE spreadsheet (for CPT Code 74400):

Technologist QC's images in PACS, checking for all images, reformats, and dose page	4
Review examination with interpreting MD/DO	3
Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue.	3

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code)

The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional--- directly related to physician work time or Perform procedure/service---NOT directly related to physician work time:*

The radiologic technologist is operating the fluoroscope and acquiring images throughout the procedure.

10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

We are recommending intra-service time ‘not related to physician work’

11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

N/A

12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.

N/A

13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:

N/A

14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:

N/A

15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:

EL014 room, radiographic-flouro – highly technical formula

ED050 Tech PACS workstation – PACS formula

ED053 Prof PACS workstation – Other formula. We used the guidelines for calculating the professional PACS (from physician work survey – half pre time + full intra time)

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:

N/A

17. If there is any other item on your spreadsheet that needs further explanation please include here:

N/A

18. Please include an explanation of each line item:

drape, sterile, c-arm, fluoro	SB008	Required for sterile preparation of imaging equipment
disinfectant, surface (Envirocide, Sanizide)	SM013	For cleaning imaging equipment after usage.

	A	B	C	D	E	F	G	H
1	RUC Practice	Expense Spreadsheet					REFERENCE CODE	
2	AtMeeting	Meeting Date: October 2018 Tab: 18 Urography Specialty: SIR, ACR, AUA RUC Collaboration Website					74400 Urography (pyelography), intravenous, with or without KUB, with or without tomography	
3	Clinical Activity Code	***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment. "	Standards/Guidelines	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute		
4							Non Fac	Facility
5		LOCATION					XXX	XXX
6		GLOBAL PERIOD						
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME					\$ 72.64	\$ -
8		TOTAL CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	55	0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	0	0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	55	0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	0	0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE					\$ 22.55	\$ -
13		PRE-SERVICE PERIOD						
14		Start: Following visit when decision for surgery or procedure made						
15	CA001	Complete pre-service diagnostic and referral forms	90 DAY: NF5, F5*	L037D	RN/LPN/MTA	0.37		
16	CA002	Coordinate pre-surgery services (including test results)	90 DAY: NF10, F20*	L037D	RN/LPN/MTA	0.37		
17	CA003	Schedule space and equipment in facility	90 DAY: NF0, F8*	L037D	RN/LPN/MTA	0.37		
18	CA004	Provide pre-service education/obtain consent	90 DAY: NF10, F20*	L037D	RN/LPN/MTA	0.37		
19	CA005	Complete pre-procedure phone calls and prescription	90 DAY: NF10, F7*	L037D	RN/LPN/MTA	0.37		
20	CA006	Confirm availability of prior images/studies	Standard time for this activity is 2 minutes. For use in imaging services.	L041B	Radiologic Technologist	0.41		
21	CA007	Review patient clinical extant information and questionnaire	Standard time for this activity is 1 minute. For use in imaging services.	L041B	Radiologic Technologist	0.41		
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	0	L037D	RN/LPN/MTA	0.37		
29		End: When patient enters office/facility for surgery/procedure						
30		SERVICE PERIOD						
31		Start: When patient enters office/facility for surgery/procedure:						
32		Pre-Service (of service period)						
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	Standard time for this activity is 3 minutes.	L041B	Radiologic Technologist	0.41	3	
34	CA010	Obtain vital signs	Vital Sign Standards	L037D	RN/LPN/MTA	0.37		
35	CA011	Provide education/obtain consent	Include only the additional education/consent activities not included in the pre-service period.	L041B	Radiologic Technologist	0.41	3	
36	CA012	Review requisition, assess for special needs	0	L037D	RN/LPN/MTA	0.37		
37	CA013	Prepare room, equipment and supplies	2 minute standard	L041B	Radiologic Technologist	0.41	2	
38	CA014	Confirm order, protocol exam	Standard time for this activity is 1 minute. For use in imaging services.	L041B	Radiologic Technologist	0.41		
39	CA015	Setup scope (nonfacility setting only)	5 minutes standard for scope set up in the 2 minute standard	L037D	RN/LPN/MTA	0.37		
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient		L041B	Radiologic Technologist	0.41	1	
41	CA017	Sedate/apply anesthesia	2 minute standard RN/LPN/MA	L037D	RN/LPN/MTA	0.37		
48		Intra-service (of service period)						
49	CA018	Assist physician or other qualified healthcare professional---directly	100% of physician or other qualified	L041B	Radiologic	0.41		
50	CA019	Assist physician or other qualified healthcare professional---directly	67% of physician or other qualified	L037D	RN/LPN/MTA	0.37		
51	CA020	Assist physician or other qualified healthcare professional---directly	other% of physician or other qualified	L037D	RN/LPN/MTA	0.37		
52	CA021	Perform procedure/service---NOT directly related to physician work time	0	L041B	Radiologic Technologist	0.41	33	
59		Post-Service (of service period)						
60	CA022	Monitor patient following procedure/service, multitasking 1:4	For monitoring following procedure, the	L037D	RN/LPN/MTA	0.37		
61	CA023	Monitor patient following procedure/service, no multitasking	0	L037D	RN/LPN/MTA	0.37		
62	CA024	Clean room/equipment by clinical staff	3 minute standard	L041B	Radiologic Technologist	0.41	3	
63	CA025	Clean scope	Standards For Scope Cleaning	L037D	RN/LPN/MTA	0.37		
64	CA026	Clean surgical instrument package	Standard for cleaning instruments	L037D	RN/LPN/MTA	0.37		
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	0	L037D	RN/LPN/MTA	0.37		
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	0	L037D	RN/LPN/MTA	0.37		
67	CA029	Check dressings, catheters, wounds	Standard time for this activity is 1 minute.	L037D	RN/LPN/MTA	0.37		
68	CA030	Technologist QC's images in PACS, checking for all images, reformat, and dose page	Baseline time for this activity is 2 minute. For use in imaging services.	L041B	Radiologic Technologist	0.41	4	
69	CA031	Review examination with interpreting MD/DO	Standard time for this activity is 2 minute. For use in imaging services.	L041B	Radiologic Technologist	0.41	3	
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue.	Standard time for this activity is 1 minute. For use in imaging services.	L041B	Radiologic Technologist	0.41	3	
71	CA033	Perform regulatory mandated quality assurance activity (service period)	0	L037D	RN/LPN/MTA	0.37		
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry)	0	L037D	RN/LPN/MTA	0.37		
73	CA035	Review home care instructions, coordinate visits/prescriptions	Standard time for this activity is 2 minutes.	L037D	RN/LPN/MTA	0.37		
74	CA036	Discharge day management	Dischrg mgmt same day (0.5 x 99238) (enter	L037D	RN/LPN/MTA	0.37	n/a	
81		End: Patient leaves office						
82		POST-SERVICE PERIOD						
83		Start: Patient leaves office/facility						
84	CA037	Conduct patient communications	Phone calls/emails/texts are in 3 minute	L037D	RN/LPN/MTA	0.37		
85	CA038	Coordinate post-procedure services	0	L037D	RN/LPN/MTA	0.37		
86		Office visits: List Number and Level of Office Visits		MINUTES			# visits	# visits
92	CA039	Post-operative visits (total time)		L037D	RN/LPN/MTA	0.37	0.0	0.0
99		End: with last office visit before end of global period						

	A	B	C	D	E	F	G	H
1	RUC Practice	Expense Spreadsheet					REFERENCE CODE	
2	AtMeeting	Meeting Date: October 2018 Tab: 18 Urography Specialty: SIR, ACR, AUA					74400 Urography (pyelography), intravenous, with or without KUB, with or without tomography	
3		RUC Collaboration Website						
4	Clinical Activity Code	***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment. "	Standards/Guidelines	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute		
5		LOCATION					Non Fac	Facility
6		GLOBAL PERIOD					XXX	XXX
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME					\$ 72.64	\$ -
8		TOTAL CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	55	0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	0	0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	55	0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	0	0
100	Supply Code	MEDICAL SUPPLIES		PRICE	UNIT			
101		TOTAL COST OF SUPPLY QUANTITY x PRICE					\$ 6.69	\$ -
102	SB008	drape, sterile, c-arm, fluoro		4.504	item			
103	SM013	disinfectant, surface (Envirocide, Sanizide)		0.163	oz			
104	SB006	drape, non-sterile, sheet 40in x 60in		0.222	item		1	
105	SB022	gloves, non-sterile		0.084	pair		1	
106	SB026	gown, patient		0.533	item		1	
107	SC018	iv infusion set		1.112	item		1	
108	SC028	needle, 18-26g 1.5-3.5in, spinal		3.314	item		1	
109	SC030	needle, 19-25g, butterfly		0.798	item		1	
110	SC054	syringe 30 ml		0.63	item		1	
111								
112		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A						
114	Equipment Code	EQUIPMENT		Purchase Price	Equipment Formula	Cost Per Minute		
115		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE					\$ 43.40	\$ -
116	EL014	room, radiographic-fluoroscopic		367664	Highly Technical	1.393085936		
117	ED050	Technologist PACS workstation		5557	PACS	0.022017924	55	
118	ED053	Professional PACS Workstation		14616.93	Other Formula	0.057915145	18	
119	EL012	room, basic radiology		127750	Default	0.484047196	85	
120								
121								
122		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A						

	A	B	K	L
1	RUC Practice	Expense Spreadsheet	RECOMMENDED	
2	AtMeeting	Meeting Date: October 2018 Tab: 18 Urography Specialty: SIR, ACR, AUA	74425	
3		RUC Collaboration Website	Urography, antegrade (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation	
4	Clinical Activity Code	***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment. "		
5		LOCATION	Non Fac	Facility
6		GLOBAL PERIOD	XXX	XXX
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 73.32	\$ -
8		TOTAL CLINICAL STAFF TIME	44	0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	3	0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	41	0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0	0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	\$ 18.04	\$ -
13		PRE-SERVICE PERIOD		
14		Start: Following visit when decision for surgery or procedure made		
15	CA001	Complete pre-service diagnostic and referral forms		
16	CA002	Coordinate pre-surgery services (including test results)		
17	CA003	Schedule space and equipment in facility		
18	CA004	Provide pre-service education/obtain consent		
19	CA005	Complete pre-procedure phone calls and prescription		
20	CA006	Confirm availability of prior images/studies	2	
21	CA007	Review patient clinical extant information and questionnaire	1	
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)		
29		End: When patient enters office/facility for surgery/procedure		
30		SERVICE PERIOD		
31		Start: When patient enters office/facility for surgery/procedure:		
32		Pre-Service (of service period)		
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are available		
34	CA010	Obtain vital signs		
35	CA011	Provide education/obtain consent		
36	CA012	Review requisition, assess for special needs		
37	CA013	Prepare room, equipment and supplies	2	
38	CA014	Confirm order, protocol exam	1	
39	CA015	Setup scope (nonfacility setting only)		
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient		
41	CA017	Sedate/apply anesthesia		
48		Intra-service (of service period)		
49	CA018	Assist physician or other qualified healthcare professional---directly		
50	CA019	Assist physician or other qualified healthcare professional---directly		
51	CA020	Assist physician or other qualified healthcare professional---directly		
52	CA021	Perform procedure/service---NOT directly related to physician work time	30	
59		Post-Service (of service period)		
60	CA022	Monitor patient following procedure/service, multitasking 1:4		
61	CA023	Monitor patient following procedure/service, no multitasking		
62	CA024	Clean room/equipment by clinical staff	3	
63	CA025	Clean scope		
64	CA026	Clean surgical instrument package		
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions		
66	CA028	Review/read post-procedure x-ray, lab and pathology reports		
67	CA029	Check dressings, catheters, wounds		
68	CA030	Technologist QC's images in PACS, checking for all images, reformat, and dose page	2	
69	CA031	Review examination with interpreting MD/DO	2	
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue.	1	
71	CA033	Perform regulatory mandated quality assurance activity (service period)		
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry		
73	CA035	Review home care instructions, coordinate visits/prescriptions		
74	CA036	Discharge day management	n/a	
81		End: Patient leaves office		
82		POST-SERVICE PERIOD		
83		Start: Patient leaves office/facility		
84	CA037	Conduct patient communications		
85	CA038	Coordinate post-procedure services		
86		Office visits: List Number and Level of Office Visits	# visits	# visits
92	CA039	Post-operative visits (total time)	0.0	0.0
99		End: with last office visit before end of global period		

	A	B	K	L
1	RUC Practice	Expense Spreadsheet	RECOMMENDED	
2	AtMeeting	Meeting Date: October 2018 Tab: 18 Urography Specialty: SIR, ACR, AUA	74425	
3		RUC Collaboration Website	Urography, antegrade (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation	
4	Clinical Activity Code	***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment. "		
5		LOCATION		
6		GLOBAL PERIOD	Non Fac XXX	Facility XXX
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 73.32	\$ -
8		TOTAL CLINICAL STAFF TIME	44	0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	3	0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	41	0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0	0
100	Supply Code	MEDICAL SUPPLIES		
101		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ 4.67	\$ -
102	SB008	drape, sterile, c-arm, fluoro	1	
103	SM013	disinfectant, surface (Envirocide, Sanizide)	1	
104	SB006	drape, non-sterile, sheet 40in x 60in		
105	SB022	gloves, non-sterile		
106	SB026	gown, patient		
107	SC018	iv infusion set		
108	SC028	needle, 18-26g 1.5-3.5in, spinal		
109	SC030	needle, 19-25g, butterfly		
110	SC054	syringe 30 ml		
111				
112		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A		
114	Equipment Code	EQUIPMENT		
115		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ 50.62	\$ -
116	EL014	room, radiographic-fluoroscopic	35	
117	ED050	Technologist PACS workstation	41	
118	ED053	Professional PACS Workstation	17	
119	EL012	room, basic radiology		
120				
121				
122		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A		

AMA/Specialty Society RVS Update Committee Summary of Recommendations
****CMS/Other Source – Medicare Utilization Over 30,000****

October 2018

Abdominal Aortography

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.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
75625	Aortography, abdominal, by serialography, radiological supervision and interpretation	XXX	1.75
(f)75630	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation	XXX	2.00

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 75625	Tracking Number	Original Specialty Recommended RVU: 1.75
		Presented Recommended RVU: 1.75
Global Period: XXX	Current Work RVU: 1.14	RUC Recommended RVU: 1.75

CPT Descriptor: Aortography, abdominal, by serialography, radiological supervision and interpretation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male presents with suspected atherosclerosis and claudication of his lower extremities. He has diminished femoral pulses. An aortogram with catheter in the aorta is performed to assess for aortoiliac occlusive disease.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is;
Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Based on the patient's symptoms, signs, physical findings, and any preprocedural studies, the area of potential disease is determined within the aorta or iliacs. Full visualization of the total region of the potentially affected aortic segment is ensured using angiographic imaging in the interventional suite. Consideration is given to the total length of expected imaging, the body habitus, limitation on movement due to underlying conditions, and positioning in order to ensure the best imaging of the abdominal aorta. In addition to assessing the affected limb(s), it is ensured that imaging equipment can be rotated to provide complete imaging from multiple angles prior to patient positioning. The risks due to the exposure to radiation and use of contrast dye or other potential imaging modality (eg, carbon dioxide) are discussed with the patient and family. The equipment being used, the close proximity of the image intensifier and potential for claustrophobia, prolonged immobility, and repositioning to ensure optimal imaging for interpretation are discussed.

Description of Intra-Service Work: X-ray is used to determine the best and safest access site for catheter positioning and contrast imaging. This requires static X-ray visualization of access site and anatomic landmarks to ensure direct anterior access to the access vessel. Upon access, multiple imaging angles are required to ensure complete visualization of the vasculature as this is a two-dimensional representation of a three-dimensional object. Due to the size and caliber of the abdominal aorta, power injection for contrast administration is used for angiography. Total dosage and dilution of contrast along with injection rate and pressure for injection are communicated and verified. Visualization of angiography of the abdominal aorta is then performed. During angiographic interpretation, different angles are required due to the course of the vasculature as well as interference from overlapping bowel and gas, other vessels and bony prominences. This requires prolonged visualization and interpretation due to multiple images. Magnified imaging is used, as necessary, for best visualization of potential vascular lesions as well as reformatting pixilation due to movement. Visualization of the vasculature above and below the area of potential disease is imperative to determine the best treatment modality and to ensure iatrogenic injury (wire manipulation, embolization) has not occurred beyond the location of disease, as well as to assess all levels of disease.

Description of Post-Service Work: All imaging studies are uploaded into the picture archiving and communication system. This includes reformatting due to movement or poor contrast flow into the affected region with peak opacification. Key

digital subtraction angiography images of areas of significant disease or for preoperative planning to be used intraoperatively are selected. Key images are copied and sent to the referring physician through a secure portal.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Matthew Sideman, MD, Francesco Aiello, MD, Richard Wright, MD, Edward Tuohy, MD, Michael Hall, MD, Curtis Anderson, MD and Clifford Kavinsky, MD				
Specialty Society(ies):	SVS, ACC, SCAI and SIR				
CPT Code:	75625				
Sample Size:	2600	Resp N:	54	Response: 2.0 %	
Description of Sample:	random samples from societies				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	30.00	100.00	700.00
Survey RVW:	1.00	1.75	1.95	2.40	4.25
Pre-Service Evaluation Time:			20.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	10.00	19.00	30.00	39.00	90.00
Immediate Post Service-Time:	20.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the **pre-service time package** that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	75625	Recommended Physician Work RVU: 1.75		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	15.00	0.00	15.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	30.00			
Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time) XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	15.00	0.00	15.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
75710	000	1.75	RUC Time

CPT Descriptor Angiography, extremity, unilateral, radiological supervision and interpretation**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
75716	000	1.97	RUC Time

CPT Descriptor Angiography, extremity, bilateral, radiological supervision and interpretation**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93351	XXX	1.75	RUC Time	253,254

CPT Descriptor 1 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
74178	XXX	2.01	RUC Time	541,254

CPT Descriptor 2 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

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 18 **% of respondents:** 33.3 %

Number of respondents who choose 2nd Key Reference Code: 12 **% of respondents:** 22.2 %

TIME ESTIMATES (Median)

	CPT Code: <u>75625</u>	Top Key Reference CPT Code: <u>75710</u>	2nd Key Reference CPT Code: <u>75716</u>
Median Pre-Service Time	15.00	15.00	15.00
Median Intra-Service Time	30.00	40.00	50.00
Median Immediate Post-service Time	15.00	15.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	60.00	70.00	80.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	11%	44%	39%	6%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	11%	56%	33%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	28%	67%	6%
Physical effort required	6%	72%	22%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	6%	78%	17%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	17%	25%	50%	8%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	17%	33%	50%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	25%	42%	33%
Physical effort required	8%	50%	42%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	17%	42%	42%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In October 2017, the RAW requested that the AMA staff compile a list of CMS/Other codes with Medicare utilization of 30,000 or more. CPT Code 75625 was identified in this screen CPT code 75630 was added as part of the 'family'.

Compelling Evidence

We believe that there is compelling evidence to recommend an increase in the value for CPT code 75625 based on evidence that: (1) incorrect assumptions were made in the previous valuation; (2) physician work has increased due to changes in technique, knowledge/technology, and patient population; and (3) dominant specialty has changed.

- (1) Flawed methodology. CPT code 75625 has never been surveyed and is the result of CMS/other inputs. While this alone does not amount to compelling evidence, comparison of the survey time results and other RUC reviewed supervision and interpretation codes show that the existing value greatly underestimates the work of CPT code 75625.
- (2) Changes in physician work. We believe that there has been a change in physician work for CPT code 75625 since CMS assigned a value and time in 1992 due to changes in technique, technology, and patient population. 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 to analog to digital imaging allow for the safer acquisition of significantly more and higher quality images of the aorta and iliac vessels. Thus the changes in patient population, technique, and technology have resulted in a change in the complexity of physician work and total time since 1992 and constitutes compelling evidence for a change in value.
- (3) Change in dominant specialty: In 1992, diagnostic radiology was the dominant provider (84%). In 2017, Medicare data indicate that vascular surgery is 43% and cardiology is 35% of the claims, while diagnostic radiology is only 8% of Medicare claims. These changes in specialties providing this service is consistent with the change in technique, technology and patient described in item 2 above.

Recommendations

We are recommending the survey 25th percentile wRVU of 1.75 with 15 pre, 30 intra and 15 post for a total time of 60 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 75630	Tracking Number	Original Specialty Recommended RVU: 2.00
		Presented Recommended RVU: 2.00
Global Period: XXX	Current Work RVU: 1.79	RUC Recommended RVU: 2.00

CPT Descriptor: Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male presents with suspected atherosclerosis and claudication of his lower extremities. He has diminished pedal pulses bilaterally. An aortogram with bilateral run-off with the catheter placement in the aorta is performed to assess for aortoiliac occlusive disease and bilateral peripheral arterial disease.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is;
Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Based on the patient's symptoms, signs, physical findings, and any preprocedural studies, the area of potential disease is determined within the aorta and iliofemoral arteries. Full visualization of the total region of the potentially affected aortic segment is ensured using angiographic imaging. Consideration is given to aorta and iliofemoral arteries, the body habitus, limitation on movement due to underlying conditions, and positioning in order to ensure the best imaging of the abdominal aorta and iliofemoral arteries. Imaging equipment is assessed to ensure proper function. The risks due to the exposure to radiation and use of contrast dye or other potential imaging modality (eg, carbon dioxide) are discussed with the patient and family. The equipment being used, the close proximity of the image intensifier and potential for claustrophobia, prolonged immobility, and repositioning to ensure optimal imaging for interpretation are discussed. Additional attention is given to ensure the ability of the bed to move under the imager to chase the dye bolus all the way down the legs without disruption.

Description of Intra-Service Work: X-ray is used to determine the best and safest access site for catheter positioning and contrast imaging of each limb. This requires static X-ray visualization of access site and anatomic landmarks to ensure direct anterior access to the access vessel. Upon access, multiple imaging angles are required to ensure complete visualization of the vasculature as this is a two-dimensional representation of a three-dimensional object. Due to the size and caliber of the abdominal aorta, power injection for contrast administration is used for angiography. Total dosage and dilution of contrast along with injection rate and pressure for injection are communicated and verified. Complete visualization of the aorta and iliofemoral arteries is performed; this requires a test run prior to angiographic imaging. During angiographic interpretation, additional images and different angles are required due to the course of the vasculature as well as interference from overlapping bowel and gas, other vessels and bony prominences. This requires prolonged visualization and interpretation due to multiple images. Magnified imaging is used, as necessary, for best visualization of potential vascular lesions as well as reformatting pixilation due to movement. Visualization of the vasculature above and below the area of potential disease is imperative to determine the best treatment modality and to ensure iatrogenic injury (wire manipulation, embolization) has not occurred beyond the location of disease, as well as to assess all levels of disease.

Description of Post-Service Work: All imaging studies are uploaded into the picture archiving and communication system. This includes reformatting due to movement or poor contrast flow into the affected region with peak opacification. Key digital subtraction angiography images of areas of significant disease or for preoperative planning to be used intraoperatively are selected. Key images are copied and sent to the referring physician through a secure portal.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Matthew Sideman, MD, Francesco Aiello, MD, Richard Wright, MD, Edward Tuohy, MD, Michael Hall, MD, Curtis Anderson, MD and Clifford Kavinsky, MD				
Specialty Society(ies):	SVS, ACC, SCAI and SIR				
CPT Code:	75630				
Sample Size:	2600	Resp N:	54	Response: 2.0 %	
Description of Sample:	random samples from societies				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	28.00	75.00	350.00
Survey RVW:	1.50	2.00	2.36	2.53	6.25
Pre-Service Evaluation Time:			24.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	12.00	25.00	35.00	58.00	120.00
Immediate Post Service-Time:	20.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the **pre-service time package** that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	75630	Recommended Physician Work RVU: 2.00		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	15.00	0.00	15.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	35.00			
Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	15.00	0.00	15.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
75716	XXX	1.97	RUC Time

CPT Descriptor Angiography, extremity, bilateral, radiological supervision and interpretation**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
75635	XXX	2.40	RUC Time

CPT Descriptor Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93351	XXX	1.75	RUC Time	253,254

CPT Descriptor 1 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
74178	XXX	2.01	RUC Time	541,254

CPT Descriptor 2 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

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 22 % of respondents: 40.7 %

Number of respondents who choose 2nd Key Reference Code: 19 % of respondents: 35.1 %

TIME ESTIMATES (Median)

	CPT Code: <u>75630</u>	Top Key Reference CPT Code: <u>75716</u>	2nd Key Reference CPT Code: <u>75635</u>
Median Pre-Service Time	15.00	15.00	10.00
Median Intra-Service Time	35.00	50.00	39.00
Median Immediate Post-service Time	15.00	15.00	8.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	65.00	80.00	57.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	5%	11%	26%	58%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	5%	37%	58%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	0%	5%	95%
Physical effort required	0%	11%	89%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	0%	16%	84%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	5%	11%	26%	58%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	5%	37%	58%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	0%	5%	95%
Physical effort required	0%	11%	89%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	0%	16%	84%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In October 2017, the RAW requested that the AMA staff compile a list of CMS/Other codes with Medicare utilization of 30,000 or more. CPT Code 75625 was identified in this screen CPT Code 75630 was added as part of the ‘family’.

Compelling Evidence

We believe that there is compelling evidence to recommend an increase in the value for CPT code 75630 based on evidence that: (1) the dominant specialty has changed; (2) incorrect assumptions were made in the previous valuation; and (3) physician work has increased due to changes in technique, knowledge/technology, and patient population.

- (1) Change in dominant specialty: In 1995, when code 75630 was last reviewed, the dominant specialty was diagnostic radiology (80%). Cardiology was 7% and interventional radiology was 5%. The 2017 Medicare data indicate that cardiology is 58%, vascular surgery is 27%, diagnostic radiology is 2% and interventional radiology is 1%. These changes in specialties providing this service is consistent with the change in technique, technology and patient described in item 3 below.
- (2) Flawed methodology: 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 75630.
- (3) Changes in physician work. We believe that there has been a change in physician work for CPT code 75630 since the previous review in 1995 due to changes in technique, technology, and patient population. In 1995, the typical patient for an aortogram with bilateral lower extremity angiogram 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. Thus the changes in patient population, technique, and technology have resulted in a change in the complexity of physician work and total time since 1995 and constitutes compelling evidence for a change in value.

Recommendations

We are recommending the survey 25th percentile wRVU of 2.00 with times of 15 pre, 35 intra and 15 post for a total of 65 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 75630

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR	AS
13	ISSUE: Abdominal Aortography																								
14	TAB: 19																								
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
17	1st REF	75710	Angiography, extremity, unilateral, radiological supervision and interpretation	18	0.027			1.75			70	15					40			15					
18	2nd REF	75716	Angiography, extremity, bilateral, radiological supervision and interpretation	12	0.026			1.97			80	15					50			15					
19	CURRENT	75625	Aortography, abdominal, by serialography, radiological supervision and interpretation		#DIV/0!			1.14			22														
20	SVY	75625	Aortography, abdominal, by serialography, radiological supervision and interpretation	54	0.035	1.00	1.75	1.95	2.40	4.25	70	20			10	19	30	39	90	20	0	10	30	100	700
21	REC				0.036	1.75					60	15					30			15					
22																									
23																									
24						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
25	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
26	1st REF	75716	Angiography, extremity, bilateral, radiological supervision and interpretation	22	0.026			1.97			80	15					50			15					
27	2nd REF	75635	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing	19	0.051			2.40			57	10					39			8					
	CURRENT	75630	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation		#DIV/0!			1.79			25														
29	SVY	75630	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation	54	0.039	1.50	2.00	2.36	2.53	6.25	79	24			12	25	35	58	120	20	0	10	28	75	350
30	REC				0.038	2.00					65	15					35			15					

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

REVISED AT MEETING

Meeting Date: October 2018

Global Period: XXX

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

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

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

SVS, ACC, SCAI and SIR convened a panel that included a number of experts to evaluate the direct practice expense inputs for these aortography procedures.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

CPT Codes 75625 and 75630 are current CPT codes with direct practice expense inputs. As such, we included the existing direct practice expense inputs on the PE spreadsheet.

**3. Is this code(s) typically billed with an E/M service?
Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)**

Codes not typically billed with E/M

- 75625 – 1%
- 75630 – 2%

Code not typically billed with E/M service in the NF

- 75625 – 1%
- 75630 – 4%

- 4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different then for the global?
(Please see provided data in PE Subcommittee folder)**

NF (All, global and 26)

- 75625 – 45% Vascular Surgery
- 75630 – 36% Cardiology

NF (Global and TC)

- 75625 – 49% Vascular Surgery
- 75630 – 34% Vascular Surgery

- 5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:**

The specialties are recommending 4 minutes for CA030 *Technologist QC's images in PACS, checking for all images, reformats, and dose page.* The baseline time for this clinical activity is 2 minutes. These services require additional time to account for the technologist adjusting contrast levels for each image of numerous angiography runs in different projections. In addition, the “mask” image must be manually adjusted for each image to correct poor image quality related to patient motion respiration.

- 6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.**

N/A

- 7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:**

N/A

- 8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code)**

The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

- 9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional--- directly related to physician work time or Perform procedure/service---NOT directly related to physician work time*:**

A radiologic technologist is in the procedure room and assists in operating the C-arm, acquires images and circulates during critical times of the procedure.

- 10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.**

The intra-service time is not directly related to physician work time for these two services. We are recommending intra-service time 'perform procedure/service' consistent with other S&I codes.

- 11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:**

N/A

- 12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.**

N/A

- 13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:**

N/A

- 14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:**

N/A

- 15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:**

EL011 room, angiography: “Other”

Followed “Rationale for Angiographic Room time Allocation”

To prevent double counting of room time between the procedure code and the S&I code the S&I code should receive a base time of 9 minutes for the room, and all other time will be allocated to the procedure code.

ED053 Professional PACS Workstation: “Other”

Followed “Guidelines for PACS Professional Workstation

Minutes equal to half the preservice physician work time and the full intraservice physician work time.

ED050 Technologist PACS workstation: “PACS” formula

- 16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:**

N/A

- 17. If there is any other item on your spreadsheet that needs further explanation please include here:**

N/A

- 18. Please include an explanation of each line item:**

drape, sterile, c-arm, fluoro	SB008	Required for sterile preparation of imaging equipment
disinfectant, surface (Envirocide, Sanizide)	SM013	For cleaning imaging equipment after usage.

	A	B	C	D	E	F	I	J
1	RUC Practice	Expense Spreadsheet					CURRENT	
2	AtMeeting	Meeting Date: October 2018 Tab: 19 Abdominal Aortography Specialty: SVS, ACC, SCAI and SIR RUC Collaboration Website					75625	
3	Clinical Activity Code	**Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment. *	Standards/Guidelines	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute	Aortography, abdominal, by serialography, radiological supervision and interpretation	
4		LOCATION					Non Fac	Facility
5		GLOBAL PERIOD					XXX	XXX
6		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME					\$ 77.95	\$ -
7		TOTAL CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	59	0
8		TOTAL PRE-SERVICE CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	6	0
9		TOTAL SERVICE PERIOD CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	53	0
10		TOTAL POST-SERVICE CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	0	0
11		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE					\$ 24.19	\$ -
12		PRE-SERVICE PERIOD						
13		Start: Following visit when decision for surgery or procedure made						
14	CA001	Complete pre-service diagnostic and referral forms	90 DAY: NF5, F5*	L037D	RN/LPN/MTA	0.37		
15	CA002	Coordinate pre-surgery services (including test results)	90 DAY: NF10, F20*	L037D	RN/LPN/MTA	0.37		
16	CA003	Schedule space and equipment in facility	90 DAY: NF0, F8*	L037D	RN/LPN/MTA	0.37		
17	CA004	Provide pre-service education/obtain consent	90 DAY: NF10, F20*	L037D	RN/LPN/MTA	0.37		
18	CA005	Complete pre-procedure phone calls and prescription	90 DAY: NF10, F7*	L037D	RN/LPN/MTA	0.37		
19	CA006	Confirm availability of prior images/studies	Standard time for this activity is 2 minutes. For use in imaging services.	L041B	Radiologic Technologist	0.41		
20	CA007	Review patient clinical extant information and questionnaire	Standard time for this activity is 1 minute.	L037D	RN/LPN/MTA	0.37		
21	CA008	Perform regulatory mandated quality assurance activity (pre-service)	0	L041B	Radiologic Technologist	0.41	6	
22		End: When patient enters office/facility for surgery/procedure						
23		SERVICE PERIOD						
24		Start: When patient enters office/facility for surgery/procedure:						
25		Pre-Service (of service period)						
26	CA009	Greet patient, provide gowning, ensure appropriate medical records are	Standard time for this activity is 3 minutes.	L037D	RN/LPN/MTA	0.37		
27	CA010	Obtain vital signs	Vital Sign Standards	L037D	RN/LPN/MTA	0.37		
28	CA011	Provide education/obtain consent	Include only the additional	L037D	RN/LPN/MTA	0.37		
29	CA012	Review requisition, assess for special needs	0	L037D	RN/LPN/MTA	0.37		
30	CA013	Prepare room, equipment and supplies	2 minute standard	L041B	Radiologic	0.41	2	
31	CA014	Confirm order, protocol exam	Standard time for this activity is 1 minute.	L037D	RN/LPN/MTA	0.37		
32	CA015	Setup scope (nonfacility setting only)	5 minutes standard for scope set up in the	L037D	RN/LPN/MTA	0.37		
33	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	2 minute standard	L041B	Radiologic	0.41	2	
34	CA017	Sedate/apply anesthesia	2 minute standard RN/LPN/MA	L037D	RN/LPN/MTA	0.37		
35		Intra-service (of service period)						
36	CA018	Assist physician or other qualified healthcare professional---directly	100% of physician or other qualified	L037D	RN/LPN/MTA	0.37		
37	CA019	Assist physician or other qualified healthcare professional---directly	67% of physician or other qualified	L037D	RN/LPN/MTA	0.37		
38	CA020	Assist physician or other qualified healthcare professional---directly	other% of physician or other qualified	L037D	RN/LPN/MTA	0.37		
39	CA021	Perform procedure/service---NOT directly related to physician work time	0	L041B	Radiologic	0.41	39	
40		Post-Service (of service period)						
41	CA022	Monitor patient following procedure/service, multitasking 1:4	For monitoring following procedure, the	L037D	RN/LPN/MTA	0.37		
42	CA023	Monitor patient following procedure/service, no multitasking	0	L037D	RN/LPN/MTA	0.37		
43	CA024	Clean room/equipment by clinical staff	3 minute standard	L041B	Radiologic	0.41	3	
44	CA025	Clean scope	Standards For Scope Cleaning	L037D	RN/LPN/MTA	0.37		
45	CA026	Clean surgical instrument package	Standard for cleaning instruments	L037D	RN/LPN/MTA	0.37		
46	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	0	L037D	RN/LPN/MTA	0.37		
47	CA028	Review/read post-procedure x-ray, lab and pathology reports	0	L037D	RN/LPN/MTA	0.37		
48	CA029	Check dressings, catheters, wounds	Standard time for this activity is 1 minute.	L037D	RN/LPN/MTA	0.37		
49	CA030	Technologist QC's images in PACS, checking for all images, reformats,	Baseline time for this activity is 2 minute. For	L041B	Radiologic	0.41	4	
50	CA031	Review examination with interpreting MD/DO	Standard time for this activity is 2 minute.	L041B	Radiologic	0.41	2	
51	CA032	Scan exam documents into PACS. Complete exam in RIS system to	Standard time for this activity is 1 minute.	L041B	Radiologic	0.41	1	
52	CA033	Perform regulatory mandated quality assurance activity (service period)	0	L037D	RN/LPN/MTA	0.37		
53	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry	0	L037D	RN/LPN/MTA	0.37		
54	CA035	Review home care instructions, coordinate visits/prescriptions	Standard time for this activity is 2 minutes.	L037D	RN/LPN/MTA	0.37		
55	CA036	Discharge day management	Dischrg mgmt same day (0.5 x 99238) (enter	L037D	RN/LPN/MTA	0.37	n/a	
56		End: Patient leaves office						
57		POST-SERVICE PERIOD						
58		Start: Patient leaves office/facility						
59	CA037	Conduct patient communications	Phone calls/emails/texts are in 3 minute	L037D	RN/LPN/MTA	0.37		
60	CA038	Coordinate post-procedure services	0	L037D	RN/LPN/MTA	0.37		
61		Office visits: List Number and Level of Office Visits		MINUTES			# visits	# visits
62	CA039	Post-operative visits (total time)		L037D	RN/LPN/MTA	0.37	0.0	0.0
63		End: with last office visit before end of global period						

	A	B	C	D	E	F	I	J
1	RUC Practice	Expense Spreadsheet					CURRENT	
2	AtMeeting	Meeting Date: October 2018 Tab: 19 Abdominal Aortography Specialty: SVS, ACC, SCAI and SIR					75625	
3		RUC Collaboration Website					Aortography, abdominal, by serialography, radiological supervision and interpretation	
4	Clinical Activity Code	**Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment. *	Standards/Guidelines	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute		
5		LOCATION					Non Fac	Facility
6		GLOBAL PERIOD					XXX	XXX
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME					\$ 77.95	\$ -
8		TOTAL CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	59	0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	6	0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	53	0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	0	0
100	Supply Code	MEDICAL SUPPLIES		PRICE	UNIT			
101		TOTAL COST OF SUPPLY QUANTITY x PRICE					\$ 4.67	\$ -
102	SB008	drape, sterile, c-arm, fluoro		4.504	item		1	
103	SM013	disinfectant, surface (Envirocide, Sanizide)		0.163	oz		1	
108		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A						
110	Equipment Code	EQUIPMENT		Purchase Price	Equipment Formula	Cost Per Minute		
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE					\$ 49.10	\$ -
112	EL011	room, angiography		1386816	Other Formula	5.25467238	9	
113	ED053	Professional PACS Workstation		14616.93	Other Formula	0.057915145	11	
114	ED050	Technologist PACS workstation		5557	PACS	0.022017924	53	
118		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A						

	A	B	K	L	M	N	O	P
1	RUC Practice	Expense Spreadsheet	RECOMMENDED		CURRENT		RECOMMENDED	
2	AtMeeting	Meeting Date: October 2018 Tab: 19 Abdominal Aortography Specialty: SVS, ACC, SCAI and SIR	75625		75630		75630	
3		RUC Collaboration Website	Aortography, abdominal, by serialography, radiological supervision and interpretation		Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation		Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation	
4	Clinical Activity Code	**Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment. *						
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	XXX	XXX	XXX	XXX	XXX	XXX
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 73.92	\$ -	\$ 78.07	\$ -	\$ 76.37	\$ -
8		TOTAL CLINICAL STAFF TIME	46	0	59	0	51	0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	4	0	6	0	4	0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	42	0	53	0	47	0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0	0	0	0	0	0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	\$ 18.86	\$ -	\$ 24.19	\$ -	\$ 20.91	\$ -
13		PRE-SERVICE PERIOD						
14		Start: Following visit when decision for surgery or procedure made						
15	CA001	Complete pre-service diagnostic and referral forms						
16	CA002	Coordinate pre-surgery services (including test results)						
17	CA003	Schedule space and equipment in facility						
18	CA004	Provide pre-service education/obtain consent						
19	CA005	Complete pre-procedure phone calls and prescription						
20	CA006	Confirm availability of prior images/studies	2				2	
21	CA007	Review patient clinical extant information and questionnaire						
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	2		6		2	
29		End: When patient enters office/facility for surgery/procedure						
30		SERVICE PERIOD						
31		Start: When patient enters office/facility for surgery/procedure:						
32		Pre-Service (of service period)						
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are						
34	CA010	Obtain vital signs						
35	CA011	Provide education/obtain consent						
36	CA012	Review requisition, assess for special needs						
37	CA013	Prepare room, equipment and supplies	2		2		2	
38	CA014	Confirm order, protocol exam						
39	CA015	Setup scope (nonfacility setting only)						
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient			2			
41	CA017	Sedate/apply anesthesia						
48		Intra-service (of service period)						
49	CA018	Assist physician or other qualified healthcare professional---directly						
50	CA019	Assist physician or other qualified healthcare professional---directly						
51	CA020	Assist physician or other qualified healthcare professional---directly						
52	CA021	Perform procedure/service---NOT directly related to physician work time	30		39		35	
59		Post-Service (of service period)						
60	CA022	Monitor patient following procedure/service, multitasking 1:4						
61	CA023	Monitor patient following procedure/service, no multitasking						
62	CA024	Clean room/equipment by clinical staff	3		3		3	
63	CA025	Clean scope						
64	CA026	Clean surgical instrument package						
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions						
66	CA028	Review/read post-procedure x-ray, lab and pathology reports						
67	CA029	Check dressings, catheters, wounds						
68	CA030	Technologist QC's images in PACS, checking for all images, reformat, 4	4		4		4	
69	CA031	Review examination with interpreting MD/DO	2		2		2	
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to	1		1		1	
71	CA033	Perform regulatory mandated quality assurance activity (service period)						
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry						
73	CA035	Review home care instructions, coordinate visits/prescriptions						
74	CA036	Discharge day management	n/a		n/a		n/a	
81		End: Patient leaves office						
82		POST-SERVICE PERIOD						
83		Start: Patient leaves office/facility						
84	CA037	Conduct patient communications						
85	CA038	Coordinate post-procedure services						
86		Office visits: List Number and Level of Office Visits	# visits	# visits	# visits	# visits	# visits	# visits
92	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0
99		End: with last office visit before end of global period						

	A	B	K	L	M	N	O	P
1	RUC Practice	Expense Spreadsheet	RECOMMENDED		CURRENT		RECOMMENDED	
2	AtMeeting	Meeting Date: October 2018 Tab: 19 Abdominal Aortography Specialty: SVS, ACC, SCAI and SIR	75625		75630		75630	
3		RUC Collaboration Website	Aortography, abdominal, by serialography, radiological supervision and interpretation		Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation		Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation	
4	Clinical Activity Code	**Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment. *						
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	XXX	XXX	XXX	XXX	XXX	XXX
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 73.92	\$ -	\$ 78.07	\$ -	\$ 76.37	\$ -
8		TOTAL CLINICAL STAFF TIME	46	0	59	0	51	0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	4	0	6	0	4	0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	42	0	53	0	47	0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0	0	0	0	0	0
100	Supply Code	MEDICAL SUPPLIES						
101		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ 4.67	\$ -	\$ 4.67	\$ -	\$ 4.67	\$ -
102	SB008	drape, sterile, c-arm, fluoro	1		1		1	
103	SM013	disinfectant, surface (Envirocide, Sanizide)	1		1		1	
108		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A						
110	Equipment Code	EQUIPMENT						
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ 50.39	\$ -	\$ 49.21	\$ -	\$ 50.79	\$ -
112	EL011	room, angiography	9		9		9	
113	ED053	Professional PACS Workstation	37.5		13		42.5	
114	ED050	Technologist PACS workstation	42		53		47	
118		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A						

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS/Other Source – Medicare Utilization Over 30,000

October 2018

Angiography

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 supraseductive (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.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
75726	Angiography, visceral, selective or supraseductive (with or without flush aortogram), radiological supervision and interpretation	XXX	2.05
75774	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)	ZZZ	1.01

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 75726	Tracking Number	Original Specialty Recommended RVU: 2.05
		Presented Recommended RVU: 2.05
Global Period: XXX	Current Work RVU: 1.14	RUC Recommended RVU: 2.05

CPT Descriptor: Angiography, visceral, selective or supraseductive (with or without flush aortogram), radiological supervision and interpretation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 76-year-old female presents with acute upper lower gastrointestinal bleeding. Arteriogram with catheter placement in the superior mesenteric artery is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 65%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Pertinent imaging, notes, and labs are reviewed as it pertains to prior radiation and contrast exposure. The risks and benefits of iodinated contrast are discussed with patient and family. The risks and benefits of ionizing radiation are discussed with patient and family. Imaging alternatives are reviewed. Pertinent imaging related details are reviewed with staff. Imaging equipment function confirmed. Contrast dilution confirmed. Ability to achieve desired imaging angles confirmed based on area of interest, body habitus, associated external wires, IVs, tubes, and other monitoring devices.

Description of Intra-Service Work: Survey fluoroscopy of the abdomen and pelvis is performed to identify clips, oral contrast, and other pertinent anatomy. Separate surgical procedure is begun. Fluoroscopy is used to position the patient for initial aortogram (catheter placement is a separate procedure). Desired rate of contrast flow and volume of contrast to be injected is determined. Magnification and filters are adjusted to optimize imaging. From review of the aortogram, visceral artery flow and anatomy is reviewed so that the appropriately shaped selective catheter can be requested for separate surgical procedure. After the work of the separately reportable selective catheterization, the table is moved to position for initial selective DSA. Magnification and filters are adjusted to optimize imaging. Based on mesenteric flow and imaging findings the rate and volume of contrast is chosen for selective DSA. Imaging is reviewed and DSA is repeated to include the entire SMA territory as it is typically too large to cover in a one sequence. DSA imaging is reviewed. Native unsubtracted images are reviewed to differentiate bowel gas motion and vascular anatomy. Additional oblique and magnified DSA is performed as based on these initial interpretations. Rate and volume of injection may be modified to optimize the exam. Imaging is compared to any prior studies for final interpretation and report creation.

Description of Post-Service Work: Subtracted and unsubtracted images are selected for archiving and imaging is reformatted to adjust for motion and bowel gas. Imaging is archived to PACS and key findings are annotated. Key images are flagged and sent to other involved physicians as needed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Michael Hall, MD, Curtis Anderson, MD, Matthew Sideman, MD and Francesco Aiello, MD				
Specialty Society(ies):	SIR and SVS				
CPT Code:	75726				
Sample Size:	2100	Resp N:	31	Response: 1.4 %	
Description of Sample:	Random surveys from society membership				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	10.00	50.00	250.00
Survey RVW:	1.40	2.05	2.40	2.80	6.00
Pre-Service Evaluation Time:			30.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	8.00	20.00	45.00	60.00	120.00
Immediate Post Service-Time:	15.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the **pre-service time package** that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	75726	Recommended Physician Work RVU: 2.05		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	15.00	0.00	15.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	45.00			
Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	15.00	0.00	15.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
75635	XXX	2.40	RUC Time

CPT Descriptor Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93312	XXX	2.30	RUC Time

CPT Descriptor Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
74178	XXX	2.01	RUC Time	541,901

CPT Descriptor 1 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

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
72158	XXX	2.29	RUC Time	260,109

CPT Descriptor 2 Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 11 % of respondents: 35.4 %

Number of respondents who choose 2nd Key Reference Code: 8 % of respondents: 25.8 %

TIME ESTIMATES (Median)

	CPT Code: <u>75726</u>	Top Key Reference CPT Code: <u>75635</u>	2nd Key Reference CPT Code: <u>93312</u>
Median Pre-Service Time	15.00	10.00	10.00
Median Intra-Service Time	45.00	39.00	30.00
Median Immediate Post-service Time	15.00	8.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	75.00	57.00	55.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	9%	9%	45%	36%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	9%	0%	91%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	0%	18%	82%
Physical effort required	0%	27%	73%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	0%	36%	64%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	13%	62%	25%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	0%	13%	87%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	0%	25%	75%
Physical effort required	0%	25%	75%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	0%	25%	75%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

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 Codes 75726 and 75774 were recommended for survey.

Compelling Evidence

We believe that there is compelling evidence to recommend an increase in the value for CPT code 75726. First, incorrect assumptions were made in the previous valuation. 75726 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 CMS/other time is significantly underestimated. The patient population has also changed. In decades past, this code would have been used for atherosclerotic disorders. In current use, 75726 used to evaluate bleeding visceral disorders and gastrointestinal neoplasms. Transarterial interventional oncologic treatments were not widely in use at the time of previous valuation.

Vignette

The rationale for low percentage agreement is consistent with the ICD data for the code which does not have a "typical" response. The ICD10 data are spread out over many different diagnoses.

Recommendations

We are recommending the 25th survey percentile wRVU of 2.05 with times of 15, 45 and 15 (total 75).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 75726

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. A national estimate is not available

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Current RUC database (2017 utilization data)

Specialty interventional radiology	Frequency 38693	Percentage 92.00 %
Specialty vascular surgery	Frequency 2103	Percentage 5.00 %
Specialty cardiology	Frequency 1264	Percentage 3.00 %

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Imaging

Imaging/procedure

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 75726

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 75774	Tracking Number	Original Specialty Recommended RVU: 1.01
		Presented Recommended RVU: 1.01
Global Period: ZZZ	Current Work RVU: 0.36	RUC Recommended RVU: 1.01

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 74-year-old male who has just undergone a selective arteriogram of the superior mesenteric artery, also requires an additional arteriogram and a microcatheter is advanced into a proximal jejunal arterial branch and a super selective arteriogram is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is;
Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: After subselective microcatheterization (separate surgical procedure) angle of imaging is chosen based on review of prior non-selective imaging and test injections of contrast. Filters and magnification are adjusted to optimize imaging. Desired rate and volume of contrast for angiography are determined. Initial DSA and unsubtracted angiogram are reviewed. Based on review of initial DSA it is typical to obtain imaging in at least one additional DSA sequence in a different view. Fluoroscopy used to reposition. Filters are adjusted. Magnification and rate/volume of contrast reconfirmed. Additional imaging reviewed. Pertinent DSA and unsubtracted images selected for transfer to PACS including reformatted images adjusting for motion/bowel gas. Additional imaging reviewed for final interpretation.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Michael Hall, MD, Curtis Anderson, MD, Matthew Sideman, MD and Francesco Aiello, MD				
Specialty Society(ies):	SIR and SVS				
CPT Code:	75774				
Sample Size:	2100	Resp N:	31	Response: 1.4 %	
Description of Sample:	Random surveys from society membership				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	5.00	38.00	250.00
Survey RVW:	0.70	1.01	1.20	2.35	3.50
Pre-Service Evaluation Time:			20.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	8.00	25.00	30.00	60.00	90.00
Immediate Post Service-Time:	20.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the **pre-service** time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	75774	Recommended Physician Work RVU: 1.01		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	0.00	0.00	0.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	30.00			
Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
ZZZ Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	0.00	0.00	0.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
36218	ZZZ	1.01	RUC Time

CPT Descriptor Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93567	ZZZ	0.97	RUC Time

CPT Descriptor Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravulvar aortography (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
64484	ZZZ	1.00	RUC Time	450,460

CPT Descriptor 1 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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
52442	ZZZ	1.20	RUC Time	51,427

CPT Descriptor 2 Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 28 % of respondents: 90.3 %

Number of respondents who choose 2nd Key Reference Code: 1 % of respondents: 3.2 %

TIME ESTIMATES (Median)

	CPT Code: <u>75774</u>	Top Key Reference CPT Code: <u>36218</u>	2nd Key Reference CPT Code: <u>93567</u>
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	30.00	30.00	15.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	30.00	30.00	15.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	4%	29%	39%	29%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	4%	25%	71%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	0%	32%	68%
Physical effort required	0%	39%	61%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	0%	36%	64%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity					

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 			

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required			
Physical effort required			

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 			

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

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 Codes 75726 and 75774 were recommended for survey.

Compelling Evidence

We believe that there is compelling evidence to recommend an increase in the value for CPT code 75774. First, incorrect assumptions were made in the previous valuation. 75774 has not previously been surveyed and is the result of CMS/Other inputs. The CMS/other time is significantly underestimated. 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, 75774 is performed to evaluate bleeding visceral disorders and gastrointestinal neoplasms. Transarterial 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.

Intensity/Complexity Measures

We included data for the key reference code, which represented 28 of the 31 responses. We did not include data points for the 2nd reference code as it was only one survey response.

Recommendations

We are recommending the survey's 25th percentile of 1.01 and 30 minutes of intra time for this add-on code.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Use 75774 in addition to code for specific initial vessel studied

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 75774

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Interventional Radiology

How often? Commonly

Specialty Vascular Surgery How often? Sometimes

Specialty Cardiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. A national estimate is not available

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 75,000

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Current RUC database (2017 utilization data)

Specialty interventional radiology	Frequency 52500	Percentage 70.00 %
------------------------------------	-----------------	--------------------

Specialty vascular surgery	Frequency 11000	Percentage 14.66 %
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Specialty cardiology	Frequency 9200	Percentage 12.26 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Imaging

BETOS Sub-classification:

Imaging/procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 75774

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR	AS
13	ISSUE: Angiography																								
14	TAB: 20																								
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
17	1st REF	75635	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing	11	0.051			2.40			57	10					39			8					
18	2nd REF	93312	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report	8	0.058			2.30			55	10					30			15					
19	CURRENT	75726	Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation		#DIV/0!			1.14			22														
20	SVY	75726	Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation	31	0.028	1.40	2.05	2.40	2.80	6.00	95	30			8	20	45	60	120	20	0	4	10	50	250
21	REC		Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation		0.031	2.05					75	15					45			15					
22																									
23																									
24						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
25	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
26	1st REF	36218	Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	28	0.067			1.01			15						15								
27	2nd REF	93567	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supraaortic aortography (List separately in addition to code for primary procedure)	1	0.065			0.97			15						15								
28	CURRENT	+.75774	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)		#DIV/0!			0.36			9														
29	SVY	+.75774	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)	31	0.010	0.70	1.01	1.20	2.35	3.50	70	20			8	25	30	60	90	20	0	2	5	38	250
30	REC		Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)		0.034	1.01					30						30								

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

REVISED AT MEETING

Meeting Date: October 2018

Global Period: XXX

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

Global Period: ZZZ

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

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

SIR and SVS convened a panel that included a number of experts to evaluate the direct practice expense inputs for these angiography procedures.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

CPT Codes 75726 and 75774 are current CPT codes with direct practice expense inputs. As such, we included the existing direct practice expense inputs on the PE spreadsheet.

**3. Is this code(s) typically billed with an E/M service?
Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)**

Codes not typically billed with E/M

- 75726 – 0%
- 75774 – 1%

Code not typically billed with E/M service in the NF

- 75726 – 0%
- 75774 – 4%

4. **What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different then for the global?
(Please see provided data in PE Subcommittee folder)**

NF (All, global and 26)

- 75726 – 58% Diagnostic Radiology
- 75774 – 36% Diagnostic Radiology

NF (Global and TC)

- 75726 – 51% Vascular Surgery
- 75774 – 45% Vascular Surgery

5. **If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:**

The specialties are recommending 4 minutes for CA030 *Technologist QC's images in PACS, checking for all images, reformats, and dose page.* The baseline time for this clinical activity is 2 minutes. These services require additional time to account for the technologist adjusting contrast levels for each image of numerous angiography runs in different projections. In addition, the “mask” image must be manually adjusted for each image to correct poor image quality related to patient motion respiration.

6. **If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.**

N/A

7. **If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:**

N/A

8. **How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code)**

The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

- 9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time or Perform procedure/service---NOT directly related to physician work time*:**

A radiologic technologist is in the procedure room and assists in operating the C-arm, acquires images and circulates during critical times of the procedure.

- 10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.**

The intra-service time is not directly related to physician work time for these two services. We are recommending intra-service time 'perform procedure/service' consistent with other S&I codes.

- 11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:**

N/A

- 12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.**

N/A

- 13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:**

N/A

- 14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:**

N/A

- 15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:**

EL011 room, angiography: “Other”

Followed “Rationale for Angiographic Room time Allocation”

To prevent double counting of room time between the procedure code and the S&I code the S&I code should receive a base time of 9 minutes for the room, and all other time will be allocated to the procedure code.

ED053 Professional PACS Workstation: “Other”

Followed “Guidelines for PACS Professional Workstation

Minutes equal to half the preservice physician work time and the full intraservice physician work time.

ED050 Technologist PACS workstation: “PACS” formula

- 16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:**

N/A

- 17. If there is any other item on your spreadsheet that needs further explanation please include here:**

N/A

- 18. Please include an explanation of each line item:**

drape, sterile, c-arm, fluoro	SB008	Required for sterile preparation of imaging equipment
disinfectant, surface (Envirocide, Sanizide)	SM013	For cleaning imaging equipment after usage.

	A	B	C	D	E	F	I	J
1	RUC Practice	Expense Spreadsheet					CURRENT	
2	AtMeeting	Meeting Date: October 2018 Tab: 20 Angiography Specialty: SIR, SVS, SCAI					75726	
3		RUC Collaboration Website					Angiography, visceral, selective or supraseductive (with or without flush aortogram), radiological supervision and	
4	Clinical Activity Code	**Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment. *	Standards/Guidelines	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute		
5		LOCATION					Non Fac	Facility
6		GLOBAL PERIOD					XXX	XXX
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME					\$ 80.98	\$ -
8		TOTAL CLINICAL STAFF TIME		L037D	RN/LPN/MTA	0.37	66	0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	6	0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	60	0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	0	0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE					\$ 27.06	\$ -
13		PRE-SERVICE PERIOD						
14		Start: Following visit when decision for surgery or procedure made						
15	CA001	Complete pre-service diagnostic and referral forms	90 DAY: NF5, F5*	L037D	RN/LPN/MTA	0.37		
16	CA002	Coordinate pre-surgery services (including test results)	90 DAY: NF10, F20*	L037D	RN/LPN/MTA	0.37		
17	CA003	Schedule space and equipment in facility	90 DAY: NF0, F8*	L037D	RN/LPN/MTA	0.37		
18	CA004	Provide pre-service education/obtain consent	90 DAY: NF10, F20*	L037D	RN/LPN/MTA	0.37		
19	CA005	Complete pre-procedure phone calls and prescription	90 DAY: NF10, F7*	L037D	RN/LPN/MTA	0.37		
20	CA006	Confirm availability of prior images/studies	Standard time for this activity is 2 minutes. For use in imaging services.	L041B	Radiologic Technologist	0.41		
21	CA007	Review patient clinical extant information and questionnaire	Standard time for this activity is 1 minute.	L037D	RN/LPN/MTA	0.37		
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	0	L041B	Radiologic Technologist	0.41	6	
29		End: When patient enters office/facility for surgery/procedure						
30		SERVICE PERIOD						
31		Start: When patient enters office/facility for surgery/procedure:						
32		Pre-Service (of service period)						
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	Standard time for this activity is 3 minutes.	L037D	RN/LPN/MTA	0.37		
34	CA010	Obtain vital signs	Vital Sign Standards	L037D	RN/LPN/MTA	0.37		
35	CA011	Provide education/obtain consent	Include only the additional	L037D	RN/LPN/MTA	0.37		
36	CA012	Review requisition, assess for special needs	0	L037D	RN/LPN/MTA	0.37		
37	CA013	Prepare room, equipment and supplies	2 minute standard	L041B	Radiologic	0.41	2	
38	CA014	Confirm order, protocol exam	Standard time for this activity is 1 minute.	L037D	RN/LPN/MTA	0.37		
39	CA015	Setup scope (nonfacility setting only)	5 minutes standard for scope set up in the	L037D	RN/LPN/MTA	0.37		
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	2 minute standard	L041B	Radiologic	0.41	2	
41	CA017	Sedate/apply anesthesia	2 minute standard RN/LPN/MA	L037D	RN/LPN/MTA	0.37		
48		Intra-service (of service period)						
49	CA018	Assist physician or other qualified healthcare professional---directly	100% of physician or other qualified	L037D	RN/LPN/MTA	0.37		
50	CA019	Assist physician or other qualified healthcare professional---directly	67% of physician or other qualified	L037D	RN/LPN/MTA	0.37		
51	CA020	Assist physician or other qualified healthcare professional---directly	other% of physician or other qualified	L037D	RN/LPN/MTA	0.37		
52	CA021	Perform procedure/service---NOT directly related to physician work time	0	L041B	Radiologic	0.41	46	
59		Post-Service (of service period)						
60	CA022	Monitor patient following procedure/service, multitasking 1:4	For monitoring following procedure, the	L037D	RN/LPN/MTA	0.37		
61	CA023	Monitor patient following procedure/service, no multitasking	0	L037D	RN/LPN/MTA	0.37		
62	CA024	Clean room/equipment by clinical staff	3 minute standard	L041B	Radiologic	0.41	3	
63	CA025	Clean scope	Standards For Scope Cleaning	L037D	RN/LPN/MTA	0.37		
64	CA026	Clean surgical instrument package	Standard for cleaning instruments	L037D	RN/LPN/MTA	0.37		
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	0	L037D	RN/LPN/MTA	0.37		
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	0	L037D	RN/LPN/MTA	0.37		
67	CA029	Check dressings, catheters, wounds	Standard time for this activity is 1 minute.	L037D	RN/LPN/MTA	0.37		
68	CA030	Technologist QC's images in PACS, checking for all images, reformat,	Baseline time for this activity is 2 minute. For	L041B	Radiologic	0.41	4	
69	CA031	Review examination with interpreting MD/DO	Standard time for this activity is 2 minute.	L041B	Radiologic	0.41	2	
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to	Standard time for this activity is 1 minute.	L041B	Radiologic	0.41	1	
71	CA033	Perform regulatory mandated quality assurance activity (service period)	0	L037D	RN/LPN/MTA	0.37		
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry	0	L037D	RN/LPN/MTA	0.37		
73	CA035	Review home care instructions, coordinate visits/prescriptions	Standard time for this activity is 2 minutes.	L037D	RN/LPN/MTA	0.37		
74	CA036	Discharge day management	Dischrg mgmt same day (0.5 x 99238) (enter	L037D	RN/LPN/MTA	0.37	n/a	
81		End: Patient leaves office						
82		POST-SERVICE PERIOD						
83		Start: Patient leaves office/facility						
84	CA037	Conduct patient communications	Phone calls/emails/texts are in 3 minute	L037D	RN/LPN/MTA	0.37		
85	CA038	Coordinate post-procedure services	0	L037D	RN/LPN/MTA	0.37		
86		Office visits: List Number and Level of Office Visits		MINUTES			# visits	# visits
92	CA039	Post-operative visits (total time)		L037D	RN/LPN/MTA	0.37	0.0	0.0
99		End: with last office visit before end of global period						

	A	B	C	D	E	F	I	J
1	RUC Practice	Expense Spreadsheet					CURRENT	
2	AtMeeting	Meeting Date: October 2018 Tab: 20 Angiography Specialty: SIR, SVS, SCAI					75726	
3		RUC Collaboration Website					Angiography, visceral, selective or supraseductive (with or without flush aortogram), radiological supervision and	
4	Clinical Activity Code	**Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment. *	Standards/Guidelines	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute		
5		LOCATION					Non Fac	Facility
6		GLOBAL PERIOD					XXX	XXX
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME					\$ 80.98	\$ -
8		TOTAL CLINICAL STAFF TIME		L037D	RN/LPN/MTA	0.37	66	0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	6	0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	60	0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME		L041B	Radiologic Technologist	0.41	0	0
100	Supply Code	MEDICAL SUPPLIES		PRICE	UNIT			
101		TOTAL COST OF SUPPLY QUANTITY x PRICE					\$ 4.67	\$ -
102	SB008	drape, sterile, c-arm, fluoro		4.504	item		1	
103	SM013	disinfectant, surface (Envirocide, Sanizide)		0.163	oz		1	
108		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A						
110	Equipment Code	EQUIPMENT		Purchase Price	Equipment Formula	Cost Per Minute		
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE					\$ 49.25	\$ -
112	EL011	room, angiography		1386816	Other Formula	5.25467238	9	
113	ED053	Professional PACS Workstation		14616.93	Other Formula	0.057915145	11	
114	ED050	Technologist PACS workstation		5557	PACS	0.022017924	60	
118		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A						

	A	B	K	L	M	N	O	P
1	RUC Practice	Expense Spreadsheet	RECOMMENDED		CURRENT		RECOMMENDED	
2	AtMeeting	Meeting Date: October 2018 Tab: 20 Angiography Specialty: SIR, SVS, SCAI	75726		75774		75774	
3		RUC Collaboration Website	Angiography, visceral, selective or supraseductive (with or without flush aortogram), radiological supervision and		Angiography, selective, each additional vessel studied after basic examination, radiological supervision and		Angiography, selective, each additional vessel studied after basic examination, radiological supervision and	
4	Clinical Activity Code	**Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment. *						
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	XXX	XXX	ZZZ	ZZZ	ZZZ	ZZZ
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 81.26	\$ -	\$ 62.71	\$ -	\$ 60.25	\$ -
8		TOTAL CLINICAL STAFF TIME	61	0	36	0	30	0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	4	0	6	0	0	0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	57	0	30	0	30	0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0	0	0	0	0	0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	\$ 25.01	\$ -	\$ 14.76	\$ -	\$ 12.30	\$ -
13		PRE-SERVICE PERIOD						
14		Start: Following visit when decision for surgery or procedure made						
15	CA001	Complete pre-service diagnostic and referral forms						
16	CA002	Coordinate pre-surgery services (including test results)						
17	CA003	Schedule space and equipment in facility						
18	CA004	Provide pre-service education/obtain consent						
19	CA005	Complete pre-procedure phone calls and prescription						
20	CA006	Confirm availability of prior images/studies	2					
21	CA007	Review patient clinical extant information and questionnaire						
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	2		6			
29		End: When patient enters office/facility for surgery/procedure						
30		SERVICE PERIOD						
31		Start: When patient enters office/facility for surgery/procedure:						
32		Pre-Service (of service period)						
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are						
34	CA010	Obtain vital signs						
35	CA011	Provide education/obtain consent						
36	CA012	Review requisition, assess for special needs						
37	CA013	Prepare room, equipment and supplies	2					
38	CA014	Confirm order, protocol exam						
39	CA015	Setup scope (nonfacility setting only)						
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient						
41	CA017	Sedate/apply anesthesia						
48		Intra-service (of service period)						
49	CA018	Assist physician or other qualified healthcare professional---directly						
50	CA019	Assist physician or other qualified healthcare professional---directly						
51	CA020	Assist physician or other qualified healthcare professional---directly						
52	CA021	Perform procedure/service---NOT directly related to physician work time	45		30		30	
59		Post-Service (of service period)						
60	CA022	Monitor patient following procedure/service, multitasking 1:4						
61	CA023	Monitor patient following procedure/service, no multitasking						
62	CA024	Clean room/equipment by clinical staff	3					
63	CA025	Clean scope						
64	CA026	Clean surgical instrument package						
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions						
66	CA028	Review/read post-procedure x-ray, lab and pathology reports						
67	CA029	Check dressings, catheters, wounds						
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,	4					
69	CA031	Review examination with interpreting MD/DO	2					
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to	1					
71	CA033	Perform regulatory mandated quality assurance activity (service period)						
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry						
73	CA035	Review home care instructions, coordinate visits/prescriptions						
74	CA036	Discharge day management	n/a		n/a		n/a	
81		End: Patient leaves office						
82		POST-SERVICE PERIOD						
83		Start: Patient leaves office/facility						
84	CA037	Conduct patient communications						
85	CA038	Coordinate post-procedure services						
86		Office visits: List Number and Level of Office Visits	# visits	# visits	# visits	# visits	# visits	# visits
92	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0
99		End: with last office visit before end of global period						

	A	B	K	L	M	N	O	P
1	RUC Practice	Expense Spreadsheet	RECOMMENDED		CURRENT		RECOMMENDED	
2	AtMeeting	Meeting Date: October 2018 Tab: 20 Angiography Specialty: SIR, SVS, SCAI	75726		75774		75774	
3		RUC Collaboration Website	Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and		Angiography, selective, each additional vessel studied after basic examination, radiological supervision and		Angiography, selective, each additional vessel studied after basic examination, radiological supervision and	
4	Clinical Activity Code	<p><i>**Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i></p> <p><i>*Please do not modify formulas in gray shaded cells</i></p> <p><i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment. *</i></p>						
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	XXX	XXX	ZZZ	ZZZ	ZZZ	ZZZ
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 81.26	\$ -	\$ 62.71	\$ -	\$ 60.25	\$ -
8		TOTAL CLINICAL STAFF TIME	61	0	36	0	30	0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	4	0	6	0	0	0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	57	0	30	0	30	0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0	0	0	0	0	0
100	Supply Code	MEDICAL SUPPLIES						
101		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ 4.67	\$ -	\$ -	\$ -	\$ -	\$ -
102	SB008	drape, sterile, c-arm, fluoro	1					
103	SM013	disinfectant, surface (Envirocide, Sanizide)	1					
108		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A						
110	Equipment Code	EQUIPMENT						
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ 51.59	\$ -	\$ 47.95	\$ -	\$ 47.95	\$ -
112	EL011	room, angiography	9		9		9	
113	ED053	Professional PACS Workstation	52.5					
114	ED050	Technologist PACS workstation	57		30		30	
118		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A						

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS/Other Source – Medicare Utilization Over 30,000

October 2018

X-Ray Exam Specimen

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.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
76098	Radiological examination, surgical specimen	XXX	0.31

September 4, 2018

Peter Smith, MD, RUC Chair
American Medical Association
330 N. Wabash Ave.
Chicago, IL 60611

Subject: ACR Request for X-Ray Specimen Billed Together Methodology To Be Reviewed by Research

Dear Dr. Smith,

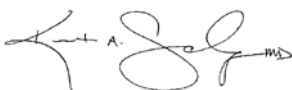
The ACR would like to have the following issue sent to the Research Subcommittee for further consideration:

At the April 2018 RUC meeting, the ACR presented time and value recommendations for CPT code 76098 (*Radiological examination, surgical specimen*). Our recommendations were ultimately accepted by the RUC panel at the meeting. However, concern arose regarding the billed together data provided by the AMA; specifically, whether or not it is appropriate to combine multiple similar codes when determining billed together status. The ACR noted that adding individual billed together rates will result in double counting when three or more of those codes are billed together, rendering the data inaccurate unless this overlap is accounted for. Additionally, the ACR expressed concern that this method of determining billed together status reflects a change in RUC procedure and should be validated through the Research Subcommittee before establishing precedent. Since this was a complex, multi-code issue, the RUC decided to revisit this issue at the October 2018 RUC meeting where AMA staff could present their research on this matter.

After performing our own analyses, the ACR would like the RUC to consider whether combining multiple codes is an appropriate method of calculating billed together data for all specialties at the RUC. The potential for overlap in data occurring with the additive calculation method for billed together data is one issue that could result in invalid billed together data for any specialty using this technique. Additionally, there will rarely be universal agreement on which codes are “similar enough” to combine, which presents another layer of complexity and subjectivity. We would like the RUC to consider providing a clear, cross-specialty procedural standard for calculating billed together data, as it is imperative to establish an accurate precedent for interpreting billed together data moving forward.

Thank you for your consideration of our request.

Sincerely,



Kurt A. Schoppe, MD
ACR RUC Advisor

AMA Staff Provided Following Information to ACR in June 2018:

For X-ray specimen, please see following analysis regarding how often 76098 is on the same claim as one or more of the codes in the range 19281-19288 (same provider, same beneficiary, same day):

This was regarding how often CPT 76098 was performed with any code in the 19281-19288 range – on the same day, for the same beneficiary, by the same provider. All sites of service were considered and TC-only utilization of 76098 was excluded. The results:

- *There were 2,730 occurrences of 76098 and 76098/26 on the 2016 5% file. There was one duplicate record where the global and PC-only were provided on the same bene/date/npi, leaving 2,729 unique occurrences of 76098+76098/26.*
- *There were 2,943 occurrences of 19281-19288 on the 2016 5% file. There were 235 duplicate records where more than one of these services was provided on the same bene/date/npi, leaving 2,708 unique occurrences of codes in the 19281-19288 range.*

Matching these two sets of services, there were 1,731 occurring on the same bene/date/npi. In percentage terms, a code in the 19281-19288 range was provided for 63% (1,731/2,729) of the unique occurrences of 76098+76098/26

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 76098	Tracking Number	Original Specialty Recommended RVU: 0.40
		Presented Recommended RVU: 0.31
Global Period: XXX	Current Work RVU: 0.40	RUC Recommended RVU: 0.31

CPT Descriptor: Radiological examination, surgical specimen

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female was recently diagnosed with invasive breast cancer following image-guided biopsy and clip placement. Needle localization was performed prior to lumpectomy. A specimen x-ray is obtained during surgery to ensure that the tumor, localization wire, and/or biopsy clip were appropriately removed.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is;
Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review clinical history; review initial diagnostic images and localization images obtained prior to surgery to determine type and number of mass(es), calcifications, or other lesion(s) expected to be present within the surgically excised tissue specimen. Also, evaluate the accuracy and method of localization and the type and number of needle biopsy clip marker(s), radioactive or other localizing seed(s), and/or localizing wire(s) expected to be present in the surgically excised tissue specimen.

Description of Intra-Service Work: Evaluate the specimen x-ray for presence of needle biopsy clip marker(s) from initial histologic diagnosis, radioactive or other localizing seed(s), and/or localizing wire(s). In the case of wire localization, evaluate the integrity of the wire(s) and measure the length of the wire(s) in the excised tissue, ensuring there is no fracture or partial loss of the wire(s), which could remain in the body. Note if expected mass(es), calcifications, or other lesion(s) are present within the specimen. Dictate the report including pertinent positives or negatives.

Description of Post-Service Work: Communicate findings with the surgeon in the operating room real time prior to wound closure. Sign the dictated report.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Kurt Schoppe, MD; Daniel Wessell, MD; Lauren Golding, MD				
Specialty(s):	American College of Radiology				
CPT Code:	76098				
Sample Size:	750	Resp N:	49	Response: 6.5 %	
Description of Sample:	The ACR surveyed a total of 750 members (a random sample of 375 members and a separate random sample of 375 members who perform radiography, mammography, and women's imaging procedures).				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	15.00	48.00	100.00	400.00
Survey RVW:	0.10	0.18	0.40	0.77	1.50
Pre-Service Evaluation Time:			7.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	1.00	2.00	5.00	6.00	20.00
Immediate Post Service-Time:	3.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	76098	Recommended Physician Work RVU: 0.31		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	3.00	0.00	3.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	5.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	3.00	0.00	3.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
77065	XXX	0.81	RUC Time

CPT Descriptor Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
71045	XXX	0.18	RUC Time

CPT Descriptor Radiologic examination, chest; single view**KEY MPC COMPARISON CODES:**

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
76857	XXX	0.50	RUC Time	213,274

CPT Descriptor 1 Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93922	XXX	0.25	RUC Time	664,275

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99281	XXX	0.45	RUC Time

CPT Descriptor Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are

provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 14 **% of respondents:** 28.5 %

Number of respondents who choose 2nd Key Reference Code: 10 **% of respondents:** 20.4 %

TIME ESTIMATES (Median)

	CPT Code: <u>76098</u>	Top Key Reference CPT Code: <u>77065</u>	2nd Key Reference CPT Code: <u>71045</u>
Median Pre-Service Time	3.00	5.00	1.00
Median Intra-Service Time	5.00	10.00	3.00
Median Immediate Post-service Time	3.00	6.00	1.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	11.00	21.00	5.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	21%	36%	36%	7%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	36%	29%	36%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	29%	50%	21%
Physical effort required	36%	50%	14%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	43%	36%	21%

<u>2nd Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	30%	30%	20%	20%

<u>Mental Effort and Judgment</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	40%	10%	50%

<u>Technical Skill/Physical Effort</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	50%	30%	20%
Physical effort required	40%	50%	10%

<u>Psychological Stress</u>	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The risk of significant complications, morbidity and/or mortality Outcome depends on the skill and judgment of physician Estimated risk of malpractice suit with poor outcome 	20%	10%	70%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

CPT code 76098 (*Radiological examination, surgical specimen*) was identified as potentially mis-valued through the CMS/Other - Utilization over 30,000 screen.

When this code was originally presented in April 2018, there were concerns regarding whether 76098 is typically performed with a needle localization procedure by the same radiologist on the same day. Our initial recommendation was based on the fact that 76098 does not meet billed together criteria with any single other code, however we were informed of AMA data showing that if the billed together frequency for multiple codes in the range of 19281-19288 were added together, then 76098 may meet billed together criteria. The ACR had some concerns that the AMA data does not account for double counting when more than two of these procedures were performed together on the same day. The RUC agreed to accept an interim value of 0.40 RVU based on survey times and bring the code back in October once the billed together data had been reviewed in more detail.

Survey Process

The ACR surveyed a total of 750 members (a random sample of 375 members and a separate random sample of 375 members who perform radiography, mammography, or women's imaging procedures).

Work RVU Recommendation:

We recommend a work RVU of 0.31, which falls between the 25th percentile survey value of 0.17 RVU and the median survey value of 0.40 RVU. We propose 72082 (*Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); 2 or 3 views*) as a crosswalk.

Compelling Evidence

We are requesting an increase in value for CPT code 76098 based on flawed methodology with inadequate time assigned to the code under the existing CMS/Other value.

Additionally, there has been a change in patient population since 76098 was originally valued, substantiating the increased time reflected by our survey values. When previously valued, the specimen radiograph was typically obtained after a stereotactic biopsy by the same technologist and interpreted by the same radiologist that performed the biopsy. The post-biopsy specimen radiograph was bundled with the biopsy code 19081 (*Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance*)) in 2014. It is now typical for 76098 to be performed in patients undergoing lumpectomy, mastectomy, or surgical excision in the operating room. If a needle localization has been performed prior to the specimen radiograph, these procedures are typically separated by several hours and multiple intervening patients. Therefore, pre-service work now needs to be accounted for in this code, as described in the description of work: "review clinical history, review initial diagnostic images and localization images obtained prior to surgery to determine type and number of mass(es), calcifications, or other lesion(s) expected to be present within the surgically excised tissue specimen. Also, evaluate the accuracy and method of localization and the type and number of needle biopsy clip marker(s), radioactive or other localizing seed(s), and/or localizing wire(s) expected to be present in the surgically excised tissue specimen."

Time Recommendation:

We recommend the following times: 3 minutes pre-service, 5 minutes intra-service, and 3 minutes post-service. This is a total time of 11 minutes compared to the existing CMS/Other time of 5 minutes.

Our research colleagues at the Harvey L. Neiman Health Policy Institute examined the 5% file and calculated the percentage of unique occurrences of 76098 billed with any of the needle localization codes. They found that double-counting combinations of codes accounted for about 6% of the total percentage, however 76098 is still performed with any one of the needle localization codes more than 50% of the time, at around 63%. The ACR agrees that, for this particular code, it is appropriate to combine the billed together rates for the range of needle localization codes since these procedures are essentially the same other than modality used for image guidance.

Since we accept that 76098 is typically performed with another procedure on the same day by the same radiologist, we recommend adjusting the pre-service time to account for some overlap of work. We recommend decreasing the survey pre-service time of 7 minutes to 3 minutes. These specimen radiographs are performed hours after the needle localization procedure and the radiologist has typically done other needle localizations, other biopsies, and seen other diagnostic patients in the interim. While there is some familiarity with the patient's history and prior imaging, the pre-service work is not entirely duplicative. The pre-service activities in the description of work must still be performed or at least refreshed at the time the specimen radiograph is interpreted: Review clinical history; review initial diagnostic images and localization images obtained prior to surgery to determine type and number of mass(es), calcifications, or other lesion(s) expected to be present within the surgically excised tissue specimen. Also, evaluate the accuracy and method of localization and the type and number of needle biopsy clip marker(s), radioactive or other localizing seed(s), and/or localizing wire(s) expected to be present in the surgically excised tissue specimen. We feel that 3 minutes of pre-service time accurately captures the amount of unique work performed for this code.

Key Reference Services

Our recommendation compares favorably with the key reference services selected by the survey respondents. In the table below, the two most common key reference services are compared with the recommendation for 76098 (*Radiological examination, surgical specimen*), which account for 49% of the survey respondents.

77065 (*Diagnostic mammography, including CAD, unilateral*) has longer total and intra-service times and is appropriately valued higher at 0.81 RVU compared to the recommended value of 0.31 RVU for 76098.

71045 (*Radiologic exam, chest single view*) has significantly less time than the survey times for 76098, supporting the flawed methodology of the existing CMS/Other value of 0.16 RVU.

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWPUT	% chosen
71045	Radiologic exam, chest single view	0.18	5	1	3	1	0.045	20%
76098	Radiological examination, surgical specimen	0.31	11	3	5	3	0.035	
77065	Diagnostic mammography, including CAD, unilateral	0.81	21	5	10	6	0.056	29%

MPC Codes

Our recommendation compares favorably in rank order with multiple other MPC codes, one of which is also a radiology exam:

- **76857** (*Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)*).
- **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)*);
- **99281** (*Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.*); and,

CPT code 76857 has more total time than 76098 (17 minutes compared to 11 minutes) with additional minutes in the intra-service period specifically. 76857 is appropriately valued higher at 0.50 RVU compared to our recommendation of 0.31 for 76098.

Additionally, 76098 compares well with two non-radiology MPC codes. 76098 has the same intra-service time as 93922, but 1 more minute of pre- and post-service time and has a higher intensity, which justifies the higher recommended value of 0.31 RVU compared to 0.25 RVU of 93922. As well, there is slightly more total time in 99281 (13 minutes compared to 11 minutes in 76098) and this code has 2 more minutes of intra-service time (7 minutes compared to 5 minutes) and describes an emergency room encounter. These two factors justify the higher valuation and IWPUT of 99281 relative to 76098.

The table below provides comparison between the MPC codes and the recommendation for 76098.

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWPUT
93922	Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries	0.25	10	3	5	2	0.028
76098	X-Ray, surgical specimen	0.31	11	3	5	3	0.035
99281	ER Visit	0.45	13	2	7	4	0.045
76857	US, pelvic (nonobstetric), w/img documentation; limited or follow-up	0.50	17	5	7	5	0.039

Among codes with 5 minutes of intraservice time and greater than 7 minutes total time, the recommended crosswalk value of 0.31 RVU for 76098 compares well. 93018 (*Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only*) is the most similar with the same total time of 11 minutes and an RVU of 0.30.

CPT Code	Short Descriptor	wRVU	Total Time	Pre	Intra	Post	IWPUT
93018	Cardiovascular stress test	0.30	11	2	5	4	0.033
71048	X-Ray, chest; 4 or more views	0.31	7	1	5	1	0.053
76098	X-Ray, surgical specimen	0.31	11	3	5	3	0.035

93293	Transtelephonic rhythm strip pacemaker evaluation(s)	0.31	13	3	5	5	0.026
72114	X-Ray, spine, lumbosacral; min of 6 views	0.32	8	1	5	2	0.051
74022	X-Ray, abdomen; single view chest	0.32	7	1	5	1	0.055
72052	X-Ray, spine, cervical; 6 or more views	0.36	8	1	5	2	0.059

Conclusion

The survey results and comparison with applicable codes support increasing the existing value for 76098 (*Radiological examination, surgical specimen*) to 0.31 RVU, with service period times of 3, 5, and 3 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☒ Other reason (please explain) Separate procedures performed at different times.

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. see above discussion

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 76098

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 176115

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The overall number of services described by code 76098 provided nationally in a one-year period is estimated to be 176,115.

Specialty Diagnostic Radiology

Frequency 142610

Percentage 80.97 %

Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 58,705
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The ACR estimates that CPT code 76098 will be provided 58,705 times to Medicare patients nationally in a one-year period.

Specialty Diagnostic Radiology	Frequency 47537	Percentage 80.97 %
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Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Imaging

BETOS Sub-classification:

Standard imaging

BETOS Sub-classification Level II:

Breast

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 76098

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	AO	AP	AQ	AR	AS
12	ISSUE: X-Ray Specimen TAB: 21																								
13																									
14																									
15						RVW					Total	PRE-TIME			INTRA-TIME			IMMD	SURVEY EXPERIENCE						
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
17	1st REF	77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral	14	0.056			0.81			21	5					10			6					
18	2nd REF	71045	Radiologic examination, chest; single view	10	0.045			0.18			5	1					3			1					
19	CROSSWALK	72082	Radiologic examination, spine, entire thoracic and lumbar, including skull,		0.044			0.31			8	1					6			1					
20	CURRENT	76098	Radiological examination, surgical specimen		#DIV/0!			0.16			5														
21	SVY	76098	Radiological examination, surgical specimen	49	0.035	0.10	0.18	0.40	0.77	1.50	15	7			1	2	5	6	20	3	0	15	48	100	400
22	ACR - Subset	76098	Radiological examination, surgical specimen	35	0.026	0.10	0.18	0.40	0.77	1.50	17	8			1	2	5	6	20	4	0	14	40	100	400
23	ACR - Random	76098	Radiological examination, surgical specimen	14	0.046	0.10	0.20	0.43	0.78	0.99	14	6			1	3	5	6	15	3	4	23	75	98	250
24	REC	76098	Radiological examination, surgical specimen		0.035	0.31					11	3				5				3					

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor:

76098	Radiological examination, surgical specimen
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Global Period: XXX Meeting Date: April 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

The American College of Radiology (ACR) convened a consensus panel to finalize the practice expense data for the surgical specimen x-ray code, CPT code 76908.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code.** You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

The society included the existing PE inputs for code 76098 on the spreadsheet to serve as a reference.

3. Is this code(s) typically billed with an E/M service?
Is this code(s) typically billed with the E/M service in the nonfacility?
(Please see provided data in PE Subcommittee folder)

No, this code is not typically billed with an E/M service in the global or nonfacility.

4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different then for the global?
(Please see provided data in PE Subcommittee folder)

Diagnostic Radiology is the dominant provider for this procedure in the nonfacility at 78%.
Diagnostic Radiology is also the dominant provider for this procedure for the global.

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

We are asking for additional pre-service time to schedule space and equipment in facility, complete pre-procedure phone calls, and confirm availability of prior images/studies. When 76098 was previously valued, the specimen radiograph was typically obtained after a stereotactic biopsy by the same technologist and radiologist that performed the biopsy. The post-biopsy specimen radiograph was bundled with the biopsy code (19081) in 2014. It is now typical for 76098 to be performed in patients undergoing lumpectomy, mastectomy, or surgical excision in the operating room. The technologist must

coordinate with the OR ahead of time to ensure that staff and the mammography unit will be available when the specimen is removed. The technologist must review prior imaging and patient history in order to know what the surgeon is looking for in the specimen (biopsy clip, localization wire, calcifications, etc.). The technologist receives a phone call from OR staff when the surgeon is ready for the specimen to be imaged. These services are not included in the existing PE for 76098.

Additionally, equipment costs have increased because this code is being updated with the modern PE inputs for Mammography equipment. It is typical for the specimen radiograph to be acquired on a diagnostic mammography unit in the office setting, so those inputs were included in this code (mirrored from the diagnostic mammography codes).

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:

N/A

8. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

Arrive in the OR, receive the specimen, and confirm with surgeon what he/she is looking for to ensure adequate tissue removal. Transport specimen to the mammography room. Position specimen on the mammography unit in appropriate orientation with laterality markers. Step behind shielding to control panel. Set appropriate exposure parameters. Take exposure. Review the image on the monitor, checking for adequate exposure, coverage, etc. and repeat if necessary.

9. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

10. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

N/A

11. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.

N/A

12. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:

N/A

13. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:

14. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

- **Technologist PACS Workstation Proxy (ED050)** –PACS formula; Equals total service period time

- **PACS Mammo Workstation (ED054)** – Equals physician work pre and intra time
- **Room, digital mammography (breakdown of items below)** – all use the highly technical formula
 - a. **Densitometer (EL020)**
 - b. **2D Selenia Dimensions Mammography System (EL021)**
 - c. **Mammo Accreditation Phantom (EL022)**
 - d. **Cenova 2D Tower System (EL023)**
 - e. **Image Checker CAD (9.4) License for One FFDM (EL024)**
 - f. **MRS V7 SQL Reporting System (EL025)**
 - g. **Worksheet Printing (EL026)**
 - h. **Site License (EL027)**

15. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:

N/A

16. If there is any other item on your spreadsheet that needs further explanation please include here:

N/A

17. Please include an explanation of each line item:

N/A

	A	B	D	E	F	I	K
1		RUC Practice Expense Spreadsheet				CURRENT	RECOMMENDED
2		<i>column C. For more complete information about summaries and</i>				76098	76098
3		RUC Collaboration Website				Radiologic examination, surgical specimen (Aug 2003)	Radiologic examination, surgical specimen (April 2018)
4	Clinical Activity Code	Meeting Date: April 2018 Tab: 22 X-Ray Exam - Specimen Specialty: ACR	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute		
5		LOCATION				Non Fac	Non Fac
6		GLOBAL PERIOD				XXX	XXX
7		TOTAL COST OF CLINICAL STAFF, SUPPLIES AND EQUIPMENT				\$ 5.92	\$ 22.05
8		TOTAL CLINICAL STAFF TIME				12.0	17.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME				0.0	4.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME				12.0	13.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME				0.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE				\$ 5.16	\$ 7.31
13		PRE-SERVICE PERIOD					
14		Start: Following visit when decision for surgery or procedure made					
15	CA001	Complete pre-service diagnostic and referral forms					
16	CA002	Coordinate pre-surgery services (including test results)					
17	CA003	Schedule space and equipment in facility	L043A	Mammography	0.43		1
18	CA004	Provide pre-service education/obtain consent					
19	CA005	Complete pre-procedure phone calls and prescription	L043A	Mammography Technologist	0.43		1
20	CA006	Confirm availability of prior images/studies	L043A	Mammography Technologist	0.43		2
21	CA007	Review patient clinical extant information and questionnaire					
22	CA008	Perform regulatory mandated quality assurance activity (pre-					
29		End: When patient enters office/facility for surgery/procedure					
30		SERVICE PERIOD					
31		Start: When patient enters office/facility for surgery/procedure:					
32		Pre-Service (of service period)					
33	CA009	Greet patient, provide gowning, ensure appropriate medical records					
34	CA010	Obtain vital signs					
35	CA011	Provide education/obtain consent					
36	CA012	Review requisition, assess for special needs					
37	CA013	Prepare room, equipment and supplies	L043A	Mammography	0.43		2
38	CA014	Confirm order, protocol exam					
39	CA015	Setup scope (nonfacility setting only)					
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of					
41	CA017	Sedate/apply anesthesia					
48		Intra-service (of service period)					
49	CA018	Assist physician or other qualified healthcare professional---directly					
50	CA019	Assist physician or other qualified healthcare professional---directly					
51	CA020	Assist physician or other qualified healthcare professional---directly					
52	CA021	Perform procedure/service---NOT directly related to physician work	L043A	Mammography	0.43	3	3
59		Post-Service (of service period)					
60	CA022	Monitor patient following procedure/service, multitasking 1:4					
61	CA023	Monitor patient following procedure/service, no multitasking					
62	CA024	Clean room/equipment by clinical staff	L043A	Mammography	0.43	4	3
68	CA030	Technologist QC's images in PACS, checking for all images,	L043A	Mammography	0.43	5	2
69	CA031	Review examination with interpreting MD/DO	L043A	Mammography	0.43		2
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to	L043A	Mammography	0.43		1
71	CA033	Perform regulatory mandated quality assurance activity (service					
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry					
73	CA035	Review home care instructions, coordinate visits/prescriptions					
74	CA036	Discharge day management				n/a	n/a
81		End: Patient leaves office					
82		POST-SERVICE PERIOD					

	A	B	D	E	F	I	K
1		RUC Practice Expense Spreadsheet				CURRENT	RECOMMENDED
2		<i>column C. For more complete information about summaries and</i>				76098	76098
3		RUC Collaboration Website				Radiologic examination, surgical specimen (Aug 2003)	Radiologic examination, surgical specimen (April 2018)
4	Clinical Activity Code	Meeting Date: April 2018 Tab: 22 X-Ray Exam - Specimen Specialty: ACR	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute		
5		LOCATION				Non Fac	Non Fac
6		GLOBAL PERIOD				XXX	XXX
7		TOTAL COST OF CLINICAL STAFF, SUPPLIES AND EQUIPMENT				\$ 5.92	\$ 22.05
8		TOTAL CLINICAL STAFF TIME				12.0	17.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME				0.0	4.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME				12.0	13.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME				0.0	0.0
100	Medical	MEDICAL SUPPLIES	PRICE	UNIT			
101		TOTAL COST OF SUPPLY QUANTITY x PRICE				\$ 0.50	\$ 0.17
102	SB006	drape, non-sterile, sheet 40in x 60in	0.222	item		1	
103	SB022	gloves, non-sterile	0.084	pair		1	1
104	SB043	towel, professional 13in x 18in	0.04	item		1	
105	SG051	gauze, non-sterile 4in x 4in	0.035	item		1	
106	SM013	disinfectant, surface (Envirocide, Sanizide)	0.163	oz		0.5	0.5
107	SM021	sanitizing cloth-wipe (patient)	0.037	item		1	
108		<i>Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A</i>					
110	Equipment Code	EQUIPMENT	Purchase Price	Equipment Formula	Cost Per Minute		
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE				\$ 0.26	\$ 14.58
112	ED050	Technologist PACS workstation	5557	PACS	0.0220179	12	13
113	ED054	PACS Mammography Workstation	106252.1	Other Formula	0.4025914		9
114	EL020	Densitometer (for mammography room)	3660	Highly Technical	0.0145016		8
115	EL021	2D Selenia Dimensions Mammography System (for mammography room)	285000	Highly Technical	1.0798705		8
116	EL022	Mammo Accreditation Phantom (for mammography room)	1025	Highly Technical	0.0040613		8
117	EL023	Cenova 2D Tower System (for mammography room)	15000	Highly Technical	0.0594329		8
118	EL024	Image Checker CAD (9.4) License for One FFDM (for mammography room)	35000	Highly Technical	0.1356295		8
119	EL025	MRS V7 SQL Reporting System (for mammography room)	12500	Highly Technical	0.0495275		8
120	EL026	Worksheet Printing (for mammography room)	3000	Highly Technical	0.0118866		8
121	EL027	Site License (for mammography room)	1000	Highly Technical	0.0039622		8
122		<i>Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A</i>					

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS Request

October 2018

Remote Interrogation Device Evaluation(s) (PE Only)

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.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
93297 (f)	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional	XXX	0.52 (Reviewed for PE Only)
93298 (f)	Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional	XXX	0.52 (Reviewed for PE Only)
93299	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	XXX	0.00 (PE Only)

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor: **93298** Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional

Global Period: XXX Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

The ACC and HRS utilized a consensus panel process to develop recommended inputs. As noted in the cover sheet for these codes, CMS opted to allow carrier pricing after hearing concerns from stakeholders that the RUC-recommended inputs would underpay in comparison. ACC and HRS are revisiting the inputs after the RAW executed a screen of carrier-priced codes with utilization over 10,000. To better scrutinize the inputs that were a straight crosswalk when these codes were reviewed in January 2017 as part of a large family, we engaged industry to see whether some information may be available the inform recommendations.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

93296 is the 90-day remote pacemaker and ICD device monitoring technical code that has similarities to this service.

3. Is this code(s) typically billed with an E/M service? no
Is this code(s) typically billed with the E/M service in the nonfacility? no
(Please see provided data in PE Subcommittee folder)
4. What specialty is the dominant provider in the nonfacility? cardiology, cardiac EP
What percent of the time does the dominant provider provide the service(s) in the nonfacility? 45%, 44%
Is the dominant provider in the nonfacility different then for the global? no
(Please see provided data in PE Subcommittee folder)
5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

The PE for this code is currently contained in 93299 that was originally meant to be a catch-all for both types of 30-day remote monitoring services. In the following decade, it has become clear that ICM and ILR services are different and cannot be appropriately captured in a single technical code. We present recommendations for incorporating direct PE inputs to both 93297 and 93298 that align with each of those services. We have not been able to identify exactly why they were designed that way in 2007. It

could have been to allow for the possibility that the technical work would be provided by vendors, but that is not how the service is being provided. It would have also be somewhat in parallel with other remote monitoring/diagnostic services, such as Holter monitors, to compartmentalize these aspects. Regardless, we thought it made sense to create PE inputs for each code directly since 93299 is an awkward mix of technical work of two different services that both happen to have a 30-day interval.

Compelling Evidence

PE inputs for 93297-93299 were last evaluated by the RUC in 2016/2017 when work and PE for the large family of cardiac device monitoring services were all revalued. Updating that family of 21 codes with work, PE or both was a daunting task. As is still the case, 93299 was carrier priced at that time. Societies identified code 93296 that also describes the technical component of remote monitoring services as a comparison code and recommended it be used as a crosswalk. Stakeholder comments and CMS's decision to maintain carrier 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, we have been able to better quantify the clinical staff time necessary to perform the technical components of 93299/93298/93297 and agree that the current valuation was based on a "flawed crosswalk" and "analysis of additional data."

93298

We were able to obtain data from one manufacturer that sells the vast majority of ILR devices on 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 a separate and additional 26 minutes.

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

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: n/a
8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) 0

The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: no vital signs are obtained

9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

The electrodiagnostic technologist educates the patient about the device and transmittal protocols, troubleshoots hardware/connectivity issues, receives and reviews remote transmissions, distributes results, and prepares a report.

10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. n/a
11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: n/a
12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. n/a
13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: n/a
14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: n/a
15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

EQ198: default formula

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:
17. If there is any other item on your spreadsheet that needs further explanation please include here:
18. Please include an explanation of each line item:

Line 52, CA021: clinical staff assists the patient, processes remote transmissions, and creates reports as described in Question 6.

Line 102, SK057: paper is used to print reports to facilitate interpretation

Line 112, EQ198: a pacemaker follow-up system is used by the clinical staff

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Non Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor: **93297** Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional

Global Period: XXX Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

The ACC and HRS utilized a consensus panel process to develop recommended inputs. As noted in the cover sheet for these codes, CMS opted to allow carrier pricing after hearing concerns from stakeholders that the RUC-recommended inputs would underpay in comparison. ACC and HRS are revisiting the inputs after the RAW executed a screen of carrier-priced codes with utilization over 10,000. To better scrutinize the inputs that were a straight crosswalk when these codes were reviewed in January 2017 as part of a large family, we engaged industry to see whether some information may be available the inform recommendations.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

93296 is the 90-day remote pacemaker and ICD device monitoring technical code that has similarities to this service.

3. Is this code(s) typically billed with an E/M service? no
Is this code(s) typically billed with the E/M service in the nonfacility? no
(Please see provided data in PE Subcommittee folder)
4. What specialty is the dominant provider in the nonfacility? cardiology, cardiac EP
What percent of the time does the dominant provider provide the service(s) in the nonfacility? 48%, 40%
Is the dominant provider in the nonfacility different then for the global? no
(Please see provided data in PE Subcommittee folder)
5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

The PE for this code is currently contained in 93299 that was originally meant to be a catch-all for both types of 30-day remote monitoring services. In the following decade, it has become clear that ICM and ILR services are different and cannot be appropriately captured in a single technical code. We present recommendations for incorporating direct PE inputs to both 93297 and 93298 that align with each of

those services. We have not been able to identify exactly why they were designed that way in 2007. It could have been to allow for the possibility that the technical work would be provided by vendors, but that is not how the service is being provided. It would have also be somewhat in parallel with other remote monitoring/diagnostic services, such as Holter monitors, to compartmentalize these aspects. Regardless, we thought it made sense to create PE inputs for each code directly since 93299 is an awkward mix of technical work of two different services that both happen to have a 30-day interval.

Compelling Evidence

PE inputs for 93297-93299 were last evaluated by the RUC in 2016/2017 when work and PE for the large family of cardiac device monitoring services were all revalued. Updating that family of 21 codes with work, PE or both was a daunting task. As is still the case, 93299 was carrier priced at that time. Societies identified code 93296 that also describes the technical component of remote monitoring services as a comparison code and recommended it be used as a crosswalk. Stakeholder comments and CMS's decision to maintain carrier 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, we have been able to better quantify the clinical staff time necessary to perform the technical components of 93299/93298/93297 and agree that the current valuation was based on a "flawed crosswalk" and "analysis of additional data."

93297

We were able to obtain data from one manufacturer quantifying ILR notifications, transmissions, and reports. Such information was not available for ICM. Should that change we will update these recommendations accordingly.

The expert panel considered that the data for ILR direct PE, being informed by data based on 18 months of monitoring services, to be accurate and in alignment with their clinical experience. Applying that clinical experience, the expert panel believes it would be appropriate to the ILR clinical staff and equipment time for ICM PE from the following components: 14 minutes for a monthly report, 11 minutes for a once a month average patient-generated notification (this is an expert panel recommendation), 4 minutes for troubleshooting non-connective monitoring hardware, and 11 minutes to perform education about the device and re-education protocols after initial enrollment for a sum of 40 minutes. This results in clinical staff time of about half what we recommend for ILRs.

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

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: n/a
8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) 0
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: Vitals are not obtained.

9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

The electrodiagnostic technologist educates the patient about the device and transmittal protocols, troubleshoots hardware/connectivity issues, receives and reviews remote transmissions, distributes results, and prepares a report.

10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. n/a
11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: n/a
12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. n/a
13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: n/a
14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: n/a
15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

EQ198: Default formula

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: n/a
17. If there is any other item on your spreadsheet that needs further explanation please include here: n/a
18. Please include an explanation of each line item:

Line 52, CA021: clinical staff assists the patient, processes remote transmissions, and creates reports as described in Question 6.

Line 102, SK057: paper is used to print reports to facilitate interpretation

Line 112, EQ198: a pacemaker follow-up system is used by the clinical staff

CPT Code: 93298, 93297, 93299
Specialty Society: HRS, ACC

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor: **93299** Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results

Global Period: XXX Meeting Date: October 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

The ACC and HRS utilized a consensus panel process to develop recommended inputs. As noted in the cover sheet for these codes, CMS opted to allow carrier pricing after hearing concerns from stakeholders that the RUC-recommended inputs would underpay in comparison. ACC and HRS are revisiting the inputs after the RAW executed a screen of carrier-priced codes with utilization over 10,000. To better scrutinize the inputs that were a straight crosswalk when these codes were reviewed in January 2017 as part of a large family, we engaged industry to see whether some information may be available the inform recommendations.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

93296 is the 90-day remote pacemaker and ICD device monitoring technical code that has similarities to this service.

3. Is this code(s) typically billed with an E/M service? no
Is this code(s) typically billed with the E/M service in the nonfacility? no
(Please see provided data in PE Subcommittee folder)
4. What specialty is the dominant provider in the nonfacility? cardiology, cardiac EP
What percent of the time does the dominant provider provide the service(s) in the nonfacility? 44%, 39%
Is the dominant provider in the nonfacility different then for the global? no
(Please see provided data in PE Subcommittee folder)
5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time. We have not been able to identify exactly why they were designed that way in 2007. It could have been to allow for the possibility that the technical work would be provided by vendors, but that is not how the service is being provided. It would have also be somewhat in parallel with other remote monitoring/diagnostic services, such as Holter monitors, to compartmentalize these aspects. Regardless, we thought it made sense to create PE inputs for each code directly since 93299 is an awkward mix of technical work of two different services that both happen to have a 30-day interval.

Compelling Evidence

PE inputs for 93297-93299 were last evaluated by the RUC in 2016/2017 when work and PE for the large family of cardiac device monitoring services were all revalued. Updating that family of 21 codes with work, PE or both was a daunting task. As is still the case, 93299 was carrier priced at that time. Societies identified code 93296 that also describes the technical component of remote monitoring services as a comparison code and recommended it be used as a crosswalk. Stakeholder comments and CMS's decision to maintain carrier 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, we have been able to better quantify the clinical staff time necessary to perform the technical components of 93299/93298/93297 and agree that the current valuation was based on a "flawed crosswalk" and "analysis of additional data."

93299

93299 is a technical code meant to capture the PE for remote monitoring of implantable cardiac monitors (93297) and implantable loop recorders (93298). Both are 30-day codes. But in the decade since these codes were created we now see a bifurcation in the way each is used and the amount of PE each requires. We are presenting recommendations to create direct PE inputs for both 30-day remote interrogation codes. Unless/until a change is made to 93299 at CPT, since 93298 is the service typically and most commonly (54%) billed with 93299, we recommend the same inputs for 93298 be applied to 93299.

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

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:
8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) 0
The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: No vitals are obtained.
9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

The electrodiagnostic technologist educates the patient about the device and transmittal protocols, troubleshoots hardware/connectivity issues, receives and reviews remote transmissions, distributes results, and prepares a report.

10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. n/a
11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: n/a
12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>.
13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: n/a
14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: n/a
15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

EQ198: default formula

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: n/a
17. If there is any other item on your spreadsheet that needs further explanation please include here: n/a
18. Please include an explanation of each line item:

Line 52, CA021: clinical staff assists the patient, processes remote transmissions, and creates reports as described in Question 6.

Line 102, SK057: paper is used to print reports to facilitate interpretation

Line 112, EQ198: a pacemaker follow-up system is used by the clinical staff

	A	B	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
1	RUC Practice Expense Spreadsheet					REFERENCE CODE		CURRENT		RECOMMENDED			REFERENCE CODE		CURRENT		RECOMMENDED		
2		*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.				93296		93298		93298			93296		93297		93297		
3		RUC Collaboration Website				Interrogation device evaluation(s) (remote), up to 90 days; single, dual,		Interrogation device evaluation(s), (remote) up to 30 days; implantable		Interrogation device evaluation(s), (remote) up to 30 days; implantable			Interrogation device evaluation(s) (remote), up to 90 days; single, dual,		Interrogation device evaluation(s), (remote) up to 30 days; implantable		Interrogation device evaluation(s), (remote) up to 30 days; implantable		
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 22 Specialty: HRS, ACC	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility		Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	
5		LOCATION																	
6		GLOBAL PERIOD																	
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				\$ 23.49	\$ -	\$ -	\$ -	\$ 33.94	\$ -		\$ 23.49	\$ -	\$ -	\$ -	\$ 17.88	\$ -	
8		TOTAL CLINICAL STAFF TIME	L037A	Electrodiagnos	0.37	28.0	0.0	0.0	0.0	76.0	0.0		28.0	0.0	0.0	0.0	40.0	0.0	
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037A	Electrodiagnos	0.37	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037A	Electrodiagnos	0.37	28.0	0.0	0.0	0.0	76.0	0.0		28.0	0.0	0.0	0.0	40.0	0.0	
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037A	Electrodiagnos	0.37	0.0	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0	0.0	0.0	0.0	
12		TOTAL COST OF CLINICAL STAFF				\$ 10.36	\$ -	\$ -	\$ -	\$ 28.12	\$ -		\$ 10.36	\$ -	\$ -	\$ -	\$ 14.80	\$ -	
13		PRE-SERVICE PERIOD																	
14		Start: Following visit when decision for surgery or procedure made																	
15	CA001	Complete pre-service diagnostic and	L037D	RN/LPN/MTA	0.37														
16	CA002	Coordinate pre-surgery services	L037D	RN/LPN/MTA	0.37														
17	CA003	Schedule space and equipment in	L037D	RN/LPN/MTA	0.37														
18	CA004	Provide pre-service education/obtain	L037D	RN/LPN/MTA	0.37														
19	CA005	Complete pre-procedure phone calls	L037D	RN/LPN/MTA	0.37														
20	CA006	Confirm availability of prior	L037D	RN/LPN/MTA	0.37														
21	CA007	Review patient clinical extant	L037D	RN/LPN/MTA	0.37														
22	CA008	Perform regulatory mandated quality	L037D	RN/LPN/MTA	0.37														
29		End: When patient enters office/facility for surgery/procedure																	
30		SERVICE PERIOD																	
31		Start: When patient enters office/facility for surgery/procedure:																	
32		Pre-Service (of service period)																	
33	CA009	Greet patient, provide gowning,	L037D	RN/LPN/MTA	0.37														
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37														
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37														
36	CA012	Review requisition, assess for special	L037D	RN/LPN/MTA	0.37														
37	CA013	Prepare room, equipment and	L037D	RN/LPN/MTA	0.37														
38	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37														
39	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37														
40	CA016	Prepare, set-up and start IV, initial	L037D	RN/LPN/MTA	0.37														
41	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37														
48		Intra-service (of service period)																	
49	CA018	Assist physician or other qualified	L037A	Electrodiagno	0.37	28							28						

	A	B	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
1	RUC Practice Expense Spreadsheet					REFERENCE CODE		CURRENT		RECOMMENDED			REFERENCE CODE		CURRENT		RECOMMENDED		
2		<i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>																	
3		RUC Collaboration Website				Interrogation device evaluation(s) (remote), up to 90 days; single, dual,		Interrogation device evaluation(s), (remote) up to 30 days; implantable		Interrogation device evaluation(s), (remote) up to 30 days; implantable			Interrogation device evaluation(s) (remote), up to 90 days; single, dual,		Interrogation device evaluation(s), (remote) up to 30 days; implantable		Interrogation device evaluation(s), (remote) up to 30 days; implantable		
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 22 Specialty: HRS, ACC	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute	Non Fac Facility		Non Fac Facility		Non Fac Facility			Non Fac Facility		Non Fac Facility		Non Fac Facility		
5		LOCATION																	
6		GLOBAL PERIOD																	
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				\$ 23.49 \$ -		\$ - \$ -		\$ 33.94 \$ -			\$ 23.49 \$ -		\$ - \$ -		\$ 17.88 \$ -		
8		TOTAL CLINICAL STAFF TIME	L037A	Electrodiagnos	0.37	28.0 0.0		0.0 0.0		76.0 0.0			28.0 0.0		0.0 0.0		40.0 0.0		
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037A	Electrodiagnos	0.37	0.0 0.0		0.0 0.0		0.0 0.0			0.0 0.0		0.0 0.0		0.0 0.0		
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037A	Electrodiagnos	0.37	28.0 0.0		0.0 0.0		76.0 0.0			28.0 0.0		0.0 0.0		40.0 0.0		
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037A	Electrodiagnos	0.37	0.0 0.0		0.0 0.0		0.0 0.0			0.0 0.0		0.0 0.0		0.0 0.0		
50	CA019	Assist physician or other qualified	L037D	RN/LPN/MTA	0.37														
51	CA020	Assist physician or other qualified	L037D	RN/LPN/MTA	0.37														
52	CA021	Perform procedure/service---NOT	L037A	Electrodiagno	0.37					76							40		
59		Post-Service (of service period)																	
60	CA022	Monitor patient following	L037D	RN/LPN/MTA	0.37														
61	CA023	Monitor patient following	L037D	RN/LPN/MTA	0.37														
62	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37														
63	CA025	Clean scope	L037D	RN/LPN/MTA	0.37														
64	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37														
65	CA027	Complete post-procedure diagnostic	L037D	RN/LPN/MTA	0.37														
66	CA028	Review/read post-procedure x-ray, lab	L037D	RN/LPN/MTA	0.37														
67	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37														
68	CA030	Technologist QC's images in PACS,	L037D	RN/LPN/MTA	0.37														
69	CA031	Review examination with interpreting	L037D	RN/LPN/MTA	0.37														
70	CA032	Scan exam documents into PACS.	L037D	RN/LPN/MTA	0.37														
71	CA033	Perform regulatory mandated quality	L037D	RN/LPN/MTA	0.37														
72	CA034	Document procedure (nonPACS) (e.g.	L037D	RN/LPN/MTA	0.37														
73	CA035	Review home care instructions,	L037D	RN/LPN/MTA	0.37														
74	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	n/a		n/a		n/a			n/a		n/a		n/a		
81		End: Patient leaves office																	
82		POST-SERVICE PERIOD																	
83		Start: Patient leaves office/facility																	
84	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37														
85	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37														
92	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	0.0 0.0		0.0 0.0		0.0 0.0			0.0 0.0		0.0 0.0		0.0 0.0		
99		End: with last office visit before end																	

[illegible]

[illegible]

	A	B	U	V	W	X	Y	Z
1	RUC Practice Expense Spreadsheet		REFERENCE CODE		RUC-October 2016		RECOMMENDED	
2		<p><i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i></p> <p><i>*Please do not modify formulas in gray shaded cells</i></p> <p><i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i></p>	93296		93299		93299	
3		RUC Collaboration Website	Interrogation device evaluation(s) (remote), up to 90 days; single, dual,		Interrogation device evaluation(s), (remote) up to 30 days; implantable		Interrogation device evaluation(s), (remote) up to 30 days; implantable	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 22 Specialty: HRS, ACC						
5		LOCATION						
6		GLOBAL PERIOD						
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 23.49	\$ -	\$ 12.53	\$ -	\$ 33.94	\$ -
8		TOTAL CLINICAL STAFF TIME	28.0	0.0	28.0	0.0	76.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	28.0	0.0	28.0	0.0	76.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0
12		TOTAL COST OF CLINICAL STAFF	\$ 10.36	\$ -	\$ 10.36	\$ -	\$ 28.12	\$ -
13		PRE-SERVICE PERIOD						
14		Start: Following visit when decision f						
15	CA001	Complete pre-service diagnostic and						
16	CA002	Coordinate pre-surgery services						
17	CA003	Schedule space and equipment in						
18	CA004	Provide pre-service education/obtain						
19	CA005	Complete pre-procedure phone calls						
20	CA006	Confirm availability of prior						
21	CA007	Review patient clinical extant						
22	CA008	Perform regulatory mandated quality						
29		End: When patient enters office/facilit						
30		SERVICE PERIOD						
31		Start: When patient enters office/facili						
32		Pre-Service (of service period)						
33	CA009	Greet patient, provide gowning,						
34	CA010	Obtain vital signs						
35	CA011	Provide education/obtain consent						
36	CA012	Review requisition, assess for special						
37	CA013	Prepare room, equipment and						
38	CA014	Confirm order, protocol exam						
39	CA015	Setup scope (nonfacility setting only)						
40	CA016	Prepare, set-up and start IV, initial						
41	CA017	Sedate/apply anesthesia						
48		Intra-service (of service period)						
49	CA018	Assist physician or other qualified	28					

	A	B	U	V	W	X	Y	Z
1	RUC Practice Expense Spreadsheet		REFERENCE CODE		RUC-October 2016		RECOMMENDED	
2		<p><i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i></p> <p><i>*Please do not modify formulas in gray shaded cells</i></p> <p><i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i></p>	93296		93299		93299	
3		RUC Collaboration Website	Interrogation device evaluation(s) (remote), up to 90 days; single, dual,		Interrogation device evaluation(s), (remote) up to 30 days; implantable		Interrogation device evaluation(s), (remote) up to 30 days; implantable	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 22 Specialty: HRS, ACC						
5		LOCATION						
6		GLOBAL PERIOD						
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 23.49	\$ -	\$ 12.53	\$ -	\$ 33.94	\$ -
8		TOTAL CLINICAL STAFF TIME	28.0	0.0	28.0	0.0	76.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	28.0	0.0	28.0	0.0	76.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0
50	CA019	Assist physician or other qualified						
51	CA020	Assist physician or other qualified						
52	CA021	Perform procedure/service---NOT			28		76	
59		Post-Service (of service period)						
60	CA022	Monitor patient following						
61	CA023	Monitor patient following						
62	CA024	Clean room/equipment by clinical staff						
63	CA025	Clean scope						
64	CA026	Clean surgical instrument package						
65	CA027	Complete post-procedure diagnostic						
66	CA028	Review/read post-procedure x-ray, lab						
67	CA029	Check dressings, catheters, wounds						
68	CA030	Technologist QC's images in PACS,						
69	CA031	Review examination with interpreting						
70	CA032	Scan exam documents into PACS.						
71	CA033	Perform regulatory mandated quality						
72	CA034	Document procedure (nonPACS) (e.g.						
73	CA035	Review home care instructions,						
74	CA036	Discharge day management	n/a		n/a		n/a	
81		End: Patient leaves office						
82		POST-SERVICE PERIOD						
83		Start: Patient leaves office/facility						
84	CA037	Conduct patient communications						
85	CA038	Coordinate post-procedure services						
92	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0
99		End: with last office visit before end						

	A	B	U	V	W	X	Y	Z
1	RUC Practice Expense Spreadsheet		REFERENCE CODE		RUC-October 2016		RECOMMENDED	
2		<p><i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i></p> <p><i>*Please do not modify formulas in gray shaded cells</i></p> <p><i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i></p>	93296		93299		93299	
3		RUC Collaboration Website	Interrogation device evaluation(s) (remote), up to 90 days; single, dual,		Interrogation device evaluation(s), (remote) up to 30 days; implantable		Interrogation device evaluation(s), (remote) up to 30 days; implantable	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 22 Specialty: HRS, ACC						
5		LOCATION						
6		GLOBAL PERIOD						
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 23.49	\$ -	\$ 12.53	\$ -	\$ 33.94	\$ -
8		TOTAL CLINICAL STAFF TIME	28.0	0.0	28.0	0.0	76.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	28.0	0.0	28.0	0.0	76.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0
100	Supply Code	MEDICAL SUPPLIES						
101		TOTAL COST OF SUPPLY QUANTITY x PRICE	\$ 0.05	\$ -	\$ 0.05	\$ -	\$ 0.05	\$ -
102	SK057	paper, laser printing (each sheet)	10		10		10	
103								
104								
105								
106								
107								
108		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A						
110	Equipment Code	EQUIPMENT						
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	\$ 13.08	\$ -	\$ 2.12	\$ -	\$ 5.77	\$ -
112	EQ198	pacemaker follow-up system (incl software and hardware) (Paceart)			28		76	
113	EQ320	pacemaker interrogation, system	28					
114								
115								
116								
117								

	A	B	U	V	W	X	Y	Z
1	RUC Practice Expense Spreadsheet		REFERENCE CODE		RUC-October 2016		RECOMMENDED	
2		<p><i>*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i></p> <p><i>*Please do not modify formulas in gray shaded cells</i></p> <p><i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i></p>	93296		93299		93299	
3		RUC Collaboration Website	Interrogation device evaluation(s) (remote), up to 90 days; single, dual,		Interrogation device evaluation(s), (remote) up to 30 days; implantable		Interrogation device evaluation(s), (remote) up to 30 days; implantable	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 22 Specialty: HRS, ACC						
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD						
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	\$ 23.49	\$ -	\$ 12.53	\$ -	\$ 33.94	\$ -
8		TOTAL CLINICAL STAFF TIME	28.0	0.0	28.0	0.0	76.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	28.0	0.0	28.0	0.0	76.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0
118		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A						

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Surveyed by one Specialty and Now Performed by a Different Specialty

October 2018

Open Wound Debridement

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 IWPUR 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.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
(f) 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	000	0.88

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)	ZZZ	0.50
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**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 97597	Tracking Number	Original Specialty Recommended RVU: 1.00
		Presented Recommended RVU: 1.00
Global Period: 000	Current Work RVU: 0.51	RUC Recommended RVU: 0.88

CPT Descriptor: 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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old male presents with a neuropathic diabetic ulcer on the left plantar forefoot. The wound edges and the wound bed are viable with granulations, but covered with an adherent proteinaceous slough, fibrin, and debris. He undergoes debridement to the depth of dermis.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is;
Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review patient chart and referral from physician. Perform an updated history of medications with special attention to current blood thinners. Review pertinent past medical problems and any new problems that may have arisen since the previous visit. Position patient and remove existing dressings. Document wound status, classification, location, drainage, color, texture, temperature, vascularity, and size and depth of the area to be targeted for debridement. Inspect for and document sinus tracts, undermining, odor, and quality of the wound bed tissue. Inspect and palpate surrounding skin, wound edge, and exposed soft tissue. Administer topical or local anesthesia as needed.

Description of Intra-Service Work: Cleanse the wound thoroughly with copious irrigation. Remove proteinaceous slough, fibrin, and debris covering wound bed with curette, scalpel, and forceps or scissors until healthy tissue is visualized. Ensure hemostasis.

Description of Post-Service Work: Apply an appropriate surgical dressing. Provide for a moist healing environment to help assist with subsequent wound healing and granulation tissue formation. Determine type of padding and specific material needed to offload the ulcer area; cut pad to properly remove pressure; and apply padding. Instruct patient and/or caregiver on appropriate home care, including dressing changes, as necessary. Instruct on importance of controlling concomitant medical conditions. Enter patient progress notes in medical chart. Answer patient and/or family questions. Discuss (oral and written) patient progress with PCP/referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		10/2018				
Presenter(s):	Brooke A. Bisbee, DPM; Lloyd S. Smith, DPM; Charles Mabry, MD, FACS; Nader Massarweh, MD, FACS; Megan Adamson, MD					
Specialty(s):	American Podiatric Medical Association; American College of Surgeons; American Academy of Family Physicians					
CPT Code:	97597					
Sample Size:	6971	Resp N:	139	Response: 1.9 %		
Description of Sample:	random from society membership database					
		<u>Low</u>	<u>25th pctl</u>	<u>Median*</u>	<u>75th pctl</u>	<u>High</u>
Service Performance Rate		0.00	10.00	40.00	100.00	1400.00
Survey RVW:		0.55	0.88	1.00	1.10	2.30
Pre-Service Evaluation Time:				10.00		
Pre-Service Positioning Time:				2.00		
Pre-Service Scrub, Dress, Wait Time:				5.00		
Intra-Service Time:		3.00	10.00	15.00	18.00	45.00
Immediate Post Service-Time:	<u>5.00</u>					
<u>Post Operative Visits</u>	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>				
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00		
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00		

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the **pre-service time package** that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

5-NF Proc w minimal anes care (if no deduct 1 min)

CPT Code:	97597	Recommended Physician Work RVU: 0.88		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time
Pre-Service Evaluation Time:		7.00	7.00	0.00
Pre-Service Positioning Time:		1.00	0.00	1.00
Pre-Service Scrub, Dress, Wait Time:		1.00	1.00	0.00
Intra-Service Time:		15.00		
Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
N/A Survey Code is Non-Facility				
		Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:		5.00	0.00	5.00

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11042	000	1.01	RUC Time

CPT Descriptor Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less**SECOND HIGHEST KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99213	XXX	0.97	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
23350	000	1.00	RUC Time	37,824

CPT Descriptor 1 Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
12002	000	1.14	RUC Time	146,808

CPT Descriptor 2 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 63 **% of respondents:** 45.3 %

Number of respondents who choose 2nd Key Reference Code: 15 **% of respondents:** 10.7 %

TIME ESTIMATES (Median)

	CPT Code: <u>97597</u>	Top Key Reference CPT Code: <u>11042</u>	2nd Key Reference CPT Code: <u>99213</u>
Median Pre-Service Time	9.00	11.00	3.00
Median Intra-Service Time	15.00	15.00	15.00
Median Immediate Post-service Time	5.00	10.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	29.00	36.00	23.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	31%	48%	14%	6%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	25%	59%	16%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	16%	72%	13%

Physical effort required	19%	67%	14%
--------------------------	-----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

28%

53%

19%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	13%	33%	40%	13%
------------------------------	----	-----	-----	-----	-----

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

13%

60%

27%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	27%	7%	67%
--------------------------	-----	----	-----

Physical effort required	13%	33%	53%
--------------------------	-----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

27%

27%

47%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

For CPT 2001, code 97601 was created to report "Removal of devitalized tissue from wound; selective debridement, without anesthesia." This was meant to replace G0169 that CMS created as a therapy service for purposes of the outpatient rehabilitation payment system for use by physical and occupational therapists. Physical therapists became the

dominant provider of 97601, while surgeons, podiatry and family medicine were the dominant providers of 11040 and 11041.

For CPT 2005, code 97601 (any size) was deleted and codes 97597 (< 20 sq cm) and 97598 (> 20 sq cm) were created to bundle the work described by 97601 plus code 97022 (whirlpool) which was typically reported with 97601. Physical therapists, the dominant provider of 97601 surveyed the two new XXX-global codes and the HCPAC recommended wRVUs were based on work neutrality:

Total wRVUs with CMS Values for Existing Code:

97597: 82,119 x **0.50** = 41,059

97022: 82,119 x 0.75 x **0.17** = 10,470 (75% of 97597 is billed with 97022 - originally billed separately)

Total wRVUs = **51,529**

Total wRVUs with HCPAC Recommended Values for New Codes:

97597: 61,589 x **0.58** = 35,721

97598: 20,530 x **0.80** = 16,424

Total wRVUs for new codes = **52,145**

For CPT 2011, codes 11040 and 11041 were deleted and codes 97597 and 97598 were revised.

From: "*Removal of devitalized tissues from wound(s), selective debridement, without anesthesia*" (global change from XXX to 000)

To: "*Debridement, open wound, first 20 sq cm or less*" and "*Debridement, open wound, each additional 20 sq cm*" (global change from XXX to ZZZ)

Because codes 97597 and 97598 were typically reported by physical therapy, podiatry, and family medicine, the surgical specialties did not participate in the survey of the revised codes.

Despite comparisons to reference codes that showed code 97597 was undervalued, the physical therapists and podiatry could offer no compelling evidence to support an increase in the wRVU. Therefore, the specialty societies and the HCPAC developed wRVUs for the revised codes that would ensure work neutrality, in conjunction with deleted codes 10040 and 10041. The HCPAC recommended 0.54 wRVU for 97597 and 0.40 wRVU for 97598. CMS disagreed and finalized 0.51 wRVU for 97597 and 0.24 wRVU for 97598.

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

Compelling Evidence

Flawed methodology – survey process

Code 97597 was surveyed in 2010 as an XXX code using an RSL that included both XXX and ZZZ codes, but no 000 global codes. In addition, physical therapy modality services not requiring constant patient contact and E/M and other services not familiar to physical therapists were included in the RSL. It was not until after the survey that the specialties and the HCPAC requested a change to a 000 global and CMS agreed. Because an XXX survey does not describe and differentiate pre, intra, and post-surgical work (eg, pre-service evaluation, positioning, and scrub/dress/wait or skin-to-skin work), it is possible that survey respondents were not clear about the components of work of a global procedure code. In fact, code 15003 *Surgical preparation of an open wound, add'l 100 sq cm* (global period ZZZ) was chosen as the key reference service by almost half of the 30 respondents, even though physical therapists and podiatrists never or very rarely report this service. **Therefore, we believe the survey methodology for 97597 was flawed.**

Different patient population

The RUC surgical specialties that chose not to survey the revised codes and the HCPAC members reviewing the revised codes did not appreciate the change in the code descriptors for 97597 and 97598 when 11040 and 11041 were deleted; especially, the revision to add "open wound" and delete "without anesthesia." These changes resulted in a dramatic change in physical therapist utilization (a decrease from 40% to 2%) and a dramatic decrease in total utilization (1.75 million claims for 11040, 11041, 97597, and 97598 to 1.17 million claims for 97597 and 97598). **Therefore, we**

believe there was a change in the typical patient for 97597 and 97598 to include patients that previously would have undergone excisional debridement of partial and full thickness skin requiring a local or topical anesthetic.

Flawed methodology – utilization and work neutrality calculations

Because the surveying specialties and the HCPAC could not anticipate the dramatic change in reporting for the revised codes, the calculations that further reduced the HCPAC facilitated wRVUs were flawed. The HCPAC values were then further reduced by CMS.

Recommendation – 97597

We recommend the survey median work RVU of 1.00 for code 97597.

Pre-Time: Package 5 - Procedure with minimal anesthesia care

Evaluation: The package time is recommended to review the patient chart; update history of medications with special attention to current blood thinners; remove existing dressings; document wound status, classification, location, drainage, color, texture, temperature, vascularity, and size and depth of the area to be targeted for debridement; inspect for and document sinus tracts, undermining, odor, and quality of the wound bed tissue; and inspect and palpate surrounding skin, wound edge, and exposed soft tissue.

Positioning: One minute is recommended to position and drape the patient.

Scrub/dress/wait: The package time of one minute is recommended for gowning, gloving, and applying topical or local anesthetic as needed.

Postservice time:

Post-time packages do not apply to office-based procedures. Five minutes is recommended for post-procedure work on the day of the procedure to apply an appropriate surgical dressing including padding and specific material needed to offload the ulcer area; instruct the patient and/or caregiver on appropriate home care, including dressing changes, as necessary; instruct on importance of controlling concomitant medical conditions; enter patient progress notes in medical chart; and answer patient and/or family questions.

Key Reference Comparison

CPT	DESCRIPTION	RVW	IWPUT	TOT MIN	PRE	INTRA	POST
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.	0.97	0.053	23	3	15	5
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	1.00	0.047	29	9	15	5
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	1.01	0.037	36	11	15	10

MPC comparison

MPC CPT	DESCRIPTION	RVW	IWPUT	TOT MIN	PRE	INTRA	POST
23350	Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography	1.00	0.049	28	8	15	5
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	1.00	0.047	29	9	15	5

	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						
12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm	1.14	0.059	27	7	15	5

The table below presents **all 0-day global MPC codes** with 15 minutes of intra-time, further supporting the wRVU value of 1.00 for 97597.

Year	CPT	Descriptor	RVW	IWPUT	Total	Pack	INTRA	POST
2011	23350	Injection for shoulder x-ray	1.00	0.049	28	8	15	5
	97597	Debridement open wound, surface area; first 20 sq cm or less	1.00	0.047	29	9	15	5
2010	11042	Deb subq tissue 20 sq cm/<	1.01	0.037	36	11	15	10
2010	12002	Rpr s/n/ax/gen/trnk2.6-7.5cm	1.14	0.059	27	7	15	5
2010	12013	Rpr f/e/n/l/m 2.6-5.0 cm	1.22	0.064	27	7	15	5
2012	43450	Dilate esophagus 1/mult pass	1.28	0.036	51	22	15	14
2010	51710	Change of bladder tube	1.35	0.050	42	12	15	15
2002	57452	Exam of cervix w/scope	1.50	0.063	40	15	15	10
2016	36556	Insert non-tunnel cv cath	1.75	0.084	40	20	15	5
2006	54150	Circumcision w/regional block	1.90	0.087	45	25	15	5
2009	64483	Inj foramen epidural l/s	1.90	0.082	49	24	15	10
2009	64479	Inj foramen epidural c/t	2.29	0.108	49	24	15	10

Comparison to Other 000 Global Codes

The table below presents **all 0-day global codes** with 15 minutes of intra-time that have been reviewed by the RUC from 2015 to 2017 and finalized by CMS, further supporting the wRVU value of 1.00 for 97597.

Year	CPT	Descriptor	RVW	IWPUT	Total	Pack	INTRA	POST
2017	36470	Njx sclrsnt single incmptnt vein	0.75	0.029	30	10	15	5
	97597	Debridement open wound, surface area; first 20 sq cm or less	1.00	0.047	29	9	15	5
2015	50431	Njx px nfrosgm &/urtrgrm	1.10	0.019	55	25	15	15
2015	47531	Injection for cholangiogram	1.30	0.034	54	27	15	12
2016	51703	Insert bladder cath complex	1.47	0.058	45	20	15	10
2016	30903	Control of nosebleed	1.54	0.072	39	14	15	10
2017	36516	Apheresis immunoads slctv	1.56	0.052	50	25	15	10
2015	10035	Perq dev soft tiss 1st imag	1.70	0.073	45	20	15	10
2016	36569	Insert picc cath	1.70	0.076	44	19	15	10
2016	36556	Insert non-tunnel cv cath	1.75	0.084	40	20	15	5
2015	64461	Pvb thoracic single inj site	1.75	0.078	44	19	15	10
2015	62326	Njx interlaminar lmb/sac	1.78	0.082	43	18	15	10
2015	62320	Njx interlaminar crv/thrc	1.80	0.083	43	18	15	10
2015	62323	Njx interlaminar lmb/sac	1.80	0.080	45	20	15	10
2015	47537	Removal biliary drg cath	1.84	0.073	52	27	15	10
2015	62324	Njx interlaminar crv/thrc	1.89	0.089	43	18	15	10
2015	62327	Njx interlaminar lmb/sac	1.90	0.087	45	20	15	10
2016	36555	Insert non-tunnel cv cath	1.93	0.084	48	23	15	10
2015	62321	Njx interlaminar crv/thrc	1.95	0.090	45	20	15	10
2016	93503	Insert/place heart catheter	2.00	0.105	37	12	15	10
2015	31577	Largsc w/rmvl foreign bdy(s)	2.19	0.105	48	23	15	10
2015	62325	Njx interlaminar crv/thrc	2.20	0.107	45	20	15	10
2015	31573	Largsc w/ther injection	2.43	0.115	52	27	15	10
2015	31574	Largsc w/njx augmentation	2.43	0.111	55	30	15	10
2015	31578	Largsc w/removal lesion	2.43	0.117	51	26	15	10

Year	CPT	Descriptor	RVW	IWPUT	Total	Pack	INTRA	POST
2016	55700	Biopsy of prostate	2.50	0.142	35	15	15	5

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 97597

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty podiatry How often? Commonly

Specialty general surgery How often? Commonly

Specialty family medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national utilization not available

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

994,938 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2018v2 RUC database

Specialty podiatry Frequency 535000 Percentage 53.77 %

Specialty general surgery Frequency 93000 Percentage 9.34 %

Specialty family medicine

Frequency 70000

Percentage 7.03 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Minor procedure

BETOS Sub-classification Level II:

Skin

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 97597

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION**

CPT Code: 97598	Tracking Number	Original Specialty Recommended RVU: 0.50
		Presented Recommended RVU: 0.50
Global Period: ZZZ	Current Work RVU: 0.24	RUC Recommended RVU: 0.50

CPT Descriptor: 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)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old female presents with chronic open wounds. She has just undergone debridement of the first 20 sq cm to the depth of dermis (reported separately with code 97597). She now undergoes debridement of an additional 20 sq cm of tissue to the depth of dermis from wounds that are granulating but covered with adherent, yellow proteinaceous slough and fibrous tissue. Note: This is an add-on service. Only consider the additional work related to debridement of an additional 20 sq cm of tissue.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is;
Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: [Note: When debridement greater than 20 sq cm is performed, more than one wound is typically involved.] Following debridement of the first 20 sq cm (reported separately with code 97597), addition debridement is performed, including: repositioning the patient as needed, administration of additional topical or local anesthesia as needed and additional wound cleansing, including removal of proteinaceous slough, fibrin, and debris covering the wound bed with curette, scalpel, and forceps or scissors until healthy tissue is visualized. Hemostasis is obtained and appropriate surgical dressings and padding as needed are applied.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Charles Mabry, MD, FACS; Nader Massarweh, MD, FACS; Megan Adamson, MD				
Specialty(s):	American College of Surgeons; American Academy of Family Physicians				
CPT Code:	97598				
Sample Size:	5750	Resp N:	58	Response:	1.0 %
Description of Sample:	random from society membership database				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	5.00	14.00	150.00
Survey RVW:	0.35	0.50	0.75	1.05	2.60
Pre-Service Evaluation Time:			0.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	7.00	15.00	20.00	20.00	45.00
Immediate Post Service-Time:	0.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	97598	Recommended Physician Work RVU: 0.50		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	0.00	0.00	0.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	20.00			
Please, pick the <u>post-service</u> time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
ZZZ Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	0.00	0.00	0.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11045	ZZZ	0.50	RUC Time

CPT Descriptor 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)

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11046	ZZZ	1.03	RUC Time

CPT Descriptor 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)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
96367	ZZZ	0.19	RUC Time	1,523,880

CPT Descriptor 1 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
15003	ZZZ	0.80	RUC Time	43,679

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

CPT Descriptor**RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:**

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 32 % of respondents: 55.1 %

Number of respondents who choose 2nd Key Reference Code: 11 % of respondents: 18.9 %

TIME ESTIMATES (Median)

	CPT Code: <u>97598</u>	Top Key Reference CPT Code: <u>11045</u>	2nd Key Reference CPT Code: <u>11046</u>
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	20.00	15.00	20.00
Median Immediate Post-service Time	0.00	0.00	1.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	20.00	15.00	21.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	9%	59%	28%	3%

Mental Effort and Judgment

	<u>Less</u>	<u>Identical</u>	<u>More</u>
<ul style="list-style-type: none"> The number of possible diagnosis and/or the number of management options that must be considered The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed Urgency of medical decision making 	28%	47%	25%

Technical Skill/Physical Effort

	<u>Less</u>	<u>Identical</u>	<u>More</u>
Technical skill required	16%	69%	16%

Physical effort required	22%	56%	22%
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Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

19%

53%

28%

2nd Key Reference Code**Much Less****Somewhat Less****Identical****Somewhat More****Much More**

Overall intensity/complexity	0%	9%	45%	27%	18%
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Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

18%

55%

27%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required	18%	55%	27%
--------------------------	-----	-----	-----

Physical effort required	27%	45%	27%
--------------------------	-----	-----	-----

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

27%

36%

36%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

For CPT 2001, code 97601 was created to report "Removal of devitalized tissue from wound; selective debridement, without anesthesia." This was meant to replace G0169 that CMS created as a therapy service for purposes of the outpatient rehabilitation payment system for use by physical and occupational therapists. Physical therapists became the

dominant provider of 97601, while surgeons, podiatry and family medicine were the dominant providers of 11040 and 11041.

For CPT 2005, code 97601 (any size) was deleted and codes 97597 (< 20 sq cm) and 97598 (> 20 sq cm) were created to bundle the work described by 97601 plus code 97022 (whirlpool) which was typically reported with 97601. Physical therapists, the dominant provider of 97601 surveyed the two new XXX-global codes and the HCPAC recommended wRVUs were based on work neutrality:

Total wRVUs with CMS Values for Existing Code:

97597: $82,119 \times 0.50 = 41,059$

97022: $82,119 \times 0.75 \times 0.17 = 10,470$ (75% of 97597 is billed with 97022 - originally billed separately)

Total wRVUs = **51,529**

Total wRVUs with HCPAC Recommended Values for New Codes:

97597: $61,589 \times 0.58 = 35,721$

97598: $20,530 \times 0.80 = 16,424$

Total wRVUs for new codes = **52,145**

For CPT 2011, codes 11040 and 11041 were deleted and codes 97597 and 97598 were revised.

From: "*Removal of devitalized tissues from wound(s), selective debridement, without anesthesia*" (global change from XXX to 000)

To: "*Debridement, open wound, first 20 sq cm or less*" and "*Debridement, open wound, each additional 20 sq cm*" (global change from XXX to ZZZ)

Because codes 97597 and 97598 were typically reported by physical therapy, podiatry, and family medicine, the surgical specialties did not participate in the survey of the revised codes.

Despite comparisons to reference codes that showed code 97597 was undervalued, the physical therapists and podiatry could offer no compelling evidence to support an increase in the wRVU. Therefore, the specialty societies and the HCPAC developed wRVUs for the revised codes that would ensure work neutrality, in conjunction with deleted codes 10040 and 10041. The HCPAC recommended 0.54 wRVU for 97597 and 0.40 wRVU for 97598. CMS disagreed and finalized 0.51 wRVU for 97597 and 0.24 wRVU for 97598.

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

Compelling Evidence

Different patient population

The RUC surgical specialties that chose not to survey the revised codes and the HCPAC members reviewing the revised codes did not appreciate the change in the code descriptors for 97597 and 97598 when 11040 and 11041 were deleted; especially, the revision to add "open wound" and delete "without anesthesia." In fact, the RUC rationale states: "The HCPAC understands that this add-on code will seldom be reported as the total wound size for a majority of patients will be 20 square centimeters or less." However, these changes resulted in a dramatic change in physical therapist utilization (a decrease from 40% to 2%) and a dramatic decrease in total utilization (1.75 million claims for 11040, 11041, 97597, and 97598 to 1.17 million claims for 97597 and 97598). **Therefore, we believe there was a change in the typical patient for 97597 and 97598 to include patients that previously would have undergone excisional debridement of partial and full thickness skin (ie, 11040 and 11041).**

Flawed methodology – utilization and work neutrality calculations

Because the surveying specialties and the HCPAC could not anticipate the dramatic change in reporting for the revised codes, the calculations that further reduced the HCPAC facilitated wRVUs were flawed. The HCPAC values were then further reduced by CMS.

Recommendation – 97598

We recommend the survey 25th percentile work RVU of 0.50 and intra-service time of 20 minutes for code 97598.

Intra-service time: The typical patient undergoing debridement to the depth of dermis and a total surface area that is greater than 20 sq cm will typically have more than one open wound and require additional documentation, repositioning, re-draping, and anesthetic. Therefore, the total time for the additional 20 sq cm (20 minutes) will be greater than the intra-time for the initial 20 sq cm or less (15 minutes).

Key Reference Comparison

CPT	DESCRIPTION	RVW	IWPUT	TOT MIN	PRE	INTRA	POST
+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)	0.50	0.033	15	0	15	0
+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)	0.50	0.025	20	0	20	0
+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)	1.03	0.050	21	0	20	1

MPC Comparison

MPC CPT	DESCRIPTION	RVW	IWPUT	TOT MIN	PRE	INTRA	POST
+96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)	0.19	0.034	6	0	5	0
+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)	0.50	0.025	20	0	20	0
+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)	0.80	0.052	16	0	15	1

Comparison to Other ZZZ Global Codes

The table below presents **all** ZZZ-day global codes with 15-20 minutes of intra-time that have been reviewed by the RUC from 2015 to 2017 and finalized by CMS, further supporting the wRVU of 0.50 for 97598.

Year	CPT	Descriptor	RVW	IWPUT	Total	PRE	INTRA	POST
	+97598	Debridement, open wound, total wound(s) surface area; each additional 20 sq cm, or part thereof	0.50	0.025	20	0	20	0
2016	+36218	Place catheter in artery	1.01	0.067	15	0	15	0

CPT Code: 97598								
2015	+31632	Bronchoscopy/lung bx addl	1.03	0.057	18	0	18	0
2015	+64462	Pvb thoracic 2nd+ inj site	1.10	0.073	15	0	15	0
2017	+20939	Bone marrow aspir bone grfg	1.16	0.077	15	0	15	0
2015	+31633	Bronchoscopy/needle bx addl	1.32	0.066	20	0	20	0
2017	+36483	Endoven ther chem adhes sbsq	1.75	0.088	20	0	20	0
2017	+34713	Perq access & clsr fem art	2.50	0.125	20	0	20	0

SERVICES REPORTED WITH MULTIPLE CPT CODES

- Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

- Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Code 97598 is an add-on code and will always be reported with code 97597.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 97598

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty family medicine How often? Commonly

Specialty generally surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national utilization not available

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
 143,287 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
 Please explain the rationale for this estimate. 2018v2 RUC database

Specialty family medicine	Frequency 18000	Percentage 12.56 %
---------------------------	-----------------	--------------------

Specialty general surgery	Frequency 25000	Percentage 17.44 %
---------------------------	-----------------	--------------------

Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Procedures

BETOS Sub-classification:

Minor procedure

BETOS Sub-classification Level II:

Skin

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 97598

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

ISSUE: Open Wound Debridement
TAB: 23

					RVW					Total	pre	PRE			INTRA					POST	POST
SOURCE	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	pkg	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	pkg
REF1	11042	Debridement, subcutaneous tissue (incl	63	0.037			1.01			36	1a	9	1	1			15			10	
REF2	99213	Office or other outpatient visit for the ev	15	0.053			0.97			23		3					15			5	
current	97597	Debridement (eg, high pressure waterje		0.020			0.51			24	XXX	5					14			5	N/A
SVY	97597	Debridement (eg, high pressure waterje	139	0.039	0.55	0.88	1.00	1.10	2.30	37		10	2	5	3	10	15	18	45	5	
	97597	25th pctl		0.039			0.88			29	5	7	1	1			15			5	N/A

REF1	11045	Debridement, subcutaneous tissue (incl	32	0.033				0.50			15	ZZZ	0					15			0	
REF2	11046	Debridement, muscle and/or fascia (incl	11	0.050				1.03			21	ZZZ	0					20			1	
current	97598	Debridement (eg, high pressure waterje		0.017				0.24			14	ZZZ	0					14			0	
SVY	97598	Debridement (eg, high pressure waterje	58	0.038		0.35	0.50	0.75	1.05	2.60	20		0			7	15	20	20	45	0	
	97598	25th pctl		0.025				0.50			20	ZZZ	0					20			0	N/A

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT	DESCRIPTOR	GLOBAL
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	000
97598	each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	ZZZ

Meeting Date: October, 2018

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel: [The APMA, ACS, and AAFP Advisors reviewed and updated the current PE inputs.](#)
2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here: [The current codes are used as references.](#)
3. Is this code(s) typically billed with an E/M service? [No](#)
Is this code(s) typically billed with the E/M service in the nonfacility? [No](#)
(Please see provided data in PE Subcommittee folder)
4. What specialty is the dominant provider in the nonfacility? [Podiatry](#)
What percent of the time does the dominant provider provide the service(s) in the nonfacility? [83% for code 97597 and 27% for code 97598](#)
Is the dominant provider in the nonfacility different then for the global? [Yes](#)
(Please see provided data in PE Subcommittee folder)
5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: [N/A](#)
6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time. [The total aggregate cost for 97597 is less than current cost. For code 97598, the total aggregate cost is greater, mostly due to an increase in time. However, two additional supply items have been added \(SB011 and SB024\) to account for the fact that when 97598 is reported, there will typically be more than one wound.](#)
7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: [N/A](#)
8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) [3 minutes](#)

The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: **Three minutes for blood pressure, pulse, and weight.**

9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*: **For both codes, the clinical staff will circulate and provide clean supplies and instruments and retrieve used/contaminated supplies and instruments as needed.**
10. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. **N/A**
11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: **N/A**
12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. **N/A**
13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**
14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**
15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

			97597	97598
EQ168	light, exam	Default	=+I33+I34+I35+I36+I37+I46+I57+I61	=M119
EF031	table, power	Default	=+I33+I34+I35+I36+I37+I46+I57+I61	=M119
EQ137	instrument pack, basic (\$500-\$1499)	Instrument Packs	=+I33+I34+I35+I36+I37+I46+I58	=M119
EF015	mayo stand	Default	=+I33+I34+I35+I36+I37+I46+I57+I61	=M119

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: **N/A**
17. If there is any other item on your spreadsheet that needs further explanation please include here: **N/A**
18. Please include an explanation of each line item:

		2010	REC	2010	REC	EM is not typical
		97597	97597	97598	97598	
	LOCATION	NF	NF	NF	NF	
	GLOBAL PERIOD	000	000	ZZZ	ZZZ	
	PRE-SERVICE PERIOD					
Code	SERVICE PERIOD					
	Pre-Service (of service period)					
CA009	Greet patient, provide gowning,	3	3			Standard time. Assist patient with

CPT Code: 97597, 97598
Specialty Society(ies) APMA, ACS, AAFP

		2010 97597	REC 97597	2010 97598	REC 97598	
	LOCATION	NF	NF	NF	NF	
	GLOBAL PERIOD	000	000	ZZZ	ZZZ	EM is not typical
	ensure appropriate medical records are available					gowning. Assemble reports (eg, labs, photos from prior visit)
CA010	Obtain vital signs	3	3			Level 1 (1-3 vitals) = 3 minutes blood pressure, pulse, weight
CA011	Provide education/obtain consent	3	2			Explain procedure, obtain consent
CA013	Prepare room, equipment and supplies	2	2			Set up instrument pack and supplies
CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	2	2			Assist physician with positioning patient and removing prior dressings. These patients are often debilitated and do not ambulate well.
	Intra-service (of service period)					
CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)	14	15	14	20	97597: 100% of physician or other qualified healthcare professional intra-service time. 97598: When total wound surface is greater than 20 sq cm, there will typically be more than one wound. The intraservice work will include additional positioning, draping, dressings.
	Post-Service (of service period)					
CA024	Clean room/equipment by clinical staff	3	3			Standard time
CA026	Clean surgical instrument package	10	10			Standard for cleaning Basic Surgical Instrument Package
CA029	Check dressings, catheters, wounds	7	1			Final check of dressing (eg, not oozing, securely placed)
CA035	Review home care instructions, coordinate visits/prescriptions		2			Reinforce education about care of wound, dressings, medications, activity – with patient/family/caregiver
Code	POST-SERVICE PERIOD					
CA037	Conduct patient communications	3	3			EM not typical. One phone call after procedure to reinforce wound care and to answer patient/family/caregiver questions.
Code	MEDICAL SUPPLIES					
SA048	pack, minimum multi-specialty visit	1	1			required for procedure
SB007	drape, sterile barrier 16in x 29in	1	1			required for procedure
SB011	drape, sterile, fenestrated 16in x 29in	1	1		1	97597: required for procedure 97598: Two sites typical for larger total surface area
SB012	drape, sterile, for Mayo stand	1	1			required for procedure
SB027	gown, staff, impervious	1	1			required for procedure
SB024	gloves, sterile		1		1	97597: required for procedure 97598: Two sites typical for larger total surface area
SB044	underpad 2ft x 3ft (Chux)	1	1			required for procedure
SJ028	hydrogen peroxide	10	10	10	10	97597: required for procedure 97598: additional supply for larger total surface area - Two sites typical for larger total surface area
SC056	syringe 50-60ml	1	1			required for procedure
SH069	sodium chloride 0.9% irrigation (500-1000ml uou)	1	1	1	1	97597: required for procedure 97598: additional supply for larger total surface area - Two sites typical for larger total surface area
SG056	gauze, sterile 4in x 4in (10 pack uou)	2	2	1	1	97597: required for procedure 97598: additional supply for larger total surface area - Two sites typical for larger total surface area

CPT Code: 97597, 97598
Specialty Society(ies) APMA, ACS, AAFP

		2010	REC	2010	REC	
		97597	97597	97598	97598	
	LOCATION	NF	NF	NF	NF	
	GLOBAL PERIOD	000	000	ZZZ	ZZZ	EM is not typical
SJ009	basin, irrigation	1	1			required for procedure
SB042	towel, non-sterile	2	2	1	1	97597: required for procedure 97598: additional supply for larger total surface area - Two sites typical for larger total surface area
SF007	blade, surgical (Bard-Parker)	2	1	1	1	97597: required for procedure 97598: additional supply for larger total surface area - Two sites typical for larger total surface area
SJ046	silver nitrate applicator	1	1			required for procedure
SG018	bandage, Kling, non-sterile 3in	1	1	1	1	97597: required for procedure 97598: additional supply for larger total surface area - Two sites typical for larger total surface area
SG035	dressing, 3in x 4in (Telfa, Release)	2	2	2	2	97597: required for procedure 97598: additional supply for larger total surface area - Two sites typical for larger total surface area
SG052	gauze, self-adherent roll 0.5in to 2in (Fabco, Gauztex)	72	72			required for procedure
SG079	tape, surgical paper 1in (Micropore)	12	12	12	12	97597: required for procedure 97598: additional supply for larger total surface area - Two sites typical for larger total surface area
SA043	pack, cleaning, surgical instruments	1	1			required for procedure
Code	EQUIPMENT					
EQ168	light, exam	37	31	14	20	Typical equipment for dominant office provider
EF031	table, power	37	31	14	20	Typical equipment for dominant office provider
EQ137	instrument pack, basic (\$500-\$1499)	44	37	14	20	required for procedure
EF015	mayo stand	37	31	14	20	required for procedure

	A	B	D	E	F	G	H	I	J	K	L	M	N
1	RUC Practice Expense Spreadsheet					CURRENT		RECOMMENDED		CURRENT		RECOMMENDED	
2		column C. For more complete information about summaries and				97597		97597		97598		97598	
3		RUC Collaboration Website				Debridement (eg, high pressure waterjet with/without suction, sharp selective		Debridement (eg, high pressure waterjet with/without suction, sharp selective		Debridement (eg, high pressure waterjet with/without suction, sharp selective		Debridement (eg, high pressure waterjet with/without suction, sharp selective	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 23 Specialty: APMA, ACS, AAFP	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute	Debridement (eg, high pressure waterjet with/without suction, sharp selective		Debridement (eg, high pressure waterjet with/without suction, sharp selective		Debridement (eg, high pressure waterjet with/without suction, sharp selective		Debridement (eg, high pressure waterjet with/without suction, sharp selective	
5		LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD				000	000	000	000	ZZZ	ZZZ	ZZZ	ZZZ
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				\$ 39.13	\$ -	\$ 37.80	\$ -	\$ 10.16	\$ -	\$ 13.93	\$ -
8		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN	0.37	50	0	46	0	14	0	20	0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN	0.37	0	0	0	0	0	0	0	0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN	0.37	47	0	43	0	14	0	20	0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN	0.37	3	0	3	0	0	0	0	0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE				\$ 18.50	\$ -	\$ 17.02	\$ -	\$ 5.18	\$ -	\$ 7.40	\$ -
13	PRE-SERVICE PERIOD												
14	Start: Following visit when decision for surgery or procedure made												
29	End: When patient enters office/facility for surgery/procedure												
30	SERVICE PERIOD												
31	Start: When patient enters office/facility for surgery/procedure:												
32	Pre-Service (of service period)												
33	CA009	Greet patient, provide gowning, ensure appropriate medical records	L037D	RN/LPN	0.37	3		3					
34	CA010	Obtain vital signs	L037D	RN/LPN	0.37	3		3					
35	CA011	Provide education/obtain consent	L037D	RN/LPN	0.37	3		2					
36	CA013	Prepare room, equipment and supplies	L037D	RN/LPN	0.37	2		2					
37	CA016	Prepare, set-up and start IV, initial positioning and monitoring of	L037D	RN/LPN	0.37	2		2					
38	CA017	Sedate/apply anesthesia	L037D	RN/LPN	0.37								
45	Intra-service (of service period)												
46	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)	L037D	RN/LPN	0.37	14		15		14		20	
56	Post-Service (of service period)												
57	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN	0.37	3		3					
58	CA026	Clean surgical instrument package	L037D	RN/LPN	0.37	10		10					
61	CA029	Check dressings, catheters, wounds	L037D	RN/LPN	0.37	7		1					
62	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN	0.37			2					
63	CA036	Discharge day management	L037D	RN/LPN	0.37	n/a		n/a		n/a		n/a	
70	End: Patient leaves office												
71	POST-SERVICE PERIOD												
72	Start: Patient leaves office/facility												
73	CA037	Conduct patient communications	L037D	RN/LPN	0.37	3		3					
74	CA038	Coordinate post-procedure services	L037D	RN/LPN	0.37								
88	End: with last office visit before end of global period												

	A	B	D	E	F	G	H	I	J	K	L	M	N
1	RUC Practice Expense Spreadsheet					CURRENT		RECOMMENDED		CURRENT		RECOMMENDED	
2		column C. For more complete information about summaries and				97597		97597		97598		97598	
3		RUC Collaboration Website				Debridement (eg, high pressure waterjet with/without suction, sharp selective		Debridement (eg, high pressure waterjet with/without suction, sharp selective		Debridement (eg, high pressure waterjet with/without suction, sharp selective		Debridement (eg, high pressure waterjet with/without suction, sharp selective	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 23 Specialty: APMA. ACS, AAFP	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute	Debridement (eg, high pressure waterjet with/without suction, sharp selective		Debridement (eg, high pressure waterjet with/without suction, sharp selective		Debridement (eg, high pressure waterjet with/without suction, sharp selective		Debridement (eg, high pressure waterjet with/without suction, sharp selective	
5		LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD				000	000	000	000	ZZZ	ZZZ	ZZZ	ZZZ
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				\$ 39.13	\$ -	\$ 37.80	\$ -	\$ 10.16	\$ -	\$ 13.93	\$ -
8		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/	0.37	50	0	46	0	14	0	20	0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/	0.37	0	0	0	0	0	0	0	0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/	0.37	47	0	43	0	14	0	20	0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/	0.37	3	0	3	0	0	0	0	0
89	Supply	MEDICAL SUPPLIES	PRICE	UNIT									
90		TOTAL COST OF SUPPLY QUANTITY x PRICE				\$ 19.72	\$ -	\$ 20.02	\$ -	\$ 4.65	\$ -	\$ 6.04	\$ -
91	SA048	pack, minimum multi-specialty visit	1.143	pack		1		1					
92	SB007	drape, sterile barrier 16in x 29in	0.494	item		1		1					
93	SB011	drape, sterile, fenestrated 16in x 29in	0.557	item		1		1				1	
94	SB012	drape, sterile, for Mayo stand	1.688	item		1		1					
95	SB027	gown, staff, impervious	1.186	item		1		1					
96	SB024	gloves, sterile	0.84	pair				1				1	
97	SB044	underpad 2ft x 3ft (Chux)	0.23	item		1		1					
98	SJ028	hydrogen peroxide	0.003	ml		10		10		10		10	
99	SC056	syringe 50-60ml	0.881	item		1		1					
100	SH069	sodium chloride 0.9% irrigation (500-1000ml uou)	2.074	item		1		1		1		1	
101	SG056	gauze, sterile 4in x 4in (10 pack uou)	0.798	item		2		2		1		1	
102	SJ009	basin, irrigation	1.542	item		1		1					
103	SB042	towel, non-sterile	0.391	item		2		2		1		1	
104	SF007	blade, surgical (Bard-Parker)	0.535	item		2		1		1		1	
105	SJ046	silver nitrate applicator	0.07	item		1		1					
106	SG018	bandage, Kling, non-sterile 3in	0.506	item		1		1		1		1	
107	SG035	dressing, 3in x 4in (Telfa, Release)	0.144	item		2		2		2		2	
108	SG052	gauze, self-adherent roll 0.5in to 2in (Fabco, Gauztex)	0.003	inch		72		72					
109	SG079	tape, surgical paper 1in (Micropore)	0.002	inch		12		12		12		12	
110	SA043	pack, cleaning, surgical instruments	5.339	pack		1		1					
111													
114	Equipment Code	EQUIPMENT	Purchase	Equipment	Cost Per Minute								
115		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE				\$ 0.91	\$ -	\$ 0.76	\$ -	\$ 0.34	\$ -	\$ 0.48	\$ -
116	EQ168	light, exam	1630.12	Default	0.00433	37		31		14		20	
117	EF031	table, power	6153.63	Default	0.01633	37		31		14		20	
118	EQ137	instrument pack, basic (\$500-\$1499)	500	Instrument	0.00232	44		37		14		20	
119	EF015	mayo stand	530.76	Default	0.00118	37		31		14		20	

AMA/Specialty Society RVS Update Committee Summary of Recommendations
New Technology/New Services

October 2018

Transitional Care Management Services

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.**

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.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
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	XXX	2.36
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	XXX	3.10

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 99495	Tracking Number	Original Specialty Recommended RVU: 2.36
		Presented Recommended RVU: 2.36
Global Period: XXX	Current Work RVU: 2.11	RUC Recommended RVU: 2.36

CPT Descriptor: 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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: (Adult) An 84-year-old woman with hypertension and osteoarthritis is discharged from the hospital after a 1-week stay for congestive heart failure.

(Child) A 6 year old who is neurologically impaired and developmentally delayed and has a chronic seizure disorder is discharged from the hospital after an admission for breakthrough seizures.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital _____, In the ASC _____, In the office _____

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day _____, Overnight stay-less than 24 hours _____, Overnight stay-more than 24 hours _____

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day _____

Description of Pre-Service Work: (none)

Description of Intra-Service Work: These services are for an established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences upon the date of discharge and continues for the next 29 days.

TCM is comprised of one face-to-face visit within the specified timeframes, in combination with non- face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his/her direction.

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional, may include:

- o communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care;
- o communication with home health agencies and other community services utilized by the patient;
- o patient and/or family/caretaker education to support self-management, independent living, and activities of daily living;
- o assessment and support for treatment regimen adherence and medication management;
- o identification of available community and health resources;
- o facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other qualified health care provider may include:

- o obtaining and reviewing the discharge information (eg, discharge summary, as available, or continuity of care documents);
- o reviewing need for or follow-up on pending diagnostic tests and treatments;
- o interaction with other qualified health care professionals who will assume or reassume care of the patient's system specific problems;
- o education of patient, family, guardian, and/or caregiver;
- o establishment or reestablishment of referrals and arranging for needed community resources;
- o assistance in scheduling any required follow-up with community providers and services.

Description of Post-Service Work: (none)

SURVEY DATA

RUC Meeting Date (mm/yyyy)		10/2018				
Presenter(s):	Audrey Chun, MD, (AGS), Amy Aronsky, DO, (AOA), Megan Adamson, MD (AAFP), Mary Newman, MD (ACP), Kevin Kerber, MD (AAN)					
Specialty Society(ies):	American Academy of Family Physicians, American Academy of Neurology, American College of Physicians, American Geriatrics Society, American Osteopathic Association					
CPT Code:	99495					
Sample Size:	16493	Resp N:	206	Response: 1.2 %		
Description of Sample:	Each medical specialty supplied several thousand randomly pulled members to survey. Halfway through the survey we added more from specialties that has low response rates.					
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	2.00	10.00	25.00	100.00
Survey RVW:		0.01	1.80	2.36	3.00	60.00
Pre-Service Evaluation Time:				0.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		3.00	30.00	47.00	60.00	300.00
Immediate Post Service-Time:	0.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00	99217x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
Sub Obs Care:	0.00	99224x 0.00	99225x 0.00	99226x 0.00		

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the **pre-service time package** that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99495	Recommended Physician Work RVU: 2.36		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time
Pre-Service Evaluation Time:		0.00	0.00	0.00
Pre-Service Positioning Time:		0.00	0.00	0.00
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00
Intra-Service Time:		47.00		
Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
		Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:		0.00	0.00	0.00

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99214	XXX	1.50	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99215	XXX	2.11	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99310	XXX	2.35	RUC Time	1,385,036

CPT Descriptor 1 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99204	XXX	2.43	RUC Time	10,292,014

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 44 **% of respondents:** 21.3 %

Number of respondents who choose 2nd Key Reference Code: 36 **% of respondents:** 17.4 %

TIME ESTIMATES (Median)

	CPT Code: <u>99495</u>	Top Key Reference CPT Code: <u>99214</u>	2nd Key Reference CPT Code: <u>99215</u>
Median Pre-Service Time	0.00	5.00	5.00
Median Intra-Service Time	47.00	25.00	35.00
Median Immediate Post-service Time	0.00	10.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	47.00	40.00	55.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	11%	73%	16%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

0%

18%

82%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

2%

59%

39%

Physical effort required

2%

45%

52%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

5%

14%

82%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

6%

42%

39%

14%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

11%

44%

44%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

11%

64%

25%

Physical effort required

25%

47%

28%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

3%

36%

61%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPOT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

NOTE: Whenever the term physician is used it encompasses physician and other qualified health professionals (QHPs).

The RUC placed codes 99495 and 99496 on the new technology/new services list when it first reviewed these codes in October 2012. These codes have also been identified on the high growth utilization screen. The surveying societies, the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Geriatrics Societies (AGS), the American Academy of Neurology (AAN), and the American Osteopathic Association (AAO) met with the Research Subcommittee and obtained approval of a research tool that included surveys of physician work and clinical staff time. This approach was used because these codes describe team-based care and include face-to-face (FTF) and non-face-to-face (NFTF) services furnished by physicians and by clinical staff under physician supervision. These services are performed episodically during the service period, and the clinical staff services are typically furnished on dates and times other than the physician services.

Background

The survey was randomly distributed to members of the AGS, AAFP, AAN, ACP, and AOA. There were 206 respondents (close to double the 2012 survey respondents 110) for 99495, 90% of whom found the vignette to be typical, and who performed a median of 10 services in the last year.

The summary table includes the results from all respondents as well the specialty specific results. The surveying societies are recommending the median survey work value of 2.36.

Compelling Evidence

As noted, the TCM codes are being surveyed because they were placed on the new technology/new services list. At the time these codes were created, physicians had no experience with the codes even though they may have had experience with the service. In addition, the creation of these codes led physicians to develop the infrastructure and work flows to implement the codes as described. The expert panel believes this change fits into the following criterion for demonstrating compelling evidence:

Evidence that technology has changed physician work (ie, diffusion of technology)

In other words, there was great variability in how physicians were performing transition of care management and the creation of the TCM codes standardized that management and required change in office and physician workflow. The expert panel believes that the original survey results reflected the service as performed before the existence of the codes.

There is now experience with the physician work required to perform the service as described by the TCM codes, and the surveying specialties believe respondents were experienced in the service as described by the codes as opposed to how it was performed previously and that the median work RVUs and times reflect this experience. Specifically, unlike the previous survey, the respondents now have experience with not only the physician work associated with direct patient contact (both FTF and NFTF) but also with the physician work of care coordination and oversight of clinical staff services that are essential components to the service described by the codes.

Furthermore, the societies believe that an inherent presumption to placing codes on the new technology list is that the initial estimation of physician work may need to be revised – up or down - after there is more experience with performing the service.

In further support our compelling evidence arguments; in a recent article July 2018 published in JAMA and referenced below, they state, "Transitional care management services were associated with reduction in mortality and total Medicare costs in the month after they were furnished." This review was conducted during January 1, 2013 and December 31, 2015, the early years of TCM. As the benefits become apparent, the utilization has increased, as the Medicare data has shown. With the increased volume and published benefits more, people have implemented the TCM services and we believe created the infrastructure to perform TCM. This also leads us to the conclusion that another compelling evidence criterion was met as shown by physician work "technique" changes and in physician time as reflected with our survey data. Therefore, we do believe that we have met the compelling evidence criteria.

The JAMA article and study can be found here:

<https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2687989>

The accompanying editorial can be found here:

<https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2687985>

Rationale for 99495

A multi-specialty and multi-disciplinary expert panel (“panel”) reviewed the surveys and developed the following rationale for the recommended work values for 99495.

The panel kept in mind that the TCM codes do not include physician or clinical staff time or work performed for unrelated activities. For example, NTF and FTF care provided for an acute respiratory infection or abdominal pain that occurs during the month a TCM code is reported are not included in the TCM code and are reported separately.

The expert panel believes that the median work RVUs and physician time place each of the codes in proper rank order to established E/M and non-E/M services as well as to each other.

The TCM codes describe the physician work and clinical staff time required to provide TCM for patients discharged from a facility to a non-facility setting. The care begins immediately after the patient is discharged. There is no overlap with discharge care reported under 99238, 99239 or other facility discharge codes. The TCM codes require that:

- contact be made with the patient or caregiver within 2 business days of discharge,
- the patient be seen within 7 or 14 days of discharge (99496 and 99495, respectively), and
- Moderate complexity or high complexity medical decision making (99495 and 99496, respectively) be involved.

All the clinical staff time and physician NTF work related to TCM for a 30-day service period after discharge (i.e., the day of discharge through the next 29 days) and the clinical staff time and physician work related to an FTF visit are included in the TCM code. Because all FTF and NTF time is included in the service, all time is intraservice time, and there is no pre or post service time. Importantly, the total time includes all related clinical staff and physician time for 30 days after discharge.

The expert panel believes that much of the NTF care is delivered by clinical staff under physician supervision and that the FTF visit involves both care delivered by the physician and the clinical staff under supervision of the physician. It is critically important to understand that the FTF visit is not intended to meet the traditional requirements of other E/M services. The only requirement is for a certain level of medical decision making; TCM services are not intended to meet the history and physical examination requirements of current E/M services. For example, the visit (which could be a home visit) could consist primarily of evaluating the functional abilities of a patient and educating the patient and/or caregiver.

Reference Services

99495 – Key Reference and Proxy Services

21% of respondents chose 99214, wRVU 1.50 and times of 5/25/10/40

17% of respondents chose 99215, wRVU of 2.11 and times 5/35/15/55

47% of respondents chose 99214 as the proxy for the face-to-face visit

The expert panel noted that all the key reference services are MPC does.

Complexity/Intensity Measures

For 99495, respondents agreed that the service was clearly more complex and intense than 99214 and, slightly more complex and intense than 99215.

The expert panel noted that the respondents had significant experience performing both services and that the variation in median wRVU and times among specialties was small. We believe this data supports that people are doing this in a more consistent way than done previously.

Then the panel compared the survey median wRVUs and times to the key reference services.

Analysis

99495

The median total time for 99495 was 47 minutes, all of it intraservice, compared with the 25 and 35 minutes of intraservice time for 99214 and 99215 respectively. Even though the total time for 99495 is less than the total time for 99215, it is all intraservice time and is more intense and complex. The societies agree that the survey median of 47 minutes is based on more experience with the service described by 99495 and is a better estimate of time than the previous survey of 40 minutes. Specifically, unlike the previous survey, where the total time was 40 minutes, which is identical to 99214, the additional 7 minutes better accounts for the time of the NTF supervision of clinical staff which, while most intense between the time of discharge and the FTF visit, continues for 30 days.

Comparison of Survey Data to Comparator Codes:

The expert panel noted that all the comparator codes below, except for 90846, are MPC codes and, even though 90846 is not an MPC code, it was reviewed by the RUC in 2017.

CPT Code	Long Desc	Global	Work RVU	Pre Eval Time	Intra Time	Post Time	Total Time	MPC	2017 Utilization
99349	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	XXX	2.33	10	40	15	65	Yes	1167920
SYV Code 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	XXX	2.36	0	47	0	40		576158
90846	Family psychotherapy (without the patient present), 50 minutes	XXX	2.4	0	50	0	50		22737
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	XXX	2.43	5	30	10	45	Yes	10292014

CPT Code: 99495									
99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	XXX	2.61	15	40	20	75	Yes	6878065
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	XXX	3.15	0	63	0	63	Yes	205671

90846, Family psychotherapy (without the patient present), 50 minutes. 90846 has a work RVU of 2.4 and a total time of 50 minutes all of it intraservice. This code was reviewed by the RUC last year and the median work RVU and time for 99495 place it in proper rank order with 90846.

99349, Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family. 99349 has a work RVU of 2.33 with times of 10/40/15/65. The expert panel believes that a work RVU of 2.36 with 47 minutes of intraservice time spent over a month caring for a patient recently discharged from the hospital, which can be reported for new or established patients, places 99495 in proper rank order with 99349.

99222, Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit. which has a work RVU of 2.61 with times of 15/40/20/75. A work RVU of 2.36 for 99495 which requires moderate or complex medical decision making and has 47 minutes of intraservice time places 99495 in the proper rank order with 99222.

99204, Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family. 99204 has a work RVU of 2.43 and times of 5/30/10/45 and the survey median work RVU and time place 99495 in proper rank order with 99204 which has less intra service and less total time but is only reported for new patients whereas 99495 can be reported for established patients.

90962, End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face physician visit per month, which has a work RVU of 3.15 and 63 minutes of total time, all of it intraservice. The expert panel noted that the survey median total time (47 minutes) and work RVU (2.36) are both exactly 75% of the time and work RVU for 90962 demonstrating that the median survey values place 99495 in proper rank order to 90962.

Comparison of 99495 Survey Median times and work RVUs to Current Times and work RVUs

Finally, the panel compared the median work RVUs and times for 99495 to the previous survey data and to each other.

99495 – The median survey time of 47 minutes is 17.5% higher than the time of 40 minutes established in 2013 and the median survey work RVU of 2.36 which is 12% higher than the work RVU of 2.11 established in 2013.

In summary, the expert panel recommends a work RVU of 2.36 and a total time of 47 minutes, all of it intraservice for 99495.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. (not applicable)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99495

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine How often? Sometimes

Specialty Family Medicine How often? Sometimes

Specialty Geriatric Medicine How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 2304632

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare claims data times 4

Specialty Internal Medicine	Frequency 996752	Percentage 43.24 %
Specialty Family Medicine	Frequency 857324	Percentage 37.20 %
Specialty Geriatric Medicine	Frequency 16592	Percentage 0.71 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

576,158 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare claims data

Specialty Internal Medicine	Frequency 249188	Percentage 43.24 %
Specialty Family Medicine	Frequency 214331	Percentage 37.20 %
Specialty Geriatric Medicine	Frequency 4148	Percentage 0.71 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Evaluation Management

BETOS Sub-classification:

BETOS Sub-classification Level II:

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99495

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION

CPT Code: 99496	Tracking Number	Original Specialty Recommended RVU: 3.10
		Presented Recommended RVU: 3.10
Global Period: XXX	Current Work RVU: 3.05	RUC Recommended RVU: 3.10

CPT Descriptor: 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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: (Adult) A 93-year-old man is discharged after hospitalization for a myocardial infarction, complicated by hyperglycemia and delirium.

(Child) A 6-month-old child born at 25 weeks gestation with a diagnosis of chronic lung disease on home oxygen, diuretics, bronchodilators and high caloric formula is discharged from the hospital after admission for respiratory failure.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital _____, In the ASC _____, In the office _____

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day _____, Overnight stay-less than 24 hours _____, Overnight stay-more than 24 hours _____

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day _____

Description of Pre-Service Work: (none)

Description of Intra-Service Work: These services are for an established patient whose medical and/or psychosocial problems require high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences upon the date of discharge and continues for the next 29 days.

TCM is comprised of one face-to-face visit within the specified timeframes, in combination with non- face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his/her direction.

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional, may include:

- o communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care;
- o communication with home health agencies and other community services utilized by the patient;
- o patient and/or family/caretaker education to support self-management, independent living, and activities of daily living;
- o assessment and support for treatment regimen adherence and medication management;
- o identification of available community and health resources;
- o facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other qualified health care provider may include:

- o obtaining and reviewing the discharge information (eg, discharge summary, as available, or continuity of care documents);
- o reviewing need for or follow-up on pending diagnostic tests and treatments;
- o interaction with other qualified health care professionals who will assume or reassume care of the patient's system specific problems;
- o education of patient, family, guardian, and/or caregiver;
- o establishment or reestablishment of referrals and arranging for needed community resources;
- o assistance in scheduling any required follow-up with community providers and services.

Description of Post-Service Work: (none)

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Audrey Chun, MD, (AGS), Amy Aronsky, DO, (AOA), Megan Adamson, MD (AAFP), Mary Newman, MD (ACP), Kevin Kerber, MD (AAN)				
Specialty Society(ies):	American Academy of Family Physicians, American Academy of Neurology, American College of Physicians, American Geriatrics Society, American Osteopathic Association				
CPT Code:	99496				
Sample Size:	16493	Resp N:	201	Response: 1.2 %	
Description of Sample:	Each medical specialty supplied several thousand randomly pulled members to survey. Halfway through the survey we added more from specialties that has low response rates.				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	8.00	20.00	400.00
Survey RVW:	0.01	2.30	3.10	3.70	60.00
Pre-Service Evaluation Time:			0.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	6.00	45.00	60.00	90.00	480.00
Immediate Post Service-Time:	0.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00			
Discharge Day Mgmt:	0.00	99238x 0.00 99239x 0.00 99217x 0.00			
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00			
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00			
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00			

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the **pre-service time package** that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99496	Recommended Physician Work RVU: 3.10		
	Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time	
Pre-Service Evaluation Time:	0.00	0.00	0.00	
Pre-Service Positioning Time:	0.00	0.00	0.00	
Pre-Service Scrub, Dress, Wait Time:	0.00	0.00	0.00	
Intra-Service Time:	60.00			
Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)				
XXX Global Code				
	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time	
Immediate Post Service-Time:	0.00	0.00	0.00	

Post-Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00	

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99215	XXX	2.11	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

SECOND HIGHEST KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99205	XXX	3.17	RUC Time

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99306	XXX	3.06	RUC Time	1,381,549

CPT Descriptor 1 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99205	XXX	3.17	RUC Time	2,894,800

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 43 **% of respondents:** 20.8 %

Number of respondents who choose 2nd Key Reference Code: 37 **% of respondents:** 17.9 %

TIME ESTIMATES (Median)

	CPT Code: <u>99496</u>	Top Key Reference CPT Code: <u>99215</u>	2nd Key Reference CPT Code: <u>99205</u>
Median Pre-Service Time	0.00	5.00	7.00
Median Intra-Service Time	60.00	35.00	45.00
Median Immediate Post-service Time	0.00	15.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	60.00	55.00	67.00
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

<u>Top Key Reference Code</u>	<u>Much Less</u>	<u>Somewhat Less</u>	<u>Identical</u>	<u>Somewhat More</u>	<u>Much More</u>
Overall intensity/complexity	0%	0%	21%	42%	37%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

0%

23%

77%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

5%

58%

37%

Physical effort required

9%

51%

40%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

0%

14%

86%

2nd Key Reference Code**Much
Less****Somewhat
Less****Identical****Somewhat
More****Much
More****Overall intensity/complexity**

0%

5%

43%

27%

24%

Mental Effort and Judgment**Less****Identical****More**

- The number of possible diagnosis and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed
- Urgency of medical decision making

0%

59%

41%

Technical Skill/Physical Effort**Less****Identical****More**

Technical skill required

5%

68%

27%

Physical effort required

8%

57%

35%

Psychological Stress**Less****Identical****More**

- The risk of significant complications, morbidity and/or mortality
- Outcome depends on the skill and judgment of physician
- Estimated risk of malpractice suit with poor outcome

5%

38%

57%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

NOTE: Whenever the term physician is used it encompasses physician and other qualified health professionals (QHPs).

The RUC placed codes 99495 and 99496 on the new technology/new services list when it first reviewed these codes in October 2012. These codes have also been identified on the high growth utilization screen. The surveying societies, the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Geriatrics Societies (AGS), the American Academy of Neurology (AAN), and the American Osteopathic Association (AAO) met with the Research Subcommittee and obtained approval of a research tool that included surveys of physician work and clinical staff time. This approach was used because these codes describe team-based care and include face-to-face (FTF) and non-face-to-face (NFTF) services furnished by physicians and by clinical staff under physician supervision. These services are performed episodically during the service period, and the clinical staff services are typically furnished on dates and times other than the physician services.

Background

The survey was randomly distributed to members of the AGS, AAFP, AAN, ACP, and AOA. For 99496 there were 201 respondents (again close to double the 2012 survey respondents 110), 94% of whom found the vignette typical and who performed a median of 8 services in the last year.

The summary table includes the results from all respondents as well as the specialty specific results. The surveying specialties are recommending the median survey work value of 3.10.

Compelling Evidence

As noted, the TCM codes are being surveyed because they were placed on the new technology/new services list. At the time these codes were created, physicians had no experience with the codes even though they may have had experience with the service. In addition, the creation of these codes led physicians to develop the infrastructure and work flows to implement the codes as described. The expert panel believes this change fits into the following criterion for demonstrating compelling evidence:

Evidence that technology has changed physician work (ie, diffusion of technology)

In other words, there was great variability in how physicians were performing transition of care management and the creation of the TCM codes standardized that management and required change in office and physician workflow. The expert panel believes that the original survey results reflected the service as performed before the existence of the codes.

There is now experience with the physician work required to perform the service as described by the TCM codes, and the surveying specialties believe respondents were experienced in the service as described by the codes as opposed to how it was performed previously and that the median work RVUs and times reflect this experience. Specifically, unlike the previous survey, the respondents now have experience with not only the physician work associated with direct patient contact (both FTF and NFTF) but also with the physician work of care coordination and oversight of clinical staff services that are essential components to the service described by the codes.

Furthermore, the societies believe that an inherent presumption to placing codes on the new technology list is that the initial estimation of physician work may need to be revised – up or down - after there is more experience with performing the service.

In further support our compelling evidence arguments; in a recent article July 2018 published in JAMA and referenced below, they state, "Transitional care management services were associated with reduction in mortality and total Medicare costs in the month after they were furnished." This review was conducted during January 1, 2013 and December 31, 2015, the early years of TCM. As the benefits become apparent, the utilization has increased, as the Medicare data has shown. With the increased volume and published benefits more, people have implemented the TCM services and we believe created the infrastructure to perform TCM. This also leads us to the conclusion that another compelling evidence criterion was met as shown by physician work "technique" changes and in physician time as reflected with our survey data. Therefore, we do believe that we have met the compelling evidence criteria.

The JAMA article and study can be found here:

<https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2687989>

The accompanying editorial can be found here:

<https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2687985>

Rationale for 99496

A multi-specialty and multi-disciplinary expert panel (“panel”) reviewed the surveys and developed the following rationale for the recommended work values for 99496.

The panel kept in mind that the TCM codes do not include physician or clinical staff time or work performed for unrelated activities. For example, NFTF and FTF care provided for an acute respiratory infection or abdominal pain that occurs during the month a TCM code is reported are not included in the TCM code and are reported separately.

The expert panel believes that the median work RVUs and physician time place each of the codes in proper rank order to established E/M and non-E/M services as well as to each other.

The TCM codes describe the physician work and clinical staff time required to provide TCM for patients discharged from a facility to a non-facility setting. The care begins immediately after the patient is discharged. There is no overlap with discharge care reported under 99238, 99239 or other facility discharge codes. The TCM codes require that:

- contact be made with the patient or caregiver within 2 business days of discharge,
- the patient be seen within 7 or 14 days of discharge (99496 and 99495, respectively), and
- Moderate complexity or high complexity medical decision making (99495 and 99496, respectively) be involved.

All the clinical staff time and physician NFTF work related to TCM for a 30-day service period after discharge (i.e., the day of discharge through the next 29 days) and the clinical staff time and physician work related to an FTF visit are included in the TCM code. Because all FTF and NFTF time is included in the service, all time is intraservice time, and there is no pre or post service time. Importantly, the total time includes all related clinical staff and physician time for 30 days after discharge.

The expert panel believes that much of the NFTF care is delivered by clinical staff under physician supervision and that the FTF visit involves both care delivered by the physician and the clinical staff under supervision of the physician. It is critically important to understand that the FTF visit is not intended to meet the traditional requirements of other E/M services. The only requirement is for a certain level of medical decision making; TCM services are not intended to meet the history and physical examination requirements of current E/M services. For example, the visit (which could be a home visit) could consist primarily of evaluating the functional abilities of a patient and educating the patient and/or caregiver.

Reference Services

99496 – Key Reference and Proxy Services

21% of respondents chose 99215, wRVU of 2.11 and times of 5/35/15/55

18% of respondents chose 99205, wRVU of 3.17 and times of 7/45/15/67

52% of respondents chose 99215 as the proxy for the face-to-face visit

The expert panel noted that all the key reference services are MPC does.

Complexity/Intensity Measures

For 99496, respondents agreed that the service was much more complex and intense than 99215 and more similar to 99205 in complexity and intensity.

The expert panel noted that the respondents had significant experience performing both services and that the variation in median wRVU and times among specialties was small. We believe this data supports that people are doing this in a more consistent way than done previously.

Then the panel compared the survey median wRVUs and times to the key reference services.

Analysis

99496

The expert panel notes that the survey median (and total) time of 60 minutes is much longer than the intraservice and total time for 99215. More importantly, 60 minutes is just 7 minutes less than the total time for 99205 which has a work RVU of 3.17. This places the 3.10 survey median work RVU for 99496 in proper rank order to 99205.

Comparison of Survey Data to Comparator Codes

The expert panel noted that all the comparator codes below are MPC codes.

CPT Code	Long Desc	Global	Work RVU	Pre Eval Time	Intra Time	Post Time	Total Time	MPC	2017 Utilization
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	XXX	2.43	5	30	10	45	Yes	10292014
99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	XXX	2.61	15	40	20	75	Yes	6878065
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	XXX	3.10	0	60	0	60		546526
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	XXX	3.15	0	63	0	63	Yes	205671
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	XXX	3.17	7	45	15	67	Yes	2894800

90962, End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face physician visit per month, which has a work RVU of 3.15 and 63 minutes of total time, all of it intraservice. The survey median

work RVU of 3.10 for 99496 which is 98% of 3.15 and the survey median time of 60 minutes which is 95% of 63 minutes, places it in proper rank order with 90962.

99205, Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family. 99205 has a work RVU of 3.17 and times of 7/45/15/67. The survey median work RVU and times for 99496 place it in proper rank order with 99205 as 99496 has 7 fewer total minutes but 15 more intraservice minutes.

Comparison of 99495 and 99496 Survey Median times and work RVUs to Current Times and work RVUs

Finally, the panel compared the median work RVUs and times for 99495 and 99496 to the previous survey data and to each other.

99496 – The median survey time of 60 minutes is 20% higher than the time of 50 minutes established in 2013, and the median survey work RVU of 3.10 is 2% higher than the work RVU of 3.05 established in 2013.

The median survey time of 60 minutes for 99496 and the median survey work RVU of 3.10 are 28% and 31% more than the median survey time and work RVU of 99495 (47 minutes and 2.36) respectively. These comparisons support the current survey medians and demonstrate that those medians place these two codes in proper rank order with each other.

In summary, the expert panel recommends a work RVU of 3.10 with a total time of 60 minutes, all of it intraservice for 99496.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. (not applicable)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99496

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine

How often? Sometimes

Specialty Family Medicine

How often? Sometimes

Specialty Geriatric Medicine

How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 2186104

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare claims data times 4

Specialty Internal MedicineI	Frequency 996644	Percentage 45.58 %
Specialty Family Medicine	Frequency 826128	Percentage 37.78 %
Specialty Geriatric Medicine	Frequency 20112	Percentage 0.91 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 546,526 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2017 Medicare claims data

Specialty Internal Medicine	Frequency 249161	Percentage 45.58 %
Specialty Family Medicine	Frequency 206532	Percentage 37.78 %
Specialty Geriatric Medicine	Frequency 5028	Percentage 0.91 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:

BETOS Sub-classification Level II:

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99496

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

ISSUE: Transitional Care Management
TAB: 24- Medical Specialty Detail

Vig Typical	Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	PRE-TIME		INTRA-TIME					IMMD POST	SURVEY EXPERIENCE				
						MIN	25th	MED	75th	MAX		EVAL	POSIT	MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX
21%	1st REF	99214	Office or other outpatient visit for the evaluation and management of the patient	44	0.047			1.50			40	5			25			10						
17%	2nd REF	99215	Office or other outpatient visit for the evaluation and management of the patient	36	0.047			2.11			55	5			35			15						
47%	Proxy V	99214	Office or other outpatient visit for the evaluation and management of the patient	96	0.047			1.50			40	5			25			10						
	CURRENT	99495	TCM, MDM moderate, F2F within 14 days of discharge		0.053			2.11			40	0			40			0						
95%	Internal Med	99495	TCM, MDM moderate, F2F within 14 days of discharge	60	0.051	0.61	1.84	2.28	3.00	60.00	45			4	30	45	60	180		0	5	14	26	100
91%	Family Med	99495	TCM, MDM moderate, F2F within 14 days of discharge	23	0.057	0.01	1.74	2.00	2.53	4.50	35			7	30	35	45	120		0	2	10	20	50
88%	Geriatrics	99495	TCM, MDM moderate, F2F within 14 days of discharge	94	0.045	0.01	1.84	2.35	3.00	30.00	53			13	30	53	74	300		0	1	8	24	100
88%	Neurology	99495	TCM, MDM moderate, F2F within 14 days of discharge	17	0.042	0.01	2.01	2.50	3.50	10.00	60			3	50	60	65	120		0	0	5	50	100
83%	Pediatrics	99495	TCM, MDM moderate, F2F within 14 days of discharge	12	0.064	1.20	1.75	2.47	2.81	5.62	39			21	30	39	60	90		0	0	4	15	72
90%	Total SVY	99495	TCM, MDM moderate, F2F within 14 days of discharge	206	0.050	0.01	1.80	2.36	3.00	60.00	47			3	30	47	60	300		0	2	10	25	100
	REC	99495	TCM, MDM moderate, F2F within 14 days of discharge		0.050	2.36					47				47									
21% 18% 52%	1st REF	99215	Office or other outpatient visit for the evaluation and management of the patient	43	0.047			2.11			55	5			35			15						
	2nd REF	99205	Office or other outpatient visit for the evaluation and management of the patient	37	0.059			3.17			67	7			45			15						
	Proxy V	99215	Office or other outpatient visit for the evaluation and management of the patient	104	0.047			2.11			55	5			35			15						
CMS revised time	CURRENT	99496	TCM, MDM high complexity , F2F within 7 days of discharge		0.061			3.05			50	0			50			0						
97%	Internal Med	99496	TCM, MDM high complexity , F2F within 7 days of discharge	59	0.052	0.81	2.40	3.10	3.70	60.00	60			6	38	60	90	360		0	4	10	20	150
91%	Family Med	99496	TCM, MDM high complexity , F2F within 7 days of discharge	23	0.062	0.01	2.24	3.10	3.85	5.00	50			14	33	50	60	180		0	1	6	10	50
96%	Geriatrics	99496	TCM, MDM high complexity , F2F within 7 days of discharge	94	0.044	0.01	2.30	3.05	3.58	30.00	70			15	45	70	94	480		0	2	8	23	400
81%	Neurology	99496	TCM, MDM high complexity , F2F within 7 days of discharge	16	0.043	0.01	2.88	3.52	3.85	10.00	83			6	60	83	99	129		0	0	4	20	50
78%	Pediatrics	99496	TCM, MDM high complexity , F2F within 7 days of discharge	9	0.051	1.20	3.00	3.30	3.50	9.83	65			30	45	65	90	110		0	0	2	10	48
94%	Total SVY	99496	TCM, MDM high complexity, F2F within 7 days of discharge	201	0.052	0.01	2.30	3.10	3.70	60.00	60			6	45	60	90	480		0	1	8	20	400
	REC	99496	TCM, MDM high complexity, F2F within 7 days of discharge		0.052	3.10					60				60									

Specialty Societies American Academy of Family Physicians, American Academy of Neurology, American College of Physicians, American Geriatrics Society, American Osteopathic Association

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs**

CPT Long Descriptor:

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

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

Global Period: **XXX** Meeting Date: **October 2018—REVISED 10-3-2018**

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

The joint societies requested the RUC create a workgroup to develop a PE survey tool to use with non-face-to-face (non-F2F) services, including the TCM codes CPT 99495 and 99496. We outlined concerns with prior surveys in our letter, specifically that prior surveys did not include any case managers' input directly.

Our societies collaborated by phone and email with the AMA staff and PE Subcommittee chair on several occasions and held multiple calls with the Research Subcommittee to define a non-F2F survey tool that would better reflect the details of the clinical staff activities that would be necessary for a productive PE Subcommittee discussion for non-F2F services. The Research Subcommittee approved a new non-F2F survey tool, and that survey was sent to case managers identified by physician respondents to the survey of physician work as well as physicians who indicated they did the work otherwise done by clinical staff. We received a total response of 33 completed PE surveys from 30 different sites across the US.

A joint consensus panel of experts from the surveying societies, including advisors and experts in TCM services, met by phone and email to review the survey results and develop the recommendations for inputs based on the survey responses. As we would do with any survey, the consensus panel reviewed, the number of participants, the number of sites and the 25th percentile, median, and all survey data collected below:

(Note this new survey did not ask the clinical staff performance rate and we recommend it be added to future non face to face services survey templates)

Clinical Intra Service Time 99495	Clinical Intra Service Time 99496	Clinical Performance Rate 99495	Clinical Performance Rate 99496	
15	10	Not asked	Not asked	Min
35	60			25th
60	90			Median
90	150			75th
180	180			Max
120	150			Mode
33	33			Total Count

Specialty Societies American Academy of Family Physicians, American Academy of Neurology, American College of Physicians, American Geriatrics Society, American Osteopathic Association

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

The consensus panel of experts chose CPT 99214 as the comparison proxy code for the face-to-face visit included in code 99495 as it was chosen by the physician work survey respondents and it also maintains consistency with the original survey in 2012.

The consensus panel of experts chose CPT 99215 as the comparison proxy code for the face-to-face visit included in code 99496 as it was chosen by the physician work survey respondents and it also maintains consistency with the original survey in 2012.

3. Is this code(s) typically billed with an E/M service? **No**
Is this code(s) typically billed with the E/M service in the nonfacility? **No**
(Please see provided data in PE Subcommittee folder)
4. What specialty is the dominant provider in the nonfacility? **Internal Medicine**
What percent of the time does the dominant provider provide the service(s) in the nonfacility? **43% (99495) & 46% (99496)**
Is the dominant provider in the nonfacility different then for the global? **No**
(Please see provided data in PE Subcommittee folder)
5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: **N/A**

If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

Compelling Evidence

At the time these codes were created, physicians and clinical staff had no experience with the codes, even though they may have had experience with the service. In addition, the creation of these codes led physicians and clinical staff to develop the infrastructure and work flows to implement the codes as described. Additionally, when first surveyed by the specialty societies, these surveys were only distributed to physicians for input, and with this survey, we also surveyed their clinical case managers directly with an approved survey tool from the Research Subcommittee. The expert panel believes these changes fit into several of the following criteria for demonstrating compelling evidence:

- Evidence that technology has changed physician work and clinical staff time (ie, diffusion of technology)
- Documentation or other reliable data that there have been changes in the clinical staff time, to one or more of the following:
 - technique

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- knowledge/technology
- physician time

In other words, there was great variability in how physicians and case managers were performing transitional care management, and the creation of the TCM codes standardized that management and required change in office and physician workflow. The expert panel believes that the original survey results reflected the service as performed before the existence of the codes.

There is now experience with the physician work and clinical staff time required to perform the service as described by the TCM codes, and the surveying specialties believe respondents were experienced in the service as described by the codes as opposed to how it was performed previously and that the median survey times from the PE survey reflect this experience. Specifically, unlike the previous survey, the respondents now have experience with not only the clinical staff work associated with direct patient contact (both F2F and non-F2F) but also with the clinical staff work of care coordination that is an essential component to the service described by the codes.

This also leads us to the conclusion that another compelling evidence criterion was met as shown by “technique” changes and in clinical time as reflected with our survey data. Therefore, we do believe that we have met the compelling evidence criteria.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: **N/A**

7. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) **5 minutes**

The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

Vitals obtained;

Height

Weight

Heart Rate/Pulse

Blood Pressure

Respiration

8. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time*:

Service Period Clinical Labor Activities:

Assist physician during exam; since we are using the survey proxy visit the activities and time are pulled from the proxy code in these cases 99214 and 99215. The research committee suggested we not modify those times or inputs, therefore no further details are given as they crosswalk to the 99214 and 99215.

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9. If you have used a percentage of the physician intra-service work time other than 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *For the clinical staff time associated with the required FTF visit, the same proxy was chosen for 99214 and 99215; per Research Subcommittee, we did not survey the clinical staff time or activities associated with the visit; we surveyed the level of visit and are using those times as identified with no modifications.*

10. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: **N/A**

Line 99 non-FTF services as outlined in detail below per the survey with survey responses.

Survey Details of Intra Service time for TCM services:

(Note: the below values are medians of the estimated percentages of the activities, therefore we would not expect the totals to add to 100%.)

Percentage Breakdown 99495	Communication (with patient, family members, guardian or caretaker, surrogate decision makers	Patient and/or family/caretaker education to support self-management, independent living,	Communication with home health agencies and other community services utilized by the patient; identification of available community and health resources; facilitating access to care and services needed by the patient and/or family	Other activities
Min	20 %	5 %	10 %	0 %
25th	40 %	20 %	20 %	0 %
Median	50 %	20 %	23 %	0 %
75th	60 %	30 %	30 %	0 %
Max	80 %	50 %	34 %	40 %
Mode	50 %	20 %	30 %	0 %
Total Count	33	33	33	33

Percentage Breakdown 99496	Communication (with patient, family members, guardian or caretaker, surrogate decision makers	Patient and/or family/caretaker education to support self-management, independent living,	Communication with home health agencies and other community services utilized by the patient; identification of available community and health resources; facilitating access to care and services needed by the patient and/or family	Other activities
Min	15 %	0 %	0 %	0 %
25th	50 %	20 %	20 %	0 %
Median	50 %	30 %	20 %	0 %
75th	60 %	30 %	25 %	0 %
Max	100 %	50 %	34 %	15 %
Mode	50 %	30 %	20 %	0 %
Total Count	33	33 %	33 %	33 %

11. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at <http://www.bls.gov>. **N/A**

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12. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**
13. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**
14. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:
Selected default
 exam table EF023, otoscope-ophthalmoscope (wall unit) EQ189. Both equipment times were calculated by totaling the service period times (rows 34 – 68)
15. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: **N/A**
16. If there is any other item on your spreadsheet that needs further explanation, please include here: **N/A**
18. Please include an explanation of each line item:

Demographics of the PE survey:

Of the 33 respondents from 30 different sites; 30 identified the clinical staff type as an RN with no additional details as to the provider of the service; 3 respondents identified the clinical staff type as a Medical/Technical Assistant (MTA).

Those taking the survey identified themselves as the following:

Total	Description
4	MD or DO
1	Nurse Practitioner
1	Pharm D
1	Doctor of Nursing, specialty pediatric transitional care mgt
5	RN alone
8	Certified case manager
4	Masters case manger
1	Master RN
3	BSN or BSN case manager
3	MTA
2	Did not answer
33	Total

	A	B	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	RUC Practice Expense Spreadsheet					REFERENCE CODE	CURRENT	RECOMMENDED	REFERENCE CODE	CURRENT	RECOMMENDED	REFERENCE CODE	CURRENT	RECOMMENDED	REFERENCE CODE	CURRENT	RECOMMENDED
2		Please see other summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.				99214	99495	99495	99215	99496	99496	99215	99496	99496	99215	99496	99496
3		RUC Collaboration Website				Office or other outpatient visit for the evaluation and management of an	Transitional Care Management Services with the following required elements:	Transitional Care Management Services with the following required elements:	Office or other outpatient visit for the evaluation and management of an	Transitional Care Management Services with the following required elements:	Transitional Care Management Services with the following required elements:	Office or other outpatient visit for the evaluation and management of an	Transitional Care Management Services with the following required elements:	Transitional Care Management Services with the following required elements:	Office or other outpatient visit for the evaluation and management of an	Transitional Care Management Services with the following required elements:	Transitional Care Management Services with the following required elements:
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 24 - REVISED 10-3-2018 Specialty: AAFP, AAN, ACP, AGS AOA	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute												
5		LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD				XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				\$ 22.81	\$ -	\$ 39.49	\$ -	\$ 45.72	\$ -	\$ 26.54	\$ -	\$ 52.98	\$ -	\$ 61.31	\$ -
8		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	53.0	0.0	92.0	0.0	107.0	0.0	63.0	0.0	125.0	0.0	145.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	3.0	0.0	3.0	0.0	3.0	0.0	4.0	0.0	4.0	0.0	4.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	44.0	0.0	44.0	0.0	44.0	0.0	51.0	0.0	51.0	0.0	51.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	6.0	0.0	6.0	0.0	6.0	0.0	8.0	0.0	8.0	0.0	8.0	0.0
12		TOTAL POST-SERVICE CLINICAL STAFF TIME	L042A	RN/LPN	0.42	45.0	0.0	45.0	0.0	60.0	0.0	70.0	0.0	70.0	0.0	90.0	0.0
13		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE				\$ 19.61	\$ -	\$ 36.29	\$ -	\$ 42.59	\$ -	\$ 23.31	\$ -	\$ 49.75	\$ -	\$ 58.15	\$ -
14		PRE-SERVICE PERIOD															
15		Start: Following visit when decision for surgery or procedure made															
16	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37												
17	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37												
18	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37												
19	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37												
20	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37												
21	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37	3		3				4		4			
22	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37					3						4	
23	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37												
27		Other activity:	L037D	RN/LPN/MTA	0.37												
30		End: When patient enters office/facility for surgery/procedure															
31		SERVICE PERIOD															
32		Start: When patient enters office/facility for surgery/procedure:															
33		Pre-Service (of service period)															
34	CA009	Greet patient, provide gowning, ensure appropriate medical records are	L037D	RN/LPN/MTA	0.37	3		3		3		3		3		3	
35	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37	5		5		5		5		5		5	
36	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37												
37	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37												
38	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37	2		2		2		2		2		2	
39	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37												
40	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37												
41	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37	2		2		2		2		2		2	
42	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37												
49		Intra-service (of service period)															
50	CA018	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37	5		5		5		6		6		6	
51	CA019	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37												
52	CA020	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37												
53	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37												
60		Post-Service (of service period)															
61	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37												
62	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37												
63	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37	3		3		3		3		3		3	
64	CA025	Clean scope	L037D	RN/LPN/MTA	0.37												
65	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37												
66	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37												
67	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37												
68	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37	11		11		11		15		15		15	
69	CA030	Technologist QC's images in PACS, checking for all images, reformats,	L037D	RN/LPN/MTA	0.37												
70	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37												
71	CA032	Scan exam documents into PACS. Complete exam in RIS system to	L037D	RN/LPN/MTA	0.37												
72	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37												
73	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry	L037D	RN/LPN/MTA	0.37												
74	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37	13		13		13		15		15		15	
75	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	n/a		n/a		n/a		n/a		n/a		n/a	
83		POST-SERVICE PERIOD															
84		Start: Patient leaves office/facility															
85	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37	6						8					
86	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37												
87	CA038	Coordinate post-procedure services	L042A	RN/LPN	0.42												

	A	B	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	RUC Practice	Expense Spreadsheet				REFERENCE CODE		CURRENT		RECOMMENDED		REFERENCE CODE		CURRENT		RECOMMENDED	
2		<p><i>Please see other summaries or the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.</i></p> <p><i>*Please do not modify formulas in gray shaded cells</i></p> <p><i>*Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i></p>				99214		99495		99495		99215		99496		99496	
3		RUC Collaboration Website															
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 24 - REVISED 10-3-2018 Specialty: AAFF, AAN, ACP, AGS AOA	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute	Office or other outpatient visit for the evaluation and management of an		Transitional Care Management Services with the following required elements:		Transitional Care Management Services with the following required elements:		Office or other outpatient visit for the evaluation and management of an		Transitional Care Management Services with the following required elements:		Transitional Care Management Services with the following required elements:	
5		LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD				XXX		XXX		XXX		XXX		XXX		XXX	
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				\$ 22.81	\$ -	\$ 39.49	\$ -	\$ 45.72	\$ -	\$ 26.54	\$ -	\$ 52.98	\$ -	\$ 61.31	\$ -
8		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	53.0	0.0	92.0	0.0	107.0	0.0	63.0	0.0	125.0	0.0	145.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	3.0	0.0	3.0	0.0	3.0	0.0	4.0	0.0	4.0	0.0	4.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	44.0	0.0	44.0	0.0	44.0	0.0	51.0	0.0	51.0	0.0	51.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	6.0	0.0		0.0		0.0	8.0	0.0		0.0		0.0
98		Other activity: Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	0.37												
99	NEW	Other activity: communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care; communication with home health agencies and other community services utilized by the patient; patient and/or family/caretaker education to support self-management, independent living, and activities of daily living; assessment and support for treatment regimen adherence and medication management; identification of available community and health resources; facilitating access to care and services needed by the patient and/or family	L042A	RN/LPN	0.42			45		60				70		90	
100		Other activity: please include short clinical description here and type	L037D														
101		End: with last office visit before end of global period															

	A	B	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	RUC Practice	Expense Spreadsheet				REFERENCE CODE		CURRENT		RECOMMENDED		REFERENCE CODE		CURRENT		RECOMMENDED	
2		<i>Please see other summaries or the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.</i>				99214		99495		99495		99215		99496		99496	
3		RUC Collaboration Website															
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 24 - REVISED 10-3-2018 Specialty: AAFP, AAN, ACP, AGS AOA	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute	Office or other outpatient visit for the evaluation and management of an		Transitional Care Management Services with the following required elements:		Transitional Care Management Services with the following required elements:		Office or other outpatient visit for the evaluation and management of an		Transitional Care Management Services with the following required elements:		Transitional Care Management Services with the following required elements:	
5		LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD				XXX		XXX		XXX		XXX		XXX		XXX	
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				\$ 22.81	\$ -	\$ 39.49	\$ -	\$ 45.72	\$ -	\$ 26.54	\$ -	\$ 52.98	\$ -	\$ 61.31	\$ -
8		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	53.0	0.0	92.0	0.0	107.0	0.0	63.0	0.0	125.0	0.0	145.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	3.0	0.0	3.0	0.0	3.0	0.0	4.0	0.0	4.0	0.0	4.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	44.0	0.0	44.0	0.0	44.0	0.0	51.0	0.0	51.0	0.0	51.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	6.0	0.0		0.0		0.0	8.0	0.0		0.0		0.0
102	Supply Code	MEDICAL SUPPLIES	PRICE	UNIT													
103		TOTAL COST OF SUPPLY QUANTITY x PRICE				\$ 2.98	\$ -	\$ 2.98	\$ -	\$ 2.98	\$ -	\$ 2.98	\$ -	\$ 2.98	\$ -	\$ 2.98	\$ -
104	SA047	pack, EM visit	2.984	pack		1		1		1		1		1		1	
110		Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A															
112	Equipment Code	EQUIPMENT	Purchase Price	Equipment Formula	Cost Per Minute												
113		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE				\$ 0.21	\$ -	\$ 0.21	\$ -	\$ 0.15	\$ -	\$ 0.25	\$ -	\$ 0.25	\$ -	\$ 0.17	\$ -
114	EF023	table, exam	1338.17	Default	0.002976617	44		44		31		51		51		36	
115	EQ189	otoscope-ophthalmoscope (wall unit)	694	Default	0.001841686	44		44		31		51		51		36	
120		Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A															