AMA/Specialty RVS Update Committee
Meeting Minutes
April 26-28, 2012

I. Welcome and Call to Order

Doctor Barbara Levy called the meeting to order on Thursday, April 26, 2012, at 3:00 pm. The following RUC Members were in attendance:

Barbara Levy, MD	Allan A. Anderson, MD*
Michael D. Bishop, MD	Margie C. Andreae, MD*
James Blankenship, MD	Gregory L. Barkley, MD
Dale Blasier, MD	Gregory DeMeo, MD
Albert Bothe, MD	Jane Dillon, MD
Joel Bradley, Jr., MD	William D. Donovan, MD
Ronald Burd, MD	Jeffrey Paul Edelstein, MD
Scott Collins, MD	Brian Galinat, MD*
John O. Gage, MD	Gilbert Johnston, MD*
William F. Gee, MD	John Lanza, MD*
Anthony Hamm, DC	M. Douglas Leahy, MD*
David C. Han, MD	Burton L. Lesnick, MD, FAAP*
David F. Hitzeman, DO	William J Mangold, Jr.,MD*
Charles F. Koopmann, Jr., MD	Terry L. Mills, MD*
Timothy Laing, MD	Eileen Moynihan, MD*
Walt Larimore, MD	Margaret Neal, MD*
Alan Lazaroff, MD	Scott D. Oates, MD*
Brenda Lewis, DO	Chad A. Rubin, MD, FACS*
J. Leonard Lichtenfeld, MD	M. Eugene Sherman, MD*
Scott Manaker, MD, PhD	Daniel Mark Siegel, MD*
Bill Moran, Jr., MD	Norman Smith, MD*
Gregory Przybylski, MD	Holly Stanley, MD*
Marc Raphaelson, MD	Stanley W. Stead, MD, MBA*
Sandra B. Reed, MD	Robert J. Stomel, DO*
Peter Smith, MD	G. Edward Vates, MD*
Arthur Traugott, MD	Jane White, PhD, RD, FADA, LDN*
J. Allan Tucker, MD	Jennifer L. Wiler, MD*
James C. Waldorf, MD	
George Williams, MD	*Alternate

II. Chair's Report

- Doctor Levy welcomed everyone to the RUC Meeting.
- Doctor Levy welcomed the following Center for Medicare & Medicaid Services (CMS) staff and representatives attending the meeting:
    - Jonathan Blum - Deputy Administrator and Director, Center for Medicare
    - Kathy Bryant – Deputy Director, Division of Practitioner Services
    - Edith Hambrick, MD – CMS Medical Officer
    - Ryan Howe – Senior Policy Analyst
    - Sara Vitolo, MSPH – Policy Analyst
    - Ferhat Kassamali – L&M Policy Research

- Doctor Levy welcomed the following Contractor Medical Director:
  - Charles Haley, MD, MS, FACP
- Doctor Levy welcomed the following MedPAC representative:
  - Ariel Winter
- Doctor Levy welcomed the following observers:
  - Miriam Laugesen, PhD, Assistant Professor of Health Policy and Management at Columbia University's Mailman School of Public Health. Dr. Laugesen has received funding from The Robert Wood Johnson Foundation to develop a book that reviews the implementation of the RBRVS and Medicare physician payment.
- Doctor Levy welcomed the following new RUC members:
  - Alan Lazaroff, MD – American Geriatric Society
- Doctor Levy said farewell and thanked the following departing RUC members:
  - Bibb Allen, MD – American College of Radiology (member since 2006)
  - Scott Manaker, MD – ACCP – Internal Medicine rotating seat
  - Bill Moran, MD – PEAC, PERC, PE Subcommittee Chair (since 2000)
  - Arthur Traugott, MD – AMA Representative Alternate/AMA Representative/HCPAC Chair (since 2000)
- A reminder that there is a confidentiality policy that needs to be signed at the registration table.
- Proceedings are recorded in order for RUC staff to create the meeting minutes.
- Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue.
- RUC members or alternates sitting at the table may not present or debate for their specialty. The RUC is an expert panel and individuals are to exercise their independent judgment and are not advocates for their specialty.

III. Administrative Subcommittee (Tab 54)

Doctor Blasier provided the Administrative Subcommittee Conference Call Report:

- Publication of the RUC vote count – at the January 2012 RUC meeting it was decided to publish the RUC total vote count after the publication of the final rule. The RUC requested that the Administrative Subcommittee discuss what information and vote counts will be published and how this documentation should appear. The documentation of voting will begin with the October 2012 meeting , following publication of the November 2013 Final Rule for the 2014 Medicare Physician Payment Schedule. The Administrative Subcommittee discussed and recommends that the following total RUC vote information be published:
  1. CPT code
  2. Long descriptor
  3. Pre-facilitation: Yes/No
  4. Pre-facilitation/reviewer comments resulted in a modified specialty recommendation: Yes/No
  5. Specialty Society recommendation to the RUC passed: Yes/No
  6. Specialty Society recommendation facilitated by the RUC: Yes/No
  7. Specialty Society recommendation value modified by the RUC: Yes/No
  8. Final RUC vote: 28-0

  (*Procedural Note: If voting on facilitation report, clicker vote must be taken to capture full vote count*)

- Review of financial disclosures pertinent to this meeting – The Administrative Subcommittee reviewed the financial disclosures submitted by Henry Woo, MD from the Congress of Neurological Surgeons for tab 14 Cervicocerebral Angiography. Doctor Woo had indicated three financial interests each >$10,000. The Subcommittee understands that these disclosures relate to the cervicocerebral angiography presented in tab 14. The Subcommittee reviewed the disclosed and additional information provided by Doctor Woo and determined that he had too great of a financial interest to present Tab 14 Cervicocerbral Angiography. The Subcommittee determined that Doctor Woo may not present at the RUC table or attend the RUC meeting.
- The Administrative Subcommittee reviewed the nominations for the Internal Medicine and Primary Care rotating seats. Lawrence Martinelli, MD, from Infectious Diseases Society of America is the only physician nominated for the Internal Medicine rotating seat. Four physicians are nominated for the Primary Care rotating seat:
    - M. Douglas Leahy, MD, MACP – American College of Physicians
    - Paul A. Martin, DO, FACOFP *dist*. – American Osteopathic Association
    - Terry Lee Mills, Jr., MD FAAFP – American Academy of Family Physicians
    - Richard H. Tuck, MD, FAAP – American Academy of Pediatrics
    - The Administrative Subcommittee reviewed the Rotating Seat Policies and Election Rules, Primary Care rotating seat candidate eligibility:
        - The Primary Care rotating seat candidate must be in active clinical practice, with at least 50% of their professional time in direct patient care.
        - The Primary Care rotating seat candidate must present documentation that he/she is defined as a primary care physician by Medicare (i.e., primary care bonus eligibility).
        - The Primary Care rotating seat candidate must be a physician with significant experience and expertise in broad-based chronic disease management, comprehensive treatment plan development and management, and preventive care.
    - The Administrative Subcommittee determined that all specialty societies submitting a nominee should submit an attestation that the nominee in fact meets the first and third requirements above. AMA Staff will collect these attestations and include them in the handout packet.
    - The Subcommittee reviewed the Primary Care documentation that the candidate is defined as a primary care physician by Medicare (i.e. eligible for the primary care bonus). The Subcommittee realized that the current language inadvertently excludes pediatricians as they typically do not treat Medicare patients. The Subcommittee noted that Pediatrics is always defined as primary care and it was not the RUC's intention to exclude Pediatrics. The Subcommittee determined that Doctor Tuck meets the requirements of the Primary Care rotating seat, even though he may not be eligible for the Medicare primary care bonus. The Subcommittee recommends that they review the Primary Care eligibility language in order to refine and include Pediatrics prior to the next election in two years.
    - The Administrative Subcommittee determined that all candidates meet the primary care rotating seat criteria and be placed on the ballot.

The RUC approved the Administrative Subcommittee report and it is attached to these minutes.

IV. Director's Report

- The RUC database has been modified to include the 2011 Medicare claims data received in March. We will be receiving the Medicaid claims data for the first time in the next few weeks. We hope to be able to analyze it and eventually provide access through the RUC database.
- Due to the litigation hold we cannot discard any materials. Boxes have been distributed. Please place any RUC materials that you do not want to take with you in these boxes.
- Tom Healy from the AMA's Office of General Counsel:
    - Insider Trading – Simply put--do not trade in securities of companies you know have business before the CPT Editorial Panel and/or the RUC, or may be affected by their decisions. Those who hold a fiduciary duty or have an obligation of confidentiality are held to special account when it comes to trading securities based on nonpublic information. Because everyone in the room has signed a confidentiality agreement, you are in a special position regarding the nonpublic information you may receive as a participant or observer at the RUC meeting. The rules against insider trading restrict trading for your own benefit as well as disclosures to others who may trade in securities. Don't hesitate to get legal advice if you have questions about your investment activities.
    - Fischer vs. Berwick – The federal government filed a motion to dismiss the case. The motion has been fully briefed by all parties. The case has not been scheduled for oral argument and it is unclear when a ruling can be expected. The background is that a number of physicians sued the government alleging that either the RUC controls CMS with respect to the Medicare Payment Schedule, in which case the Secretary has illegally delegated a statutory duty to a non-governmental entity, or, conversely, the Secretary controls the RUC, in which case the RUC is really functioning as a federal advisory committee but has not been meeting the legal requirements of a federal advisory committee. The government's pending motion to dismiss the case argues that issuance of the Medicare Payment Schedule and the deliberations that go into its development (including the setting of RVUs) are protected by statute against judicial review. The motion also argues that the RUC cannot be interpreted to be a federal advisory committee under the federal statute.
    - Noerr-Pennington Doctrine – The RVU-setting activities of the RUC and the communication of its recommendations to CMS fall within the confines of the 1st Amendment right to free speech and to petition the government. The U.S. Supreme Court has ruled that these fundamental rights trump antitrust law, going back to two cases decided a half century ago: *Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.* and *United Mine Workers v. Pennington.* There is no new case law to report regarding the application of Noerr-Pennington. As long as the RUC continues to operate under the procedures and policies that have been established, there is little risk that the work of the RUC would be successfully challenged as falling outside the protection of Noerr-Pennington.
    - A RUC member asked if the Administrative Subcommittee should be asking presenters to the RUC to disclose their securities investment specifically.
        - Healy--We have a conflict of interest policy which requires certain disclosures. It is a good policy and is adequate for our purposes. Beyond what is disclosed on the conflict form, there is no reason to go deeper into the specific holdings of any individual.

V. Approval of Minutes of the January 26-28, 2012 RUC Meeting

The RUC approved the January 2012 RUC Meeting Minutes as submitted.

VI. CPT Editorial Panel Update

Doctor Albert Bothe provided the following report of the CPT Editorial Panel:

- The CPT Editorial Panel Update tab contains three items. The first is a summary of the new and revised code changes for CPT 2013, the second is the CMS requests status report, and the third is a listing of the RAW codes for the upcoming RUC review cycle.
- There are three initiatives that the Panel is working on:
    - An effort to more accurately represent the criteria for obtaining a CPT code. The criteria were first discussed and disseminated in November 1991 CPT assistant article. The Panel is updating the criteria for category I and III codes. It has been through two sets of review at the Panel, and the updated criteria is almost ready for dissemination. The updated criteria is focused on being more precise and providing clarification for those seeking category I and III codes.
    - There are four CPT Workgroups.
        - Quantitative Drug-Testing Workgroup
        - Care Coordination Workgroup
        - Mo-Path Tier 2 Workgroup
        - The Panels efforts to enhance transparency have resulted in 6 documents available on the CPT public website to review the Workgroup processes, the process the panel uses for reconsideration of any application, FAQs, and updates of the conflict of interest, lobbying and confidentiality policies.

VII. Centers for Medicare and Medicaid Services Update

Doctor Edith Hambrick provided the report of the Center for Medicare and Medicaid Services (CMS):

- Kathy Bryant has joined CMS as the Deputy Director of the Division of Practitioner Services.
- The agency is currently in their rulemaking cycle and is developing notice of proposed rulemaking. If there are suggestions from the specialties for the 2013 Notice of Proposed Rulemaking, they need to be submitted immediately.
- Sherry Smith added that CMS conducted the refinement process for CPT 2012 codes early this year. It has just concluded last week. The decisions from that meeting will be published in the Final Rule.

VIII. Contractor Medical Director Update

Doctor Charles Haley provided the contractor medical director report:

- Since the last update in January, action has been taken on three of the jurisdictions :
    - J6 (Wisconsin, Illinois, Minnesota) was awarded to National Government Services (NGS) and was formerly Wisconsin Physician Services (WPS) who protested the decision. The Government Accountability Office (GAO) upheld

that protest and CMS will take corrective action, likely rebidding the area. The existing Contractors will remain the Contractors for the foreseeable future.
    - J8 (Michigan and Indiana) was awarded to Wisconsin Physician Services (WPS) last summer and National Government Services (NGS) protested the decision. The GAO dismissed that protest. Those transitions are underway and should be complete by fall.
    - H8 (Texas, Colorado, Oklahoma, New Mexico, Arkansas, Louisiana and Mississippi) was awarded to Highmark Medicare Services and was formerly Trailblazer who protested the decision. The GAO dismissed that protest. Those transitions are underway and should be complete by late November. Immediately following the award, Highmark Medicare Services was sold to Diversified Service Options a subsidiary of Blue Cross Blue Shield of Florida, and renamed Novitas. Novitas will be the new Contractor for those 7 states.
- Payment Error Reduction
    - There have been no changes in the payment error rate since the last update in January and it remains 8.6%.
    - The greatest portion of the payment error rate are errors related to inpatient services that have been billed incorrectly accounting for 70-75%
    - The MR departments of most Medicare Contractors are focusing heavily on inpatient claims that could have been billed in error and that will likely continue for the foreseeable future.
- Medicare Recovery Audit Contractors (RACs)
    - It is Doctor Haley's opinion that some of the recoveries made by the RACs have not been correct, for 2 reasons:
        - If you do not like an initial claims adjudication result, there is an appeals process and if you appeal for long enough the claims will eventually be paid.
        - First level of the appeals process is with the Medicare Administrative Contractor (MACs). CMS has recognized this and is building the MACs into the vetting process for the RAC issues. CMS has to pay the MACs to do this work and it is not currently in their budget, but will get underway around mid-summer.
    - Questions:
        - Will the consolidation of the MACs increase uniformity in the payment policy across states?
            - Yes. By the end of this year there will be nine MACs and policy will become more uniform, however it will not be uniform over the entire program. Payment policy is still carrier dependent.

IX. Sustainable Growth Rate (SGR) Spending and Utilization Growth for 2011

Kurt Gillis, PhD, Senior Economist II, AMA, gave the following presentation:

- CMS provides us with an early version of their procedure summary file and this allows us to get an early look at Medicare physician spending growth for the previous year. We are looking at 2011 spending growth, using claims processed through the end of 2011, however more claims come in after the end of the year, so these are estimates, however in the past they have been very accurate. Also this data is reflected in the updated RUC database.

- SGR spending is made up of 90% Medicare physicians fee schedule (MFS), and 10% clinical lab fee schedule. Of the clinical lab fee schedule 6% is carrier lab and 4% hospital outpatient department lab. We do not have claims data for hospital outpatient department labs. 96% of SGR spending is included in this analysis.
- Results for 2011 – Overall
    - SGR spending is up 3.4%, MFS spending is up 3.6%.
    - Change in MFS spending was due to:
        - Increase in FFS enrollment (1.3%)
        - Increase in MFS pay (1.8%)
        - Utilization growth (per enrollee) of 0.7%
    - This is the lowest rate of growth that we have had since the inception of SGR going back to 1997. CMS estimates that spending growth for 2011 is higher at 5%.
- Results for 2011 – Imaging
    - Spending for imaging is down 4%. This is on top of a 6% reduction in 2010, so this is a 10% reduction in spending over the last two years.
    - Most of the reduction is due to a coding change for CAT. The category of CAT/Other saw a 16% reduction in spending ($272 million). This is a result of some of the new CAT codes such as CPT codes 74176, 74177, 74178, that were part of the top new codes for 2011.
        - The existing codes were not deleted so this result is huge reductions in spending for some of the existing CAT codes. An example is CPT code 72193, where the professional component and utilization were down, resulting in a reduction in spending of 98%.
    - Other factors include:
        - 0% growth in utilization per enrollee
        - shift to facility setting reduced spending by 1%
- Results for 2011 – Evaluation and Management
    - 4% increase in spending
    - 1% increase in utilization per enrollee. This is below the 2-3% increase in utilization that we see in most years.
    - Over 2 million frequency and $350 million in spending for new wellness visits (G0438, G0439)
    - 0% growth in utilization per enrollee for office visits. This may have been do to the increase in wellness visits.
    - 1% increase in utilization per enrollee for hospital visits
    - 5% increase in utilization per enrollee for emergency room visits. This is the fastest rate of growth in utilization.
- Results for 2011 – Procedures
    - 4% increase in spending with 1% increase in utilization per enrollee.
    - Decline in utilization for major procedures, i.e. cardiovascular, orthopaedic
    - Large reductions in utilization for major cardiovascular procedures (CABG, PTCA)
- Results for 2011 – Other
    - Physical therapy – utilization per enrollee up 4%. Still above average, but lower than what we have seen in past years.
    - Lab and other tests – decline in utilization per enrollee. This is a new development for 2011. For 2009 and 2010 average growth for tests was 5-6%.
- Revised results for 2010
    - Estimated growth in utilization per enrollee last year was 2.4%

  - Revised estimate with more complete claims data was lower at just 1.0%.
  - 2011, looks very much like 2010, which means that we have had two years of very low growth in utilization under the MFS.
- Growth in utilization of MFS services
  - Once we started tracking this in 1997 we saw an immediate decrease and then an increase every year through 2004. Beginning in 2004 we began to see a steady decline, that has continued to the present.
- Questions and Comments
  - There is a theory that the cost curve is bending because seniors have suffered under bad economic conditions and have less money to spend on elective procedures, however this would not explain the decrease in coronary events. Do you have an explanation?
    - For Medicare this theory likely does not apply because beneficiaries are protected from cost-sharing. Roughly 90% of Medicare beneficiaries have some form of supplemental insurance.
    - Doctor Blankenship added that the American College of Cardiology (ACC) has published updated guidelines and appropriate use criteria in 2009 that have guided Cardiologists in the appropriate use of coronary interventions and a decrease in volume.
  - What is the status of the AMA assisting in improving the BETOS data?
    - A proposal has been made to CMS and they have not responded yet.
  - Doctor Levy added that the decrease in utilization since 2004 is dramatic and it illustrates the serious work that physicians and specialty societies have done to bend the cost curve within the realms of what they can influence. As a physician community we need to take credit for the work that we have done.

X. Relative Value Recommendations for *CPT 2013:*

<u>Shoulder Arthroplasty (Tab 4)</u>
William Creevy, MD (AAOS); John Heiner, MD (AAOS); Daniel Nagle, MD (ASSH); Anne Miller, MD (ASSH)

In October 2011, the CPT Editorial Panel created two new CPT codes for total shoulder revision, CPT code 23473*Revision of total shoulder arthroplasty, including allograft when performed; humeral OR glenoid component* and CPT code 23474 *Revision of total shoulder arthroplasty, including allograft when performed; humeral AND glenoid component.* The new codes were created because of a CCI edit stating that providers can no longer report an implant removal with a total shoulder revision, as it was previously reported. The specialty society surveyed for the January 2012 RUC meeting, but was not able to collect a sufficient number of surveys for an accurate review and valuation. In January 2012 the RUC approved the specialty society's request to continue collecting survey responses. CMS requested surveys for all base and family codes. CPT code 23331 *Removal of foreign body, shoulder; deep (eg, Neer hemiarthroplasty removal)* (work RVU=7.63), CPT code 23332 *Removal of foreign body, shoulder; complicated (eg, total shoulder)* (work RVU=12.37) and CPT code 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)* (work RVU=22.65) were added and surveys were conducted for the April 2012 RUC meeting. These codes are low volume and as a result have low survey response, however the RUC agreed that enough additional surveys have been collected for the specialty society to provide accurate work RVU recommendations.

23331
The RUC reviewed the code and determined that the CPT descriptor does not accurately depict the "removal of previously-placed implant" and requested that the removal portion of the service be returned to CPT for development of new "implant removal" codes to correlate with the revision shoulder arthroplasty codes. Specifically the codes should distinguish between removal of a prosthesis and a foreign body. **The RUC recommends that CPT code 23331 be referred to CPT for further clarification and that the current work RVU of 7.63 be maintained until the code is revised and resurveyed.**

23332
The RUC reviewed the code and determined that the CPT descriptor does not accurately depict the "removal of previously-placed implant" and requested that the removal portion of the service be returned to CPT for development of new "implant removal" codes to correlate with the revision shoulder arthroplasty codes. Specifically the codes should distinguish between removal of a prosthesis and a foreign body. **The RUC recommends that CPT code 23332 be referred to CPT for further clarification and that the current work RVU of 12.37 be maintained until the code is revised and resurveyed.**

23472
The RUC reviewed the survey and recommends a work RVU of 22.13, the survey's 25th percentile, a decrease from the current work RVU of 22.65. The specialty society pointed out that the intra-service time in the RUC database is listed as 165, however when the code was surveyed in 2000 the survey indicated that the intra-service time was 155. The current survey indicates that there is now 140 minutes of intra-service time to perform this service. In addition, the RUC agreed that 12 minutes of additional pre-service positioning time is warranted in order to position the patient on a radiolucent table for fluoroscopy or in the beach chair position with adequate room for portable x-ray. The RUC compared 23472 to the key reference service 23616 *Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; with proximal humeral prosthetic replacement* (work RVU=18.37) and determined that the service requires more physician time and justifies a higher value. The RUC also compared 23472 to 24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)* (work RVU=22.65) a comparable procedure in the elbow that was approved at this meeting at a work RVU of 22.00. This service has slightly more positioning work than the elbow which justifies the slightly higher value. **The RUC recommends a work RVU of 22.13 for CPT code 23472.**

23473
The RUC reviewed the survey and recommends a work RVU of 25.00, the survey's 25th percentile. In addition, the RUC agreed that 12 minutes of additional pre-service positioning time is warranted in order to position the patient on a radiolucent table for fluoroscopy or in the beach chair position with adequate room for portable x-ray. The RUC compared 23473to the key reference service 23210 *Radical resection of tumor; scapula* (work RVU=27.21, intra-service time=210) and determined that this service requires less physician time at 180 minutes intra-service time. Due to less time and in order to maintain rank order the RUC recommends a lower value than the key reference service. The RUC also agreed that the recommended work RVU maintains relativity within the family, specifically compared to 23472 which has less intra-service time. **The RUC recommends a work RVU of 25.00 for CPT code 23473.**

23474
The RUC reviewed the survey and recommends a work RVU of 27.21, below the survey's 25th percentile. The RUC agreed that a value any higher would cause a rank order anomaly in the code family and render intensity that is too high for this procedure. The work RVU recommendation for 23474 was determined based on a direct crosswalk to CPT code 23210 *Radical resection of tumor; scapula* (work RVU=27.21). These codes have intra-service times of 210 and 205 minutes, respectively and the remainder of the post-operative work is the same. The RUC also compared 23474 to 27487 *Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component* (work RVU=27.11) and determined that the codes are consistent with a total time of 513 and 520, respectively. **The RUC recommends a work RVU of 27.21 for CPT code 23474, a direct crosswalk to CPT code 23210.**

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

Practice Expense: The RUC reviewed and approved the direct practice expense inputs as recommended by the Practice Expense Subcommittee.

Elbow Arthroplasty and Implant Removal (Tab 5)
William Creevy, MD (AAOS); John Heiner, MD (AAOS); Daniel Nagle, MD (ASSH); Anne Miller, MD (ASSH)

In October 2011, the CPT Editorial Panel created two new CPT codes for revision of a total elbow arthroplasty, CPT code 24370 *Revision of total elbow arthroplasty, including allograft when performed; humeral OR ulnar component* and CPT code 24371 *Revision of total elbow arthroplasty, including allograft when performed; humeral AND ulnar component.* The new codes were created because of a CCI edit stating that providers could no longer report implant removal and total elbow arthroplasty when a revision arthroplasty was performed. The specialty societies surveyed for the January 2012 RUC meeting, but were not able to collect a sufficient number of surveys for an accurate review and valuation. In January 2012 the RUC approved the specialty society's request to continue collecting survey responses. CMS requested surveys for all base and family codes, including CPT code 24160 *Implant removal; elbow joint* (work RVU=8.00) and CPT code 24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow*) (work RVU=22.65). These procedures are low volume and as a result have low survey response, however the RUC agreed that enough additional surveys were collected for the specialty societies to present work RVU recommendations at the April 2012 RUC meeting.

24160 *Implant removal; elbow joint*
The RUC reviewed the survey results and determined the current code descriptor is non-specific to the type of implant removed. **The RUC recommends that the current work RVU of 8.00 be maintained for CPT code 24160 and that the code be referred to CPT for revision of the description.**

24363 *Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)*
The RUC reviewed the survey results and recommends a work RVU of 22.00, the survey's 25th percentile, less than the current work RVU of 22.65. The RUC compared 24363 to key reference service 24150 *Radical resection of tumor, shaft or distal humerus*

(work RVU=23.46) and determined that the reference code has 40 minutes more intraservice time, justifying the higher work RVU. The RUC also compared 24363 to CPT code 27130 *Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft* (work RVU=21.79), and noted that these services have almost identical intraservice time at 140 and 135, respectively, therefore the recommended work RVU maintains the proper relativity among similar arthroplasty services. **The RUC recommends a work RVU of 22.00 for CPT code 24363.**

24370 *Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component*
The RUC reviewed the survey results and recommends a work RVU of 23.55, the survey's 25th percentile. CPT code 24370 is revision of one side of the elbow and is performed less commonly than 24371, which is revision of both sides. The RUC compared 24370 to 24150 *Radical resection of tumor, shaft or distal humerus* (work RVU=23.46) and noted that these services have almost identical intraservice time 175 and 180, respectively, however, the complexity and intensity of work to remove and replace the elbow joint is greater than the work to resect a tumor from a bone. The recommended work RVU maintains the proper relativity among similar arthroplasty services and excision procedures. **The RUC recommends a work RVU of 23.55 for CPT code 24370.**

24371 *Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component*
The RUC reviewed the survey and recommends a work RVU of 27.50, the survey's 25th percentile. The RUC discussed changes in the work involved in this service and agreed that there have been significant changes in the removal of the prosthesis with cemented components, which is an integral part of this procedure, consistent with the increase in RVUs. It was also noted that the procedure involves removing the prosthesis as well as preserving what is necessary to complete a replacement arthroplasty, and this is the most intense time in the procedure. The RUC compared 24371 to 23210 *Radical resection of tumor; scapula* (work RVU=27.21) and noted that these services have identical intraservice time and should be valued similarly. **The RUC recommends a work RVU of 27.50 for CPT code 24371.**

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

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

Presacral Lumbar Interbody Fusion (Tab 6)

In February 2012, the CPT Editorial Panel created CPT code 22586 *Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1* interspace. The following Level of Interest process did not generate any specialty society willing to develop relative value recommendations for CPT code 22586. **Therefore, the RUC offers no recommendation for CPT code 22586.**

Denis-Browne Splint Revision (Tab 7)
William Creevy, MD (AAOS)

In February 2012, the CPT Editorial Panel accepted a request from the specialty societies to revise CPT code 29590 *Denis-Browne splint strapping* (work RVU=0.76) to more accurately describe the use of the Denis-Browne bar and to differentiate this service from other currently described services. Upon specialty survey, respondents indicated that the revised 29590 descriptor was problematic in that this code now describes manipulation and cast application. According to the specialty presenters, this service is no longer provided, as the prefabricated appliance is applied without manipulation and without casting. **The RUC recommends that the current value of code be maintained pending CPT Editorial Panel action to delete this code as originally proposed.**

Bronchial Thermoplasty (Tab 8)
Burt Lesnick MD (ACCP); Kathrin Nicolacakis, MD (ATS/ACCP); Alan Plummer, MD (ATS); Kevin Kovitz, MD (ATS/ACCP)

In February 2012, the CPT Panel transitioned CPT Category III codes 0276T and 0277T to CPT Category I codes 31660 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe* and 31661 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes.* The RUC noted that bronchial thermoplasty is used for the treatment of severe asthma that has been unresponsive to standard medication therapy. This procedure is performed with three outpatient visits typically scheduled two weeks apart. Each lower lobe is treated separately in the first two visits and reported using 31660 and the two upper lobes are treated together in the final visit and reported using 31661.

31660
The RUC reviewed the survey results of 45 pulmonologists and thoracic surgeons and determined that a work RVU of 4.50, the survey median is appropriate for 31660. There was consensus among the RUC members that the specialty societies overestimated pre-service evaluation time of 33 minutes. The RUC determined that 19 minutes was more appropriate which corresponds to the survey median. The RUC reviewed CPT Code 31636 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus* (work RVU=4.30, intra-service time= 45 minutes) and determined that 31660 is a more intense procedure, requires 5 more minutes intra-service time and should be valued higher. The RUC also reviewed 31541 *Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope or telescope* (work RVU=4.52, intra-service time=60 minutes) and agreed that these services should be valued similarly. **The RUC recommends a work RVU of 4.50 for CPT code 31660.**

31661
The RUC reviewed the survey results of 45 pulmonologists and thoracic surgeons and determined that a work RVU of 5.00, the survey median is appropriate for 31661. The RUC noted that this procedure requires 10 more minutes of intra-service time than the single lobe procedure, CPT code 31660, to treat both upper lobes for a total of 60 minutes. There was consensus among the RUC members that the specialty societies

overestimated pre-service evaluation time of 33 minutes. The RUC reviewed 31638 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)* (work RVU=4.88) and agreed that although 31638 requires the same amount of intra-service time, 31661 is a more intense procedure and should be valued higher. The RUC also reviewed 31600 *Tracheostomy, planned (separate procedure)* (work RVU=7.17) and determined that 31600 requires more total time and intensity and should be valued higher. The RUC also agreed that a work RVU of 5.00 would maintain proper rank order within this family of services. **The RUC recommends a work RVU of 5.00 for CPT code 31661.**

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

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

Bronchial Valve Procedures (Tab 9)
Alan Plummer, MD, (ATS); Burt Lesnick MD, (ACCP); Kathrin Nicolacakis, MD (ATS/ACCP); Kevin Kovitz, MD (ATS/ACCP)

At the October 2011 and February CPT meetings, the CPT Editorial Panel approved four new category I codes to report bronchial valve procedures. These services were previously reported using three category III codes, 0250T, 0251T and 0252T.

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***
The RUC reviewed the survey responses from 30 pulmnologists for CPT code 31647 and determined that a work RVU of 4.40, the survey median, is appropriate. The RUC also recommends the following physician times: 25 minutes of pre-service time, 60 minutes of intra service time and 30 minutes of post service time. The RUC reviewed 31636 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus* (work RVU=4.30) and determined that 31647 requires more physician work since 2-3 valves per lobe are inserted as opposed to one stent. The RUC also reviewed 32601 *Thoracoscopy, diagnostic (separate procedure); lungs, pericardial sac, mediastinal or pleural space, without biopsy* (work RVU=5.50) and calculated a work RVU of 4.11 if 1-99232 *Hospital visit* (5.50 – 1.39 = 4.11) was removed. However, the RUC agreed that the physician work for 31647 was more intense and should be valued higher. **The RUC recommends a work RVU of 4.40 for CPT code 31647.**

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])***
The RUC reviewed the results of 30 pulmnologists and recommends the survey 25th percentile work RVU of 1.58. The RUC reviewed key reference service 31637 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; each*

additional major bronchus stented (work RVU=1.58) and determined that these two services require similar physician work and the same amount of time to perform. The RUC also reviewed 13122 *Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less* (work RVU=1.44) and agreed that this procedure requires less physician work and intensity. The RUC also noted that a work RVU of 1.58 would maintain proper rank order within this family of services. **The RUC recommends a work RVU of 1.58 for CPT code 31651.**

31648 ***Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe***

The RUC reviewed the results of 35 pulmnologists and recommends a work RVU of 4.20. The RUC compared 31648 to key reference service 31638 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)* (work RVU=4.88) and determined that although the surveyed code requires less time, 45 minutes versus 60 minutes of intra service time, it is more intense to remove a valve as described in 31648. Furthermore, the key reference code describes the revision of a stent in which the physician goes in once whereas with the surveyed code, 31648, the physician is working with multiple valves in each lobe. The RUC also compared the surveyed code to 31636 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus* (work RVU=4.30) and noted that these services both require 45 minutes of intra service time with similar intensity. Given these comparisons, the RUC agreed with the specialty that the median survey work RVU of 4.20 is an accurate measure of the physician work and intensity involved in this service. **The RUC recommends a work RVU of 4.20 for CPT code 31648.**

31649 ***Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe***

The RUC reviewed the results of 35 pulmnologists and recommends a work RVU of 2.00. The RUC compared 31649 to 31637 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; each additional major bronchus stented* (work RVU=1.58) and noted that although the intra-service times are identical, 30 minutes, the intensity of 31649 is greater. CPT Code 31637 refers to one stent per lobe versus the removal of 2-3 valves per lobe. The RUC also compared 31649 to 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* (work RVU=2.00) and noted that these services both require 30 minutes of intra service time and therefore should be similarly valued. Given these comparisons, the RUC agreed with the specialty that the median survey work RVU of 2.00 is an accurate measure of the physician work and intensity involved in this service. **The RUC recommends a work RVU of 2.00 for CPT code 31649.**

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

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

Chest Tube Thoracostomy (Tab 10)
Christopher Senkowski, MD (ACS); Charles Mabry, MD (ACS); Francis Nichols, MD (ACS); Kevin Kovitz, MD (ATS/ACCP)

In April 2011, CPT code 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)* was identified in the Harvard Valued-Utilization over 30,000 screen. Prior to conducting a survey, the specialty societies noted a recent shift in the primary specialty from general and cardiothoracic surgery and pulmonary medicine to radiology. They attributed possible miscoding to the description which included "thoracostomy;" parenthetical examples for diagnoses (abscess, hemothorax, empyema) that may have been the primary focus for selecting the code, and an incorrect diagram in CPT following the code. In February 2012, the CPT Editorial Panel modified the code descriptor and parenthetical notes and deleted the diagram.

The RUC reviewed and discussed compelling evidence and agreed that the requirement was met to justify consideration of a different work RVU. Specifically, the methodology used to reduce the work RVU of 32551 for CY 2007 was flawed. Harvard time was cited by CMS that included post-service hospital and office visits. However, in 1993, these post service visits were removed, the global period was changed from 010 to 000, and the work RVU was reduced to 4.07. In addition, CPT Code 38300 was cited by CMS as a comparable reference. However, this code is an office/outpatient, non-urgent procedure that has a negative IWPUT (-0.039) and therefore not a valid reference. Lastly, CPT Code 38500 was also cited by CMS as a comparable reference and reverse building block methodology was used to subtract post-operative work from this minor, non-urgent 10-day global code to calculate a work RVU for 32551 which has a 000-day global period. The intra-service intensity and complexity of these two services are not comparable.

The RUC reviewed the survey results from 89 general and cardiothoracic surgeons and pulmonologists and determined that a work RVU of 3.50 which corresponds to the survey's 25th percentile is appropriate for CPT code 32551. The RUC compared 32551 to key reference CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU=4.17) and determined that although 32551 required less time, the work intensity and complexity were greater, resulting in only slightly less total work. This was supported by the survey complexity and intensity measures showing 32551 equal to or greater than all measures when compared with 32550. The RUC compared 32551 to MPC CPT code 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance* (work RVU=3.69) and determined that with 10 more minutes of intra service time, 19103 should be valued higher. The RUC compared 32551 to CPT code 16035 *Escharotomy; initial incision* (work RVU=3.74) which has the same intra-time and similar urgency of physician work. The RUC also compared 32551 to CPT code 57461 *Colposcopy of the cervix including upper/adjacent vagina; with loop electrode conization of the cervix* (work RVU=3.43) and CPT code 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* (work RVU=3.50) and agreed that these two services require similar total physician work. **The RUC recommends a work RVU of 3.50 for CPT Code 32551.**

Practice Expense:
The RUC recommends that this is a facility procedure without direct practice expense inputs.

Chest Tube Interventions (Tab 11)
Alan Plummer, MD (ATS); Burt Lesnick MD (ACCP); Kathrin Nicolacakis, MD (ATS/ACCP)
Facilitation Committee #2

In September 2011, CPT Codes 32420 *Pneumocentesis, puncture of lung for aspiration*, *32421 Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent* and 32422 *Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)* were identified in the Harvard Valued-Utilization over 30,000 screen. At that time, the specialty societies requested and the RUC agreed that these services should be referred to the CPT Editorial Panel to correctly describe current practice. In February 2012, the CPT Editorial Panel created 32554 *Thoracocentesis, needle or catheter, aspiration of the pleural space; without imaging guidance*, 32555 *Thoracocentesis, needle or catheter, aspiration of the pleural space; with imaging guidance,* 32556 *Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance* and 32557 *Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance* and deleted 32420-32422 to accurately describe these procedures.

The RUC noted that the specialty societies used a split survey process. Specifically, CPT codes 32554 and 32556 were surveyed primarily by pulmonologists and CPT codes 32555 and 32557 were surveyed by radiologists. The split survey process made it difficult to ascertain the appropriate increment of physician work within this family of services.

The RUC recommends that the entire family of codes be resurveyed for the October 2012 RUC meeting. The RUC recommends that pulmonary medicine resurvey all four codes and radiology resurvey only the imaging codes (32555 & 32557). In the interim, the RUC recommends the valuation of the current reporting for these services:

CPT code 32554 was primarily previously reported using code 32421 *Thoracentesis, puncture of the pleural cavity for aspiration, initial or subsequent* (work RVU = 1.54). **Therefore, the RUC recommends an interim work RVU of 1.54 for 32554.**

CPT code 32555 was previously reported using codes 32421 *Thoracentesis, puncture of the pleural cavity for aspiration, initial or subsequent* (work RVU = 1.54) and 76942 *Ultrasonic* guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation (work RVU = 0.67). **Therefore, the RUC recommends an interim work RVU of 2.21 for CPT code 32555.**

CPT code 32556 was primarily previously reported using code 32422 *Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)* (work RVU = 2.19). For further support, the RUC reviewed CPT Codes 31233 *Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)* (work RVU=2.18) and 57421 *Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix* (work RVU=2.20) and determined

that physician work and intensity were similar. **Therefore, the RUC recommends an interim work RVU of 2.19 for CPT code 32556.**

CPT code 32557 was previously reported using 32422 *Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)* (work RVU = 2.19) and imaging under 77012 *Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation* (work RVU = 1.16)**. Therefore, the RUC recommends an interim work RVU of 3.35 for CPT code 32557.**

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

Practice Expense:
The RUC discussed that the staff type included in practice expense for 32554 and 32556 is more appropriately listed as the RN/LPN/MTA blend rather than RN/RT. A staff type of RT for 32555 and CT Tech for 32557 is appropriate because in past reviews for imaging codes a radiologic or CT technologist has been the accepted clinical staff performing this service. The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.

Transcatheter Aortic Valve Replacement (Tab 12)
Jim Levett, MD (STS); Stephen Lahey (STS) MD; Jeff Jacobs, MD (STS); Richard Wright, MD (ACC); Clifford Kavinsky, MD (ACC)
Facilitation Committee #3

In February 2012, the CPT Editorial Panel deleted four Category III code (0256T-0259T) and approved nine codes to report transcatheter aortic valve replacement procedures.

The RUC thoroughly discussed the unique nature of these services to understand and assign the appropriate valuation for these services. First, the members noted these services require two physicians, an interventional cardiologist and a cardiothoracic surgeon, be actively working on the patient during these procedures. Each operator has distinctly required work, which are specific to the operator's skill set, and are not duplicative between the two. For these reasons, the CMS National Coverage Determination (NCD) mandates that two physicians be present for this procedure to be completed. Second, the RUC recognized the intense nature of these procedures. Patients eligible for these procedures have previously been turned down for aortic valve replacement surgery and are receiving these procedures as a last resort. The NCD further mandates this patient population and there are currently no indications that these procedure will be approved for otherwise operable patients in the future. Finally, the RUC noted that the recommendations made by the Committee will value the total work of the service. Physician time includes the clock time of the procedure and does not constitute the addition of each physician's time. Payment policy issues, related to the co-surgery modifier and resulting payment modifications, were not determined, as it is outside the purview of the RUC. The RUC understands that CMS will consider these issues.

Prior to surveying, the specialty societies obtained approval from the Research Subcommittee to conduct an alternative methodology for surveying these services. To

ensure the complete work of both physicians was captured, each survey was conducted concurrently by a thoracic surgeon and an interventional cardiologist.

33361 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach***
The RUC reviewed the survey data from 33 thoracic surgeons and cardiologists and agreed with the specialty that the appropriate physician time components for this procedure are as follows: pre-service time= 85 minutes, intra-service time= 135 minutes and post-service time= 45 minutes. This time represents the procedure time and does not duplicate the time spent by each physician. The RUC agreed with the addition of 22 minutes of pre-service time to account for the time each physician spends separately obtaining consent and reviewing the procedure with the patient. Additionally, there is greater positioning time because the patient must be positioned for each contingency of the procedure. The RUC also assigned one critical care code (99291) to this 000 day global service as the patient is cared for in the inpatient setting. This critical care visit covers the time that both physicians spend with the patient directly related to the procedure.

The RUC reviewed the survey respondents' estimated physician work value for this procedure and agreed with the specialty that 29.50, the survey median, is an appropriate work RVU for this service. To justify this value, the RUC reviewed the key reference service code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* (work RVU= 27.28, valued as a 000 day global) and agreed that while the reference code has greater total physician time, 33361 is a much more intense procedure, as indicated by the survey's intensity/complexity measures. In addition, 33361, as described above, is a unique procedure involving two physicians and is a much more complicated and involved procedure compared to the reference code. Finally, the RUC conducted the following methodology to ensure the recommended work value is relative to similar services. The Committee took CPT code 92986 *Percutaneous balloon valvuloplasty; aortic valve* (work RVU= 22.85, intra-service time= 113 minutes) and backed out the post-operative visits (remaining work RVU= 17.90) to ensure the comparison is based on a 000 day global equivalent. The difference between the two intra-service times (22 minutes) was multiplied by the IWPUT (0.16) and came to a value of 3.52. The value of 3.52 and 4.50 (the work RVU of 99291) were added to the base 17.90 work RVU of the balloon valvuloplasty code to arrive at a value of 25.92. The committee recognized that the surveyed code 33361 is a much more intense and complicated procedure compared to the balloon valvuloplasty service. **The RUC recommends a work RVU of 29.50 for CPT code 33361.**

33362 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach***
The RUC reviewed the survey data from 38 thoracic surgeons and cardiologists and agreed with the specialty that the appropriate physician time components for this procedure are as follows: pre-service time= 85 minutes, intra-service time= 150 minutes and post-service time= 45 minutes. This time represents the procedure time and does not duplicate the time spent by each physician. Agreed with the addition of 22 minutes of pre-service time to account for the time each physician spends separately obtaining consent and reviewing the procedure with the patient. Additionally, there is greater positioning time because the patient must be positioned for each contingency of the procedure. The RUC also assigned one critical care code (99291) to this 000 day global service as the patient is cared for in the

inpatient setting. This critical care visit covers the time that both physicians spend with the patient directly related to the procedure.

The RUC reviewed the survey respondents' estimated physician work value for this procedure and agreed with the specialty that 32.00, the survey median, is an appropriate work RVU for this service. To justify this value, the RUC reviewed the key reference service code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* (work RVU= 27.28, valued as a 000 day global) and agreed that while the reference code has greater total physician time, 33362 is a much more intense procedure, as indicated by the survey's intensity/complexity measures. In addition, 33362, as described above, is a unique procedure involving two physicians and is a much more complicated and involved procedure compared to the reference code. Finally, the RUC reviewed 33362 in comparison to 33361 and agreed that the increase complexity due to the open approach was accurately reflected with the increase work RVU of 2.50 and increased time of 15 minutes. **The RUC recommends a work RVU of 32.00 for CPT code 33362.**

33363 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach***
The RUC reviewed the survey data from 33 thoracic surgeons and cardiologists and agreed with the specialty that the appropriate physician time components for this procedure are as follows: pre-service time= 85 minutes, intra-service time= 180 minutes and post-service time= 45 minutes. This time represents the procedure time and does not duplicate the time spent by each physician. The RUC agreed with the addition of 22 minutes of pre-service time to account for the time each physician spends separately obtaining consent and reviewing the procedure with the patient. Additionally, there is greater positioning time because the patient must be positioned for each contingency of the procedure. The RUC also assigned one critical care code (99291) to this 000 day global service as the patient is cared for in the inpatient setting. This critical care visit covers the time that both physicians spend with the patient directly related to the procedure.

The RUC reviewed the survey respondents' estimated physician work value for this procedure and agreed with the specialty that 33.00, the survey median, is an appropriate work RVU for this service. To justify this value, the RUC reviewed the key reference service code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* (work RVU= 27.28, valued as a 000 day global) and agreed that while the reference code has greater total physician time, 33363 is a much more intense procedure, as indicated by the survey's intensity/complexity measures. In addition, 33363, as described above, is a unique procedure involving two physicians and is a much more complicated and involved procedure compared to the reference code. Finally, the RUC reviewed 33363 in comparison to 33361 and agreed that the increase complexity due to the open approach was accurately reflected with the increase work RVU of 3.50 and increased time of 45 minutes. **The RUC recommends a work RVU of 33.00 for CPT code 33363.**

33364 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach***
The RUC reviewed the survey data from 31 thoracic surgeons and cardiologists and agreed with the specialty that the appropriate physician time components for this procedure are as follows: pre-service time= 85 minutes, intra-service time= 180 minutes and post-service time= 45 minutes. This time represents the procedure time and does not duplicate the time spent by each physician. The RUC agreed with the addition of 22 minutes of pre-service time to account for the time each physician spends separately obtaining consent and reviewing the procedure with the patient. Additionally, there is greater positioning time because the patient must be positioned for each contingency of the procedure. The RUC also assigned one critical care code (99291) to this 000 day global service as the patient is cared for in the inpatient setting. This critical care visit covers the time that both physicians spend with the patient directly related to the procedure.

The RUC reviewed the survey respondents' estimated physician work value for this procedure and agreed with the specialty that 34.87, the survey median, is an appropriate work RVU for this service. To justify this value, the RUC reviewed the key reference service code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* (work RVU= 27.28, valued as a 000 day global) and agreed that while the reference code has greater total physician time, 33364 is a much more intense procedure, as indicated by the survey's intensity/complexity measures. In addition, 33364, as described above, is a unique procedure involving two physicians and is a much more complicated and involved procedure compared to the reference code. The RUC also reviewed 33364 in comparison to 33361 and agreed that the increase complexity due to the open approach was accurately reflected with the increase work RVU of 5.37 and increased time of 45 minutes. The RUC noted that while 33364 and 33363 have the same intra-service times, 33364 is a more intense procedure due to the transplant incision and longer closure times. **The RUC recommends a work RVU of 34.87 for CPT code 33364.**

33365 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)***
The RUC reviewed the survey data from 30 thoracic surgeons and cardiologists and agreed with the specialty that the appropriate physician time components for this procedure are as follows: pre-service time= 85 minutes, intra-service time= 180 minutes and post-service time= 45 minutes. This time represents the procedure time and does not duplicate the time spent by each physician. The RUC agreed with the addition of 22 minutes of pre-service time to account for the time each physician spends separately obtaining consent and reviewing the procedure with the patient. Additionally, there is greater positioning time because the patient must be positioned for each contingency of the procedure. The RUC also assigned one critical care code (99291) to this 000 day global service as the patient is cared for in the inpatient setting. This critical care visit covers the time that both physicians spend with the patient directly related to the procedure.

The RUC reviewed the survey respondents' estimated physician work value for this procedure and agreed with the specialty that 37.50, the survey median, is an appropriate work RVU for this service. To justify this value, the RUC reviewed the key reference service code 33979 *Insertion of ventricular assist device, implantable intracorporeal, single ventricle* (work RVU= 37.50) and agreed that while 33979 has more intra-service

time compared to the surveyed code, both services should be valued similarly given that 33365 is a more intense procedure, as seen in the intensity complexity measures. The RUC also reviewed CPT code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* (work RVU= 27.28, valued as a 000 day global) and agreed that while the reference code has greater total physician time, 33365 is a much more intense procedure. In addition, 33365, as described above, is a unique procedure involving two physicians and is a much more complicated and involved procedure compared to the reference code. The RUC also reviewed 33365 in comparison to 33361 and agreed that the increase complexity was accurately reflected with the increase work RVU of 8.00 and increased time of 45 minutes. The RUC noted that while 33365 and 33364 have the same intra-service times, 33364 is a more intense procedure due to complexities opening the chest via median sternotomy. **The RUC recommends a work RVU of 37.50 for CPT code 33365.**

0300XT *Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical approach (eg, left thoracotomy)*
The RUC reviewed the survey data from 31 thoracic surgeons and cardiologists and agreed with the specialty that the appropriate physician time components for this procedure are as follows: pre-service time= 85 minutes, intra-service time= 195 minutes and post-service time= 45 minutes. This time represents the procedure time and does not duplicate the time spent by each physician. The RUC agreed with the addition of 22 minutes of pre-service time to account for the time each physician spends separately obtaining consent and reviewing the procedure with the patient. Additionally, there is greater positioning time because the patient must be positioned for each contingency of the procedure. The RUC also assigned one critical care code (99291) to this 000 day global service as the patient is cared for in the inpatient setting. This critical care visit covers the time that both physicians spend with the patient directly related to the procedure.

The RUC reviewed the survey respondents' estimated physician work value for this procedure and agreed with the specialty that 40.00, the survey median, is an appropriate work RVU for this service. To justify this value, the RUC reviewed the key reference service code 33979 *Insertion of ventricular assist device, implantable intracorporeal, single ventricle* (work RVU= 37.50) and agreed that while 33979 has more intra-service time compared to the surveyed code, 0300XT should be valued slightly higher due to greater intensity, as seen in the intensity complexity measures. The RUC also reviewed CPT code 33880 *Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin* (work RVU= 27.28, valued as a 000 day global) and agreed that while the reference code has greater total physician time, 0300XT is a much more intense procedure. In addition, 0300XT, as described above, is a unique procedure involving two physicians and is a much more complicated and involved procedure compared to the reference code. The RUC also reviewed 0300XT in comparison to 33361 and agreed that the increase complexity was accurately reflected with the increase work RVU of 10.50 and increased time of 60 minutes. **The RUC recommends a work RVU of 40.00 for CPT code 33366.**

Add-On Services
The RUC noted that the three add-on cardiopulmonary bypass support services (33367-X9) are only reported by the thoracic surgeon and not performed by two physicians. These procedures are performed during standard transcatheter aortic valve replacement services upon the patient becoming hemodynamically unstable and cannot be stabilized by any standard medical means.

33367 ***Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels)***
The RUC reviewed the survey results from 35 cardiothoracic surgeons and agreed with the specialties that the appropriate intra-service time for this ZZZ global service is 90 minutes. The RUC reviewed the survey respondents' estimated physician work value and agreed with the specialties that a work RVU of 11.88 (the survey's 25th percentile) accurately reflects the physician work involved in this procedure. To justify this value, the RUC reviewed the key reference code 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* (work RVU= 4.25) and agreed that the surveyed code has double the intra-service time and is a more intense procedure. Given this, 33367 should be valued much higher. In addition, CPT code 22845 *Anterior instrumentation; 2 to 3 vertebral segments* (work RVU= 11.94) was compared to 33367 and the RUC noted that the two services have identical intra-service time, 90 minutes, with comparable physician work, and should be valued similarly. **The RUC recommends a work RVU of 11.88 for CPT code 33367.**

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)***
The RUC reviewed the survey results from 34 cardiothoracic surgeons and agreed with the specialties that the appropriate intra-service time for this ZZZ global service is 120 minutes. The RUC reviewed the survey respondents' estimated physician work value and agreed with the specialties that a work RVU of 14.39 (the survey's 25th percentile) accurately reflects the physician work involved in this procedure. To justify this value, the RUC reviewed the key reference code 33960 *Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial day* (work RVU= 10.59, valued as a ZZZ global service) and agreed that while the reference code has slightly greater intra-service time, 13 minutes, compared to 33368, the surveyed code is a more intense procedure and should be valued higher. In addition, the RUC reviewed CPT code 22843 *Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments* (work RVU= 13.44, intra-time= 120 minutes) and agreed that with identical intra-service time the surveyed code should be valued slightly higher due to greater intensity. **The RUC recommends a work RVU of 14.39 for CPT code 33368.**

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)***
The RUC reviewed the survey results from 35 cardiothoracic surgeons and agreed with the specialties that the appropriate intra-service time for this ZZZ global service is 160 minutes. The RUC reviewed the survey respondents' estimated physician work value and agreed with the specialties that a work RVU of 19.00 (the survey's 25th percentile) accurately reflects the physician work involved in this procedure. To justify this value, the RUC

reviewed the key reference code 33305 Repair of cardiac wound; with cardiopulmonary bypass (work RVU= 29.60, valued as a ZZZ global period) and agreed that while the surveyed code is a more intense procedure, the reference code should be valued higher due to greater intra-service time, 296 minutes compared to 160 minutes. In addition, the RUC reviewed CPT code 22844 *Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments* (work RVU= 16.42, intra-service time= 150 minutes) and agreed that since the surveyed code has greater intra-service time and a higher intensity the value should be higher for 33369. **The RUC recommends a work RVU of 19.00 for CPT code 33369.**

Practice Expense: The TAVR codes represent procedures that will be performed in the facility 100% of the time and will require office staff time that would be typical for a 90-day global procedure performed in the facility setting. The TAVR codes will be done jointly with the cardiologist and cardiovascular surgeon and requires additional scheduling and coordination of services because the cardiology office and the cardiovascular surgery office must both coordinate with the other specialists involved in the procedure which at a minimum include radiology, perfusionist and a specialized anesthesiologist. In addition the procedure requires a hybrid OR room requiring special equipment for the catheter-based, surgical, and imaging aspects of the procedure and the cardiopulmonary bypass equipment. Since the codes were jointly surveyed involving cardiology and cardiac surgeons, the specialty societies are recommending CMS Code L037D with a blended staff type of RN/ LP/ MTA rather then the RN staff type typical to the cardiothoracic surgery codes. The RUC reviewed and approved the direct practice expense inputs as recommended by the Practice Expense Subcommittee.

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

RUC Database: These services will be flagged in the RUC database so they are not used to validate the physician work of other services in the RBRVS.

Insertion of Percutaneous Ventricular Assist Device (Tab 13)
Richard Wright, MD (ACC); Clifford Kavinsky, MD (ACC)
Facilitation Committee #3

In February 2012, the CPT Editorial Panel deleted two Category III codes (0048T and 0050T) and created four Category I codes to describe the insertion of a percutaneous ventricular assist device.

33990 ***Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial access only***
The RUC reviewed the survey results from 33 cardiologists and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time= 47 minutes, intra-service time= 60 minutes and post-service time= 40 minutes. The RUC agreed that pre-service time is equivalent to a pre-service package 2B (difficult patient, straightforward procedure), with additional time for evaluation of the patient, was appropriate for this service because while an Evaluation and Management service is typically reported on the same day, the visit is typically performed by another physician at a separate encounter. The recommended pre and post times do not overlap with Evaluation and Management services.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overestimated the physician work involved. In addition, the RUC could not find suitable reference codes to support values at the 25th percentile (work RVU= 12.00). The RUC reviewed comparator codes with analogous time and intensity and noted that CPT code 37220 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 8.15) has identical intra-service time, 60 minutes, compared to 33990 and similar physician work. Therefore, a direct crosswalk to CPT code 37220 is justified. Finally, the RUC discussed the high intensity of this service. Candidates for this procedure are urgent, high risk patients that are not eligible for surgery. These assist devices are placed to maintain the patient until an angioplasty can be performed. Therefore, the Committee concurred that this service is appropriately valued and is an intense procedure. **The RUC recommends a work RVU of 8.15 for CPT code 33990, a direct crosswalk to CPT code 37220.**

33991 ***Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; both arterial and venous access, with transseptal puncture***

The RUC reviewed the survey results and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time= 60 minutes, intra-service time= 90 minutes and post-service time= 45 minutes. The RUC agreed that pre-service time is equivalent to a pre-service package 2B (difficult patient, straightforward procedure), with additional time for evaluation of the patient, was appropriate for this service because while an Evaluation and Management service is typically reported on the same day, the visit is typically performed by another physicians at a separate encounter. The recommended pre and post times do not overlap with Evaluation and Management services.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overestimated the physician work involved. In addition, the RUC could not find suitable reference codes to support values at the 25th percentile (work RVU= 16.63). The RUC reviewed comparator codes with analogous time and intensity and noted that CPT codes 37220 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 8.15) and CPT code 93462 *Left heart catheterization by transseptal puncture through intact septum or by transapical puncture* (work RVU= 3.73) combined have similar intra-service time, 100 minutes compared to 90, and comparable physician work to 33991. To ensure the resulting work RVU of 11.88 is relative to similar services in the RBRVS, the committee reviewed CPT code 37228 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 11.00, intra-service time 90 minutes) and agreed that these two services have analogous physician work and should be valued similarly. Finally, the RUC discussed the high intensity of this service. Candidates for this procedure are urgent, high risk patients that are not eligible for surgery. These assist devices are placed to tide the patient over so an angioplasty can be performed. Therefore, the Committee concurred that this service is appropriately valued and is relative to 33990, with similar intensity. **The RUC recommends a work RVU of 11.88 for CPT code 33991.**

33992 ***Removal of percutaneous ventricular assist device at separate and distinct session from insertion***
The RUC reviewed the survey results and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time= 30 minutes, intra-service time= 45 minutes and post-service time= 30 minutes. The RUC agreed that pre-service time is equivalent to a pre-service package 2B (difficult patient, straightforward procedure) was appropriate to evaluate and wean the patient from the assist device. The RUC also discussed the appropriate billing for this code. The typical patient, roughly 85%, receiving a percutaneous ventricular assist device will have the device removed in the catheterization laboratory during the same session as insertion. The physician work of removal in that scenario is included in the insertion codes. However, a minority of patients will require that the device be removed in the intensive care unit where 33992 would be appropriately reportable with a 59 modifier, per CPT instructions.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overestimated the physician work involved. In addition, the RUC could not find suitable reference codes to support values at the 25th percentile (work RVU= 6.44). The RUC reviewed comparator codes with analogous time and intensity and noted that CPT code 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* (work RVU= 4.00) has identical intra-service time, 45 minutes, and should have the same value as the surveyed code. **The RUC recommends a work RVU of 4.00 for CPT code 33992, a direct crosswalk to CPT code 31634.**

33993 ***Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion***
The RUC reviewed the survey results and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time= 30 minutes, intra-service time= 30 minutes and post-service time= 30 minutes. The RUC agreed that pre-service time is equivalent to a pre-service package 2B (difficult patient, straightforward procedure) was appropriate to evaluate a patient with a device that has position malfunction. As is the case with the removal code, 33992, 33993 can only be reported when repositioning of a device is performed during a separate encounter, which is not typical. Repositioning during insertion is not separately reportable.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overestimated the physician work involved. In addition, the RUC could not find suitable reference codes to support values at the 25th percentile (work RVU= 6.00). The RUC reviewed comparator codes with analogous time and intensity and noted that CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17) has identical intra-service time as 33993, 30 minutes, and analogous physician work. Therefore, the Committee agreed that the two services should be valued the same. Finally, the RUC noted that 33993 is appropriately valued compared to 33992 because although repositioning takes less time compared to the removal code, 33993 is much more intense, as shown in the intensity/complexity measures, and should be valued slightly higher. **The RUC recommends a work RVU of 4.17 for CPT code 33993, a direct crosswalk to CPT code 32550.**

Practice Expense: There are no direct practice expense inputs for these services as they are only done in the Facility setting.

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

Cervicocerebal Angiography (Tab 14)
Sean Tutton, MD (SIR); Michael Hall, MD (SIR); Gerald Niedzwiecki, MD (SIR); Robert Vogelzang, MD (SIR); Timothy Swan, MD (SIR); William Julien, MD (SIR); Geraldine McGinty, MD (ACR); Zeke Silva, MD (ACR); Gary Seabrook, MD (SVS); Robert Zwolak, MD (SVS); Mathew Sideman, MD (SVS); Michael Sutherland, MD (SVS); Sean Roddy, MD (SVS); Joshua A Hirsch, MD(ASNR); Gregory N Nicola, MD (ASNR); John Ratliff, MD (AANS); John Wilson, MD (AANS); Alexander Mason, MD (CNS); Clifford Kavinsky, MD (ACC); Richard Wright, MD (ACC)

These codes were part of the original "Codes Reported Together 75% of More Screen" by the Joint CPT/RUC Workgroup. In January 2012, the RUC requested that new guidelines and 8 codes to bundle selective catheter placement with radiological supervision and interpretation, including angiography, be established. The specialty societies report that non-invasive vascular imaging has replaced diagnostic angiography as a screening test. The use of routine noninvasive vascular imaging for diagnosis means that the smaller patient population undergoing catheter cerebral angiography are inherently a more complex patient population. These new bundled CPT codes were surveyed by a multidisciplinary population including radiology, vascular surgery, cardiology, neurosurgery, and neurology.

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***
The RUC reviewed the survey results from 55 multi-specialty respondents and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time=48 minutes, intra-service time=30 minutes and post-service time=40 minutes. The RUC agreed that the pre-service time package 2B(Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)), is appropriate. There is also additional pre-service time that has been established in the renal angiography codes, for positioning the equipment around the patient, as well as additional time in the evaluation unique to these patients, to conduct a neurological evaluation. The same neurological evaluation is included in the post-service period to ensure that there is no change in deficits, because a stroke continues to be a significant risk factor in these procedures. There is also additional time in the post-service period for review and interpretation of the imaging sequences. The RUC compared 36221 to the key reference service 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* (work RVU=5.35) and determined that the two codes have similar total time at 118 and 116, respectively. 36221 has slightly higher intensity than 36251, however the additional time for 36251 is in the intra-service period at 45 minutes, which

accounts for the higher RVU. The RUC agreed with the specialty societies that in order to maintain rank order and magnitude of estimation a direct crosswalk to the two component codes being bundled, CPT codes 36200 *Introduction of catheter, aorta* (work RVU=3.02) and 75650 *Angiography, cervicocerebral, catheter, including vessel origin, radiological supervision and interpretation* (work RVU=1.49), is justified. **The RUC recommends a work RVU of 4.51 for CPT code 36221, a direct crosswalk to CPT codes 36200 and 75650.**

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***
The RUC reviewed the survey results from 55 multi-specialty respondents and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time=48 minutes, intra-service time=40 minutes and post-service time=40 minutes. The RUC agreed that the pre-service time package 2B (Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)), is appropriate. There is also additional pre-service time that has been established in the renal angiography codes, for positioning the equipment around the patient, as well as additional time in the evaluation unique to these patients, to conduct a neurological evaluation. The same neurological evaluation is conducted in the post-service period to ensure that there is no change in deficits, because a significant risk factor in these procedures continues to be stroke. There is also additional time in the post-service period for review and interpretation of the imaging sequences. The RUC agreed with the specialties that the median survey RVU of 6.00 is an accurate measure of the physician work involved in this service. The RUC compared 36222 to the key reference service 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* (work RVU=5.35) and determined that 36222 has more total time at 128 and 116, respectively, and significantly higher level of intensity to perform. These factors account for the higher RVU. **The RUC recommends a work RVU of 6.00 for CPT code 36222.**

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***
The RUC reviewed the survey results from 55 multi-specialty respondents and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time=48 minutes, intra-service time=45 minutes and post-service time=40 minutes. The RUC agreed that the pre-service time package 2B(Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)), is appropriate. There is also additional pre-service time that has been established in the renal angiography codes, for positioning the equipment around the patient, as well as additional time in the evaluation unique to these patients, to conduct a neurological evaluation. The same neurological evaluation is conducted in the post-service period to ensure that there is no change in deficits, because a significant risk factor in these procedures continues to be stroke. There is also additional time in the post-service period

for review and interpretation of the imaging sequences. The RUC agreed with the specialties that the physician work of 36223 is analogous to the work of 36225. Both services have identical survey median times and thus should be valued identically. Therefore, the RUC recommends a work RVU of 6.50, the survey median for 36223. The RUC compared 36223 to the key reference service CPT code 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* (work RVU=7.55) and determined that the two codes have similar total time at 133 and 131 and similar levels of intensity to perform. The additional time for 36253 is in the intra-service period at 60 minutes (as compared to 45 minutes for 36223), which accounts for the higher RVU. **The RUC recommends a work RVU of 6.50 for CPT code 36223.**

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***

The RUC reviewed the survey results from 55 multi-specialty respondents and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time=48 minutes, intra-service time=50 minutes and post-service time=40 minutes. The RUC agreed that the pre-service time package 2B (Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)), is appropriate. There is also additional pre-service time that has been established in the renal angiography codes, for positioning the equipment around the patient, as well as additional time in the evaluation unique to these patients, to conduct a neurological evaluation. The same neurological evaluation is conducted in the post-service period to ensure that there is no change in deficits, because a significant risk factor in these procedures continues to be stroke. There is also additional time in the post-service period for review and interpretation of the imaging sequences. The RUC agreed with the specialties that the survey median, 8.00 work RVUs, was too high for this procedure. The RUC compared 36224 to the key reference service CPT code 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* (work RVU=7.55) and determined that the two codes have similar total time at 138 and 131 and that 36224 requires a slightly higher level of intensity to perform. The RUC agreed that these two services have similar physician work and should be valued identically. **The RUC recommends a work RVU of 7.55, a direct crosswalk to CPT code 36253, for CPT code 36224.**

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***

The RUC reviewed the survey results from 55 multi-specialty respondents and agreed with the specialty societies that the following physician times accurately reflect the

physician work involved in this service: pre-service time=48 minutes, intra-service time=45 minutes and post-service time=40 minutes. The RUC agreed that the pre-service time package 2B (Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)), is appropriate. There is also additional pre-service time that has been established in the renal angiography codes, for positioning the equipment around the patient, as well as additional time in the evaluation unique to these patients, to conduct a neurological evaluation. The same neurological evaluation is conducted in the post-service period to ensure that there is no change in deficits, because a significant risk factor in these procedures continues to be stroke. There is also additional time in the post-service period for review and interpretation of the imaging sequences. The RUC agreed with the specialties that the physician work of 36225 is analogous to the work of 36223. Both services have identical survey median times and thus should be valued identically. The RUC agreed with the specialties that the median survey RVU of 6.50 is an accurate measure of the physician work involved in this service. The RUC compared 36225 to the key reference service CPT code 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* (work RVU=5.35) and determined that the codes have identical intra-service times at 45 minutes. 36225 has more total time at 133 and 116, respectively, and a significantly higher level of intensity to perform. These factors account for the higher RVU. **The RUC recommends a work RVU of 6.50 for CPT code 36225.**

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***
The RUC reviewed the survey results from 55 multi-specialty respondents and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time=48 minutes, intra-service time=50 minutes and post-service time=40 minutes. The RUC agreed that the pre-service time package 2B (Difficult Patient/Straightforward Procedure (With sedation/anesthesia care)), is appropriate. There is also additional pre-service time that has been established in the renal angiography codes, for positioning the equipment around the patient, as well as additional time in the evaluation unique to these patients, to conduct a neurological evaluation. The same neurological evaluation is conducted in the post-service period to ensure that there is no change in deficits, because a significant risk factor in these procedures continues to be stroke. There is also additional time in the post-service period for review and interpretation of the imaging sequences. The RUC agreed with the specialties that the survey median, 8.00 work RVUs, was too high for this procedure. The RUC compared 36226 to the key reference service CPT code 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* (work RVU=7.55) and determined that the two codes have similar total time at 138 and 131 and a 36226 has a higher level of intensity to perform. The

RUC agreed that these two services have similar physician work and should be valued identically. **The RUC recommends a work RVU of 7.55, a direct crosswalk to CPT code 36253, for CPT code 36226.**

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)***
The RUC reviewed the survey results from 55 multi-specialty respondents and agreed with the specialty societies that the following physician times accurately reflect the physician work involved in this service: pre-service time=0 minutes, intra-service time=15 minutes and post-service time=0 minutes. The specialty societies recommended 10 minutes of post-service time for review and interpretation of the imaging sequences, however the RUC found that post-service time is not appropriate for ZZZ codes and the additional review and interpretation was accounted for in the base codes, as well as the intra-service time as described. The RUC discussed the estimated survey work values and agreed that the respondents overestimated the physician work involved in the service. The RUC agreed with the specialty societies that in order to maintain rank order and magnitude of estimation a direct crosswalk to the two component codes being bundled CPT codes 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)* (work RVU=1.01) and 75660 *Angiography, external carotid, unilateral, selective, radiological supervision and interpretation* (work RVU=1.31), is justified. **The RUC recommends a work RVU of 2.32 for CPT code 36227, a direct crosswalk to CPT codes 36218 and 75660.**

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)***
The RUC reviewed the survey results from 55 multi-specialty respondents and recommends to a work RVU of 4.25, the survey's 25th percentile. The RUC agreed with the specialty societies that there is 30 minutes intra-service time for this ZZZ global service. The RUC discussed whether or not post-service time was appropriate for this service and agreed that post-service time is not appropriate for ZZZ codes and the additional review and interpretation was accounted for in the base codes, as well as intra-service time as described. The RUC compared 36228 to the key reference service CPT code 61642 *Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular family (List separately in addition to code for primary procedure)* (work RVU=8.66) and determined that 61642 has significantly more intra-service time at 60 minutes accounting for the higher RVU. The RUC also compared 36228 to CPT code 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)* (work RVU=4.12) and noted that the codes are both ZZZ global service and have identical intraservice time, 30 minutes. **The RUC recommends a work RVU of 4.25 for CPT code 36228.**

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

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

Bundle Thrombolysis (Tab 15)
Gary Seabrook, MD (SVS); Robert Zwolak, MD (SVS); Mathew Sideman, MD (SVS); Michael Sutherland, MD (SVS); Sean Roddy, MD (SVS); Sean Tutton, MD (SIR); Michael Hall, MD (SIR); Robert Vogelzang, MD (SIR); Jerry Niedzwiecki, MD (SIR); Geraldine McGinty, MD (ACR); Zeke Silva, MD (ACR)

In 2010, the Relativity Assessment Workgroup identified two codes through the 75% reported together screen: 37201 *transcatheter therapy, infusion for thrombolysis other than coronary* and 75896 *transcatheter therapy, infusion, any method (eg thrombolysis other than coronary), radiological supervision and interpretation*. In October 2011, the CPT Editorial Panel created four new codes (37211-4) to describe transcatheter therapy for thrombolysis bundled with radiologic supervision and interpretation and Evaluation and Management services. In January 2012, the specialty societies requested deferment of this family of services due to late CPT changes that expanded the number of codes; the continued questions about CPT guideline text, descriptors, and parentheticals; and the imprecision of the 000-day global survey instrument to accurately survey these codes. The Research Subcommittee approved a modified 000-day global survey instrument to be used to survey this family at the RUC meeting in April 2012.

37211 ***Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day***
The RUC reviewed the survey data from 50 vascular surgeons and interventional/diagnostic radiologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 60 minutes and post-service time= 30 minutes. In accordance with prior analogous recommendations (e.g. lower extremity revascularization) additional pre-service time was added, 9 minutes, for proper positioning and additional evaluation necessary for selection and verification of numerous supplies and equipment. The RUC also noted that the post-service time, and the work value, includes the work of a subsequent hospital care service, CPT code 99233, which was previously separately reportable on the same date of service.

The RUC reviewed the survey's estimated work values and agreed with the specialty society that 8.00 work RVUs, the survey's 25th percentile, accurately reflects the physician work involved in this service. To justify this value, the RUC compared the surveyed code to reference CPT code 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* (work RVU= 7.35) and agreed that while the services have comparable work, 37211 should be valued slightly higher due to greater intra-service time, 60 minutes compared to 50 minutes. In addition, the RUC reviewed CPT code 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 (work RVU= 8.15) and agreed that this reference code should be valued slightly higher because it has slightly greater intra-service time compared to the surveyed code, 68 minutes and 60 minutes, respectively. **The RUC recommends a work RVU of 8.00 for CPT code 37211.**

37212 ***Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day***
The RUC reviewed the survey data from 50 vascular surgeons and interventional/diagnostic radiologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 60 minutes and post-service time= 30 minutes. In accordance with prior analogous recommendations (e.g. lower extremity revascularization) additional pre-service time was added, 9 minutes, for proper positioning and additional evaluation necessary for selection and verification of numerous supplies and equipment. The RUC also noted that the post-service time, and the work value, includes the work of a subsequent hospital care service, CPT code 99233, which was previously separately reportable on the same date of service.

The RUC reviewed the survey's estimated work values and agreed with the specialty society that 7.06 work RVUs, the survey's 25th percentile, accurately reflects the physician work involved in this service. To justify this value, the RUC compared the surveyed code to key reference service 37187 *Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance* (work RVU= 8.03) and agreed that reference code should be valued higher due to greater intra-service time and slightly greater total time, 145 minutes and 138 minutes, respectively. In addition, the RUC reviewed CPT code 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* (work RVU= 7.35) and agreed that while the services have comparable work, the surveyed code should be valued lower because it is a less intense and complex service. Finally, the RUC reviewed 37211 in comparison to 37212 and noted that while the two service have identical time, 37212 should be valued lower because the arterial system involved in 37211 has greater intensity due to higher risk for complication compared to the venous infusion code. **The RUC recommends a work RVU of 7.06 for CPT code 37212.**

37213 ***Transcatheter therapy, arterial other than coronary or venous infusion for thrombolysis, 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***
The RUC reviewed the survey data from 50 vascular surgeons and interventional/diagnostic radiologists and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 33 minutes and post-service time= 25 minutes. In accordance with prior analogous recommendations (e.g. lower extremity revascularization) additional pre-service time was added, 2 minutes, for proper positioning to obtain necessary views to treat the lesion. The RUC also noted that the post-service time, and the work value, includes the work of a subsequent hospital care

service, CPT code 99233, which was previously separately reportable on the same date of service. Finally, the specialty discussed that this service includes continued treatment only if the care continues into the third day. This service is not typical, and will be billed only a fraction of the time compared to CPT code 37214, which describes continued care concluded on the second day of care.

The RUC reviewed the survey's estimated work values and agreed with the specialty society that 5.00 work RVUs, the survey's 25th percentile, accurately reflects the physician work involved in this service. To justify this value, the RUC compared the surveyed code to reference CPT code 93452 *Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed* (work RVU= 4.75) and agreed that while the two services are similar services, the surveyed code should be valued slightly higher due to greater intra-service time, 33 minutes and 30 minutes, respectively. In addition, the RUC reviewed CPT code 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* (work RVU= 5.54) and the reference code should be valued slightly higher due to greater intra-service time compared to 37213. Finally, the RUC compared this service to the base arterial infusion service, 37211, and concurred that 37213 is appropriately valued relative to the family of services. **The RUC recommends a work RVU of 5.00 for CPT code 37213.**

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***

The RUC reviewed the survey data from 48 vascular surgeons and interventional/diagnostic radiologists and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 38 minutes and post-service time= 23 minutes. In accordance with prior analogous recommendations (e.g. lower extremity revascularization) additional pre-service time was added, 2 minutes, for proper positioning to obtain necessary views to treat the lesion. The RUC also noted that the post-service time, and the work value, includes the work of a subsequent hospital care service, CPT code 99233, which was previously separately reportable on the same date of service. Finally, the specialty discussed that this service includes continued treatment when the thrombolysis is concluded on the second day, which is the typical clinical scenario.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that the respondents overestimated the physician work involved in this service. To value this service accurately, the previously billed codes that are now bundled into this procedure (75898 work RVU= 1.65 and 99233 work RVU= 1.39) were summated to obtain a work RVU of 3.04. The RUC agreed that a work RVU of 3.04, below the survey's 25th percentile, is an accurate value for this service. To justify this value, the RUC compared the surveyed code to reference code 36200 *Introduction of catheter, aorta* (work RVU= 3.02) and agreed that while 37214 has 8 minutes more intra-service time compared to 36200, the reference code is a more intense procedure and the

two services should be valued similarly. In addition, the RUC reviewed CPT code 31630 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with tracheal/bronchial dilation or closed reduction of fracture* (work RVU= 3.81) and agreed that the reference code should be valued higher due to greater intra-service time compared to the surveyed code, 45 minutes and 38 minutes, respectively. Finally, the RUC reviewed code 37214 in relation to the family of services and noted that the intensity and complexity of 37214 is much less compared to 37213 and is appropriately valued lower than 37213. **The RUC recommends a work RVU of 3.04 for CPT code 37214.**

The RUC discussed the need to survey CPT codes 75896 *Transcatheter therapy, infusion other than for thrombolysis, radiological supervision and interpretation* and CPT code 75898 *Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis* since the inherent physician work has changed due to CPT Editorial Panel revisions. The specialty explained that these codes will see large utilization shifts into the new bundled codes. The specialty societies have indicated that CPT code 75898 will be addressed in the upcoming Embolization code change proposal to the CPT Editorial Panel in CPT 2013. The specialties will be providing a further recommendation for CPT code 75896 at the October 2012 RUC meeting and the resulting RUC recommendation will be sent to CMS immediately for inclusion in the CY 2013 MPFS Final Rule. **However, until recommendations are provided, the RUC recommends carrier pricing for CPT codes 75896 and 75898.**

Practice Expense: The RUC reviewed and accepted the direct practice expense inputs with minor modifications by the Practice Expense Subcommittee.

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

Bone Marrow Stem Cell Transplant (Tab 16)
James Gajewski, MD (ASBMT); Sam Silver, MD (ASH)

In February 2011, the RUC had a extensive discussion regarding the appropriate Evaluation and Management billing for CPT code 38240 *Bone marrow or blood-derived peripheral stem cell transplantation; per allogenic donor*. The specialties explained that the physician work involved in the management of infusion, including managing a reaction, is included in the intra-service work of code 38240. The RUC expressed concern that implementing CCI edits to preclude reporting an Evaluation and Management service on the same date of service would limit the ability for physicians to report the separately identifiable visit prior to the procedure on the same date. Given this, the RUC, and the specialty agreed, that this service should be referred back to the CPT Editorial Panel along with the family of services, CPT codes 38241 and 38242, to examine the current descriptors and descriptions of physician work to ensure these services are currently reported correctly and can be properly valued by the RUC.

In October 2011, the CPT Editorial Panel added introductory language, created one new code to describe hematopoietic progenitor cell boost and revised three existing codes to clarify this family of services.

The specialty societies indicated and the RUC agreed that there is compelling evidence that these services have changed since 1992. The majority of allogeneic transplants are

now from unrelated donors which have much greater risk to the patient. Additionally, the typical patient has changed, the population receiving transplants now have acute diseases, such as acute myologic leukemia, acute lympoblastic leukemia, multiple myelomas etc., whereas previously the typical patient had chronic disease.

38240 ***Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor***
The RUC reviewed the survey results from 37 bone and marrow transplant physicians and determined that the survey median work RVU of 4.00 appropriately accounts for the work required to perform this service. The RUC agreed with the surveyed physician time of 30 minutes pre-time, 60 minutes intra-time and 30 minutes post-service time. The specialty society indicated that the physician is a participant in manufacturing of the product, assessing the purity and potency of stem cells and ensuring systems are in place to deliver product properly. As part of the intra-service, the RUC determined that the physician is not checking the patient's vitals, but must be immediately available on-site, typically in the hallway. The RUC noted that the post-service time includes producing the lengthy report to the FDA. The RUC also determined that 38240 is more intense and complex than 38241, the autologous transplantation code.

The RUC compared 38240 to the key reference code 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) and determined that 38240 requires much more physician time, technical skill, physical effort and psychological stress to perform. For further support the RUC compared 38240 to codes 99223 *Initial hospital care, per day, for the evaluation and management of a patient* (work RVU = 3.86 and 55 minutes intra-service time) and 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)* (work RVU = 3.72 and 45 minutes intra-service time), both which require less physician work and time than the surveyed service. **The RUC recommends a work RVU of 4.00 for CPT code 38240.**

38241 ***Hematopoietic progenitor cell (HPC); autologous transplantation***
The RUC reviewed the survey results from 33 bone and marrow transplant physicians and determined that the survey 25th percentile work RVU of 3.00 appropriately accounts for the work required to perform this service. The RUC determined physician time of 18 minutes pre-time, 60 minutes intra-time and 30 minutes post-service time were appropriate to perform this service. This service will require less pre-service time than 38240 since the donor and recipient are the same person. The specialty society indicated that the physician is a participant in manufacturing of the product, assessing the purity and potency of stem cells and ensuring systems are in place to deliver product properly. Additionally, regarding the intra-service time, the RUC determined that the physician is not checking the patient's vitals, but must be immediately available on-site, typically in the hallway. The RUC noted that the post-service time includes producing the lengthy report to the FDA.

The RUC determined that a work RVU of 3.00 places this service in the proper rank order compared to the allogeneic code 38240. The RUC compared 38241 to code 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 (work RVU = 3.00 and 60 minutes intra-service time) and determined that both services require the same physician work and time to perform. For further support the RUC compared 38241 to code 75563 *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging* (work RVU = 3.00 and 60 minutes intra-service time), which requires the same physician work and time as the surveyed service. **The RUC recommends a work RVU of 3.00 for CPT code 38241.**

38243 *Hematopoietic progenitor cell (HPC); HPC boost*
The RUC reviewed the survey results from 30 bone and marrow transplant physicians and determined that the survey 25th percentile work RVU of 2.13 appropriately accounts for the work required to perform this service. The RUC determined the survey time of 30 minutes pre-time, 45 minutes intra-time and 30 minutes post-service time were appropriate to perform this service. The specialty society indicated that the physician is a participant in manufacturing of the product, assessing the purity and potency of stem cells and ensuring systems are in place to deliver product properly. Additionally, regarding the intra-service time, the RUC determined that the physician is not checking the patient's vitals, but must be immediately available on-site, typically in the hallway. The RUC noted that the post-service time includes producing the lengthy report to the FDA.

The RUC compared 38243 to key reference code 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 determined that 38243 requires the 10 minutes more intra-service time but similar physician work to perform. For additional support the RUC compared 38243 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* (work RVU = 2.11) and determined that the surveyed code required similar physician work to perform. **The RUC recommends a work RVU of 2.13 for CPT code 38243.**

38242 *Allogeneic lymphocyte infusion*
The RUC reviewed the survey results from 31 bone and marrow transplant physicians and determined that the survey 25th percentile work RVU of 2.11 appropriately accounts for the work required to perform this service. The RUC determined the survey time of 30 minutes pre-time, 45 minutes intra-time and 30 minutes post-service time were appropriate to perform this service. The specialty society indicated that the physician is a participant in manufacturing of the product, assessing the purity and potency of stem cells and ensuring systems are in place to deliver product properly. Additionally, regarding the intra-service time, the RUC determined that the physician is not checking the patient's vitals, but must be immediately available on-site, typically in the hallway. The RUC noted that the post-service time includes producing the lengthy report to the FDA.

The RUC compared 38242 to key reference code 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 determined that 38242 requires the 10 minutes more intra-service time but the same physician work to perform. For additional support the RUC compared 38242 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 (work RVU = 2.11) and determined that the surveyed code required the same physician work to perform. The RUC determined that a work RVU of 2.11 places this service in the proper rank order relative to 38243 (recommended work RVU = 2.13 and same physician time). **The RUC recommends a work RVU of 2.11 for CPT code 38242.**

Practice Expense
This service is performed in the facility only and therefore has no direct practice expense inputs.

Optical Endomicroscopy (Tab 17)
Joel V. Brill, MD (AGA); Nicholas Nickl, MD (ASGE); Daniel DeMarco, MD (ACG); Jonathan L. Myles, MD (CAP)

In the 2012 Medicare Physician Fee Schedule (MFS) Final Rule the Centers for Medicare and Medicaid Services (CMS) requested that the RUC review CPT codes 43235 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* and 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure*). At the February 2012 CPT Editorial Panel meeting, the specialty societies presented two new endoscopic procedures for optical endomicroscopy: 43206 *Esophagoscopy, rigid or flexible; with optical endomicroscopy; and* 43252 *Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; with optical endomicroscopy;* as well as one new pathology procedure for optical endomicroscopy: 88375 *Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session.* In the final rule, CMS stated that if new codes are introduced within a family, the entire family should be reviewed in order to maintain relativity and avoid separate valuations of codes within a specific family. Because the existing family of codes were already scheduled for review at either the October 2012 or January 2013 RUC meetings, the RUC agrees with the specialty societies that survey and review of the family of codes should be delayed in order to maintain relativity and meet CMS standards. **The RUC recommends that the specialty societies survey 43206 and the esophagoscopy family of codes for review at the October 2012 RUC meeting, and CPT codes 43252 and 88375 with the Upper Gastrointestinal Endoscopy Codes for review at the January 2013 RUC meeting. In the interim the RUC recommends that CPT codes 43206, 43252 and 88375 be carrier priced for 2013.**

Fecal Bacteriotherapy (Tab 18)
Lawrence Martinelli, MD (IDSA); Johan Bakken, MD (IDSA); Nicholas Nickl, MD (ASGE); Edward Bentley, MD (ASGE)

In February 2012, the CPT Editorial Panel created CPT code 44705 *Preparation of fecal microbiota for instillation, including assessment of donor specimen*. The specialty societies conducted a survey of this rarely performed service and only received responses from 11 physicians whom perform the service described. The RUC agreed with the specialty societies that the survey respondents overestimated the physician work involved. The RUC reviewed the results of an expert panel of physicians as presented to

the RUC and determined that a work RVU of 1.42, below the 25th percentile, appropriately accounts for the physician work required to perform this service. The RUC agreed with the survey time of 4 minutes pre-service, 20 minutes intra-service and 5 minutes post-service. This service is delivered to the donor and is primarily oriented to establish that the donor is a well patient and suitable to act as a donor. The work is equivalent to a 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 1.42). The RUC compared 44705 to 99203 and determined both services require the same physician work and physician time to perform. The RUC determined a direct crosswalk to CPT code 99203 is appropriate. **The RUC recommends a work RVU of 1.42 for CPT code 44705, a direct crosswalk to CPT code 99203.**

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

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

Bladder Chemodenervation (Tab 19)
Thomas Cooper, MD (AUA); Christopher Gonzalez, MD (AUA); Thomas Turk MD (AUA); Stephanie Klieb, MD (AUA)

In February 2012, the CPT Panel created a new code, 52287 *Cystourethroscopy, with injection(s) for chemodenervation of the bladder* to report physician work related to chemodenervation of the bladder. This procedure was previously reported using an unlisted code.

The RUC reviewed the survey results from 59 urologists and determined the survey respondents overestimated the physician work to perform this service. Additionally, there was consensus among the RUC that the survey median intra service time of 20 minutes was insufficient for a basic cystourethroscopy, which includes the work of CPT code 52000 (work RVU=2.23, intra service time=15 minutes) plus 30 injections. The RUC also agreed that this work was completely different than other chemodenervation treatments (e.g., migraine). The risks, including paralytic bladder, bleeding, perforation and urosepsis are significantly greater.

The RUC attempted to identify CPT codes with similar physician time and intensity. The RUC reviewed 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 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU=2.86) and agreed that although theses procedures have the same intra-service time of 20 minutes, the intensity of 52287 is higher. The RUC reviewed 52007 *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis* (work RVU=3.02) and determined that the physician work and intensity were similar. **The RUC recommends that 52287 be resurveyed in October 2012 to validate the intra service time and time. In the interim, the RUC recommends a work RVU of 3.02, a direct crosswalk to CPT code 52007, for CPT code 52287.**

Practice Expense:
The RUC approved the practice expense inputs as modified and submitted by the Practice Expense Subcommittee.

Chemodenervation for Chronic Migraine and Related Family (Tab 20)
Stephen Kamenetzky, M.D. (AAO); Robert Weiss, M.D. (AAO); Kevin Kerber, M.D. (AAN); Joe Zuhosky, M.D. (AAPMR)

In February 2012, the CPT Editorial Panel created one new code to describe a new injection paradigm for treatment of chronic migraine as current codes do not describe the totality of the work performed. The Panel also revised 64612 to indicate that this service is unilateral as well as clarify the parenthetical following 64614. The entire family was to be surveyed to avoid any rank order anomalies.

64612 ***Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)***
The RUC reviewed the survey results from 50 ophthalmologists, neurologists, physical and rehabilitation physicians and interventional pain physicians and determined that the survey median work RVU of 1.41, a decrease from the current value, appropriately accounts for the work required to perform this service. The RUC agreed with the survey respondents that 10 minutes pre-time, 10 minutes intra-service time and 5 minutes post-time are required to perform this service. Although the survey respondents indicated that one 99213 office visit is typically performed in the global period for this service, the RUC agreed with the specialties that one 99212 office visit is more appropriate.

The RUC compared 64612 to key reference service 64611 *Chemodenervation of parotid and submandibular salivary glands, bilateral* (work RVU = 1.03 and 5 minutes intra-service time) and determined that 64612 requires twice as much intra-service time, more physician work and is more intense and complex. The RUC also compared 64612 to MPC code 41100 *Biopsy of tongue; anterior two-thirds* (work RVU = 1.42 and 15 minutes intra-service time) and 68840 *Probing of lacrimal canaliculi, with or without irrigation* (work RVU = 1.30 and 10 minutes intra-service time) and determined that a work RVU of 1.41 places this service in the proper rank order among similar services in the Medicare physician payment schedule. **The RUC recommends a work RVU of 1.41 for CPT code 64612.**

64613 ***Chemodenervation of muscle(s); neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia)***
The American Academy of Neurology (AAN), the American Society of Interventional Pain Physicians (ASIPP), the American Academy of Physical Medicine and Rehabilitation (AAPM&R) and the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) surveyed 64613 and indicated that the current parenthetical has a multi-purpose use for spasmodic torticollis and spasmodic dysphonia. The specialties believe that the varied data is due to the different uses of this procedures when performed by an otolaryngologist who is injecting the larynx versus the other three specialties who are injecting into a neck muscle. All specialties agree that injecting into the larynx is substantially different work than injecting the neck muscle. The specialty societies requested and the RUC agreed that code 64613 be referred to the CPT Editorial Panel to create two codes to describe two separate and distinct services. **The RUC**

recommends that 64613 be referred to the CPT Editorial panel to create two codes, one to describe chemodenervation for spasmodic torticollis and another to describe chemodenervation for spasmodic dysphonia.

64614 ***Chemodenervation of muscle(s); extremity and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)***
The specialty societies indicated that CPT code 64614 was included to be surveyed as part of this family of services. However, AAN and AAPM&R recently submitted a code change proposal to split 64614 into two new codes. **The specialties requested and the RUC agreed to postpone review of this service until the October 2012 RUC meeting.**

64615 Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)
The RUC reviewed the survey results from 41 ophthalmologists, neurologists, physical and rehabilitation physicians and interventional pain physicians and determined that the survey median work RVU of 1.85 appropriately accounts for the work required to perform this service. The RUC determined that 15 minutes pre-time, 15 minutes intra-service time and 5 minutes post-time are required to perform this service. The survey respondents did not indicate that a post-operative office visit is typical, the specialty societies agreed and requests that CMS change this service to a 000-day global period.

The RUC compared 64615 to 70546 *Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences* (work RVU = 1.80 and 15 minutes intra-service time) and determined that these services require similar physician work, intensity, complexity and intra-service time to perform. The RUC also compared 64615 to MPC code 92004 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits* (work RVU = 1.22 and 25 minutes intra-service time) and determined that a work RVU of 1.85 places this service in the proper rank order among similar services in the Medicare physician payment schedule. **The RUC recommends a work RVU of 1.85 and requests a 000-global period for CPT code 64615.**

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

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

<u>Paracentesis of the Eye (Tab 21)</u>
Stephen A. Kamenetzky, MD (AAO); David Glasser, MD (AAO)

In April 2011 the RUC identified CPT code 65805 *Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous* through the Harvard-Valued Utilization over 30,000 screen and in September 2011 added 65800 to review as part of this family of services. In February 2012, specialty society brought forth a coding proposal to the CPT Editorial Panel to delete 65805 and revise 65800 as these services describe essentially the same procedure and are currently valued the same.

The RUC reviewed the survey results from 34 ophthalmologists and determined that the survey median work RVU of 1.53, lower than the current value, appropriately accounts for the physician work required to perform this service. The RUC agreed with the survey times of 12 minutes pre-evaluation, 1 minute pre-positioning and 5 minutes scrub, dress, wait time to administer topical anesthesia, insert lead, apply betadine and finally apply the gelatinous anesthetic; 5 minutes intra-service time and 5 minutes immediate post-service time. There are several codes that are similar in work and intensity to 65800. CPT *67028 Intravitreal injection of a pharmacologic agent (separate procedure)* reviewed in 2009 has a WRVU of 1.44 with times of 12/5/5. Both involve penetration of the eye with a needle and the risk of damage to internal structures. The RUC felt that the work of 67028 was similar to that of CPT 67515 *Injection of medication or other substance into Tenon's capsule* (RUC 2005, 000, 11/5/5) which has a WRVU of 1.40. CPT *67500 Retrobulbar injection; medication (separate procedure, does not include supply of medication)* (RUC 2005, 000, 15/5/5) has similar times and intensities with a WRVU of 1.44. Both of these procedures involve extraocular injections. Because the risk of serious damage from an intraocular injection is greater than an extraocular injection, the panel felt that the value of 65800 should be slightly higher. **The RUC recommends the median of the survey WRVU 1.53 as the proper value for the procedure.**

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

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

Please Note: The retrobulbar injection is not additionally reportable with this procedure. This clarification will be published in the November 2012 issue of CPT Assistant.

Thyroid Uptake/Imaging (Tab 22)
Geraldine McGinty, MD (ACR); Zeke Silva, MD (ACR); Kenneth McKusick, MD (SNM); Gary Dillehay, MD (SNM); Scott C. Bartley, MD (ACNM)

In April 2011 CPT Code 78007, *Thyroid imaging, with uptake; multiple determinations* was identified in the Harvard Valued-Utilization over 30,000 screen. In February 2012, the CPT Editorial Panel approved a plan to consolidate seven thyroid codes into three new CPT codes.

78012 ***Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression or discharge, when performed)***
The RUC reviewed the survey results of 118 respondents and determined that the survey respondents overestimated the physician work involved in this service. The RUC agreed with the specialty that the 25th percentile in intra-service time of 5 minutes was a more accurate depiction of the work involved. The RUC also noted that the survey's work values were overestimated and agreed that a work RVU of 0.19 which is below the 25th percentile is appropriate. This procedure is currently reported using CPT codes 78000 *Thyroid uptake; single determination* (work RVU=0.19), 78001 *Thyroid uptake; multiple determinations* (work RVU=0.33) and 78003 *Thyroid uptake; stimulation, suppression or discharge (not including initial uptake studies)* (work RVU=0.33) and will be bundled into 78012. The RUC agreed with the specialty that the work value of 78012 is identical

to the physician work of CPT 78000 and should have an identical work RVU of 0.19. The RUC compared 78012 to key reference service 78226 *Hepatobiliary system imaging, including gallbladder when present* (work RVU=0.74) and determined 78226 requires more time and intensity and should therefore be valued higher. The RUC also reviewed CPT Code 73560 *Radiologic examination, knee; 1 or 2 views* (work RVU=0.17) and 71020 *Radiologic examination, chest, 2 views, frontal and lateral* (work RVU=0.22) and agreed that 78012 should be valued between these two services. **The RUC recommends a work RVU of 0.19 for CPT code 78012.**

78013 ***Thyroid imaging (including vascular flow, when performed)***
The RUC reviewed the survey results of 113 respondents and determined that the survey respondents overestimated the physician work involved in this service. The RUC agreed with the specialty that the 25th percentile intra-service time of 10 minutes was a more accurate depiction of the time involved and maintains rank order with the family of services. The RUC also noted that the survey's work values were overestimated and agreed that a work RVU of 0.37, which is below the 25th percentile, is more appropriate. This procedure is currently reported using CPT codes 78010 *Thyroid imaging; only* (work RVU=0.39) and 78011 *Thyroid imaging; with vascular flow* (work RVU=0.45). The RUC agreed that the valuation of 78013 should be based on the most commonly reported current code, 78010; however the RUC made slight adjustments to preserve work neutrality across the family. Therefore, a work RVU of 0.37 for 78013 is relative to the family of services. The RUC compared 78013 to key reference service 78226 *Hepatobiliary system imaging, including gallbladder when present* (work RVU=0.74) and agreed that although the times are the same, the intensity of 78226 is higher. The RUC also reviewed 77071 *Manual application of stress performed by physician for joint radiography, including contralateral joint if indicated* (work RVU=0.41) and determined that although 78013 has more physician time, the intensity of 77071 is greater and should therefore be valued slightly higher. The RUC agreed that a work RVU of 0.37 would maintain proper rank order and budget neutrality within this family of service. **The RUC recommends a work RVU of 0.37 for CPT code 78013.**

78014 ***Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression or discharge, when performed)***
The RUC reviewed the survey results of 129 respondents and determined that the survey respondents overestimated the physician work involved in this service. The RUC agreed with the specialty that in order to maintain rank order within the family of services the intra-service time should be crosswalked to 78013, 10 minutes. The RUC also noted that the survey's work values were overestimated and agreed that a work RVU of 0.50, which is below the 25th percentile, is more appropriate. This procedure is currently reported using CPT codes 78006 *Thyroid imaging, with uptake; single determination* (work RVU=0.49) and 78007 *Thyroid imaging, with uptake; multiple determinations* (RVU=0.50) and will be bundled into 78014. The RUC agreed with the specialty that no compelling evidence for an increase exists. As such, the work value of 78014 should be equivalent to the most commonly reported service currently, CPT 78007 and should have an identical work RVU of 0.50. The RUC compared 78014 to code 78227 *Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed* (work RVU=0.90) and determined that 78227 has a higher work intensity and requires more physician time. The RUC also reviewed CPT codes 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 (work RVU=0.62) and 78306 *Bone and/or joint imaging; whole body* (work RVU=0.86) and determined that although these services require similar physician work, the intensity of 77300 and 78306 is higher. Finally, the RUC compared 78014 to 78013 and noted that while the physician time is the same, 78014 should be valued higher because it has greater intensity and complexity since it includes the work of 78012 and 78013. The RUC determined that a work RVU of 0.50 maintains proper rank order and budget neutrality within this family of services. **The RUC recommends a work RVU of 0.50 for CPT Code 78014.**

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

Practice Expense:
The RUC reviewed and approved practice expense inputs with minor modifications recommended by the Practice Expense Subcommittee.

<u>Parathyroid Imaging (Tab 23)</u>
Geraldine McGinty, MD (ACR); Zeke Silva, MD (ACR); Kenneth McKusick, MD (SNM); Gary Dillehay, MD (SNM); Scott C. Bartley, MD (ACNM)

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.

78070 ***Parathyroid planar imaging (including subtraction, when performed);***
The RUC reviewed survey results from 102 radiologists and nuclear medicine physicians and recommends a work RVU of 0.80, the survey 25th percentile. The RUC noted that 78070 was editorially revised to clarify imaging by planar technique and has a current work RVU of 0.82. However, the RUC agreed that the 25th percentile work RVU of 0.80 should be assigned. The RUC compared code 78070 to CPT code 78226 *Hepatobiliary system imaging, including gallbladder when present* (work RVU=0.74) and noted that although these two procedures require the same physician time, 78070 is a dual-phase study which requires more physician work. The RUC also reviewed 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU=0.81) and determined that the physician times are similar and they are comparable tests. **The RUC recommends a work RVU of 0.80 for CPT Code 78070**.

78071 ***Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)***
The RUC reviewed survey results from 94 radiologists and nuclear medicine physicians and determined that a work RVU of 1.20, the survey median, is appropriate. The RUC noted that currently this procedure is reported using CPT codes 78070 *Parathyroid imaging* (work RVU=0.82) and 78803 *Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SPECT)* (work RVU=1.09). The RUC compared 78071 to key reference service 78452 *Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or*

quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection (work RVU=1.62) and determined that 78452 requires more physician time and should be valued higher than 78071. The RUC also reviewed 78494 *Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing* (work RVU=1.19) and agreed that physician times and work are comparable. To further support a work RVU of 1.20, the RUC also reviewed 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU=1.27) and 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* (work RVU=1.34) and determined these procedures require similar physician time and intensity. **The RUC recommends a work RVU of 1.20 for CPT Code 78071.**

78072 ***Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization***
This service reflects new technology currently reported with unlisted codes. The RUC reviewed survey results from 86 radiologists and nuclear medicine physicians and determined that a work RVU of 1.60, the survey median, is appropriate. The RUC reviewed key reference service 78814 *Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)* (work RVU=2.20) and agreed that with 30 additional total minutes and higher intensity, the reference code should be valued higher. The RUC also reviewed 73721 *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (work RVU=1.35) and determined that this was a less intense procedure compared to the surveyed code. There was consensus among the RUC that, giving these comparators, a work RVU of 1.60 would maintain proper rank order among this family of services. **The RUC recommends a work RVU of 1.60 for CPT Code 78072.**

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

Practice Expense:
The RUC reviewed and approved practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

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

<u>Molecular Pathology – Adenomatous Polyposis Coli (Tab 24)</u>
Jonathan Myles, MD, (CAP); Aaron Bossler, MD, PhD (CAP); Roger Klein, MD, JD (CAP)

The College of American Pathologists explained to the RUC that these three Molecular Pathology codes, 81201, 81202 and 81203, are among the last and lowest volume Tier 1

molecular pathology codes developed by the CPT Editorial Panel. Previous attempts to survey low volume Molecular Pathology services have resulted in surveys with inadequate responses and it is suspected that these codes, performed by ultra-specialized molecular pathologists, would yield much less than adequate survey responses. At the September 2011 RUC meeting, the RUC agreed to crosswalk other low volume Tier 1 Molecular Pathology codes to Tier 2 molecular pathology codes. In February 2012 the RUC approved the Research Subcommittee and specialty request to use direct crosswalks to obtain credible values and time for these services.

The RUC reviewed CPT code 81201 *APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence* and agreed to directly crosswalk this service to the Molecular Pathology Tier 2 code 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)* (work RVU= 1.40). This reference service is an accurate comparator for 81201 because Level 7 is the Tier 2 level to which 81201 would have been assigned had it been placed on Tier 2 based on the physician work and practice expense involved in sequencing the 15 coding exons of the APC gene. . **The RUC recommends a work RVU of 1.40 and intra-service time of 60 minutes for CPT code 81201.**

The RUC reviewed CPT code 81202 *APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants* and agreed to directly crosswalk this service to the Molecular Pathology Tier 2 code 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)* (work RVU= 0.52). The RUC agreed that 81202 involves the physician work of DNA sequence analysis of a single exon, and not a full gene sequence analysis, compared to 81201. Therefore, 81202 should be valued the same as reference code 81403, which also describes the physician work of analyzing a single exon by DNA sequence analysis. **The RUC recommends a work RUV of 0.52 and intra-service time of 28 minutes for CPT code 81202.**

The RUC reviewed CPT code 81203 *APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants* and agreed to directly crosswalk this service to the Molecular Pathology Tier 2 code 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)* (work RVU= 0.80).Level 6 is the Tier 2 level to which 81203 would have been assigned had it been placed on Tier 2 based on the physician work and practice expense involved in duplication/deletion analysis of the 15 coding exons of the APC gene, and the RUC agreed that 81203 represents the physician work involved with duplication deletion analysis of 11 – 25 exons. The RUC noted that this service has physician work that is more complex than 81202 but less complex than 81201 and is correctly valued in between the two services. **The RUC recommends a work RVU of 0.80 and intra-service time of 30 minutes for CPT code 81203.**

Practice Expense: The RUC reviewed and accepted the direct practice expense inputs as approved by the Practice Expense Subcommittee.

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

Cell Enumeration Circulating Tumor Cells (Tab 25)
Jonathan Myles, MD (CAP)

In February 2012, the CPT Editorial Panel created two new CPT codes 86152 and 86153 to describe cell enumeration of circulating tumor cells in fluid specimens using an immunologic method and deleted the previous category III codes that described this service (0279T and 0280T). CPT code 86152 will be paid on the Clinical Laboratory Fee Schedule.

86153 ***Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood):*** **physician interpretation and report, when required**
The RUC reviewed the survey data from 36 pathologists and recommends the following physician work time components: intra-service time= 20 minutes and post-service time= 5 minutes. The specialty explained that the methodology used to survey this procedure involved a general subset of the College of American Pathologists (CAP) membership and a specified list of users supplied by the vendor of the test. Of the 36 survey respondents, 21 were from the vendor list. The RUC agreed that the survey results obtained from the vendor list is more representative of the typical practice of the interpretation and report of circulating tumor cells. Physicians' in this group are experienced and more attuned to the service provided than the group of 15 randomly selected CAP members. Therefore, the RUC agreed that a work RVU of 0.69, the 25th percentile survey results from the vendor's list, accurately reflects the physician work involved in this service.

To justify a work value of 0.69, the RUC reviewed CPT code 88305 *Level IV Surgical pathology, gross and microscopic examination* (work RVU= 0.75) and agreed that the reference code should be valued slightly higher due to greater intra-service time compared to 86153, 25 minutes and 20 minutes, respectively. In addition, the RUC compared the surveyed code to CPT code 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site* (work RVU= 0.69) and agreed that these two similar pathology services should be valued the same given analogous physician work and intensity. **The RUC recommends a work RVU of 0.69 for CPT code 86153.**

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

New Technology: This service will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Psychotherapy (Tab 26)
Jeremy Musher, MD (APA); Sherry Barron-Seabrook, MD (AACAP); James Georgoulakis, PhD (APA); Doris Tomer, LCSW (NASW)

In the 4th Five-Year Review of the RBRVS, CMS received comment letters from the providers of psychotherapy, CPT codes 90801-90880 as potentially misvalued. CMS forwarded these services to the RUC to be included in the fourth Five-Year Review

process. CPT code 90849 was withdrawn by the original commenter as the specialties indicated that very few of their members provide this service. This specialty recommendation was supported by the Medicare utilization data for this service which was very low in 2008, 343 claims. In April and May 2010, the Research Subcommittee met to review vignettes and reference service lists. The Subcommittee recommended that 90801 and 90802 be removed from the list of codes to be reviewed and be referred to the CPT Editorial Panel so that modifications could be made to the descriptors to reflect the different work performed by the physician and non-physician providers. In June 2010, a RUC Facilitation Committee met with the sponsoring specialty societies. The Pre-Facilitation Committee agreed with the Research Subcommittee's recommendations to refer 90801 and 90802 to the CPT Editorial Panel. The Pre-Facilitation Committee recommended that all of the psychotherapy codes with Evaluation and Management components (90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829, and 90862) be referred to the CPT Editorial Panel to potentially create a new coding structure based on the varying levels of evaluation and management within each code. The remainder of the CPT codes identified were surveyed for the October 2010 RUC Meeting.

At the October 2010 RUC Meeting, the specialties presented compelling evidence arguments to change the current value of the remaining psychotherapy services. The specialties indicated that the patient population receiving these services has dramatically changed since the codes were previously reviewed. Currently, according to a National Comorbidity Survey, 56% of patients receiving psychotherapy have multiple comorbid conditions, meaning having more than one mental or physical disorder, including substance abuse. Due to the prevalence of comorbid patients, the work of the provider has changed as most research treatment protocols were originally designed for patients with single disorders. Further, the specialties indicated that the site of service for patients receiving many of these services has changed. Patients, who were once treated in the hospital setting, are now more frequently being treated in the office setting as the number of psychiatric beds has dropped by more than 60% between 1970 and 2000. The RUC accepted these compelling evidence arguments to potentially modify the current value of these services.

However, the RUC review of survey data presented at the October 2010 meeting , concluded that the entire section of psychotherapy services would benefit from a restructuring within CPT. A CPT Workgroup was created to address these concerns and a coding proposal was issued from the Workgroup to the CPT Editorial Panel for review. In February 2012, after a year of analysis and participation by all providers of the services, the CPT Editorial Panel replaced the current psychotherapy section with a new structure allowing separate reporting of E/M codes, eliminating site of service differential and creation of series of add-on codes to psychotherapy to describe interactive complexity and medication management.

The new coding framework, allows all codes to be used in all settings instead of describing site specific services. There are four groupings of services. First, code 90801 *Psychiatric diagnostic interview examination* will be deleted and replaced by two new codes 90791 *Psychiatric diagnostic evaluation* and 90792 *Psychiatric diagnostic evaluation with medical service*. CPT code 90791 is a service without medical work and describes comprehensive psychiatric diagnostic evaluation of psychological and psychosocial conditions often in collaboration with referring primary care physicians. CPT code 90792 is to be reported when a complete comprehensive diagnostic evaluation

involves medical work, capturing the work and teasing out medical causes of psychiatric symptoms such as those caused by thyroid disease or metabolic infectious conditions. The next family has two groupings, psychotherapy stand alone codes without medical services (CPT codes 90832, 90834 and 90837) and the psychotherapy add-on codes, which are used only in conjunction with Evaluation and Management services (90833, 90836 and 90838). The current psychotherapy with E/M inpatient or outpatient codes contain one fixed low level E/M service combined with three levels of time-based psychotherapy services. These fixed E/M components were inadequate for today's patient and are replaced by the psychotherapy add-on codes. Thereby, using the existing E/M structure and a choice of one add-on psychotherapy time-based code, 30, 45 or 60 minutes. The selection of the time increment is based both on patient characteristics and the work to be accomplished in certain types of psychotherapy. Some patients are more resistant to open-up in a session and may require longer sessions. Additionally, some forms of psychotherapy are more geared toward 45 minute sessions (psychodynamic or cognitive behavioral therapy), whereas others are more geared towards 30 minute sessions (brief focused supportive therapy). The add-on codes will be new to many professionals and the American Psychiatric Association will offer extensive education on the use of these codes and to ensure that physicians understand that the time on E/M services is not used to determine the time of the psychotherapy service. The third grouping, psychotherapy inpatient and outpatient services that do not include E/M services (90832, 90834 and 90837) are likely to be reported by psychologists and clinical social workers in all clinical settings. The last grouping are family psychotherapy codes, with and without the patient and in a group setting, remain essentially unchanged (90845, 90846, 90847 and 90853).

90791 ***Psychiatric diagnostic evaluation***
The RUC reviewed the survey results from 202 adult and child psychiatrists, psychologists and social workers for CPT code 90791 and determined that the median work RVU of 3.00 appropriately accounts for the physician work required to perform this service. The RUC agreed with the survey times of 10 minutes pre-service, 60 minutes intra-service and 20 minutes post-service. The RUC compared the surveyed service to 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) and agreed with the survey respondents that 90791 requires more physician time to perform but is less intense and complex than 99205. The RUC also compared the surveyed service to similar services 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* (work RVU = 3.00 and 60 minutes intra-service time) and 75559 *Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging* (work RVU = 2.95 and 50 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 3.00 for CPT code 90791.**

90792 ***Psychiatric diagnostic evaluation with medical services***
The RUC reviewed the survey results from 82 adult and child psychiatrists for CPT code 90792 and determined that the median work RVU of 3.25 appropriately accounts for the physician work required to perform this service. The RUC agreed with the survey times

of 10 minutes pre-service, 60 minutes intra-service and 20 minutes post-service. The RUC compared code 90792 to 90791, which does not include medical services, and determined that the survey respondents appropriately valued the additional work required to perform this service. The RUC compared the surveyed service to 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) and agreed with the survey respondents that 90792 requires more physician time and is more intense and complex to perform than 99205. For additional support, the RUC also compared the surveyed service to similar services 99350 *Home visit for the evaluation and management of an established patient* (work RVU = 3.28 and 75 minutes intra-service time) and 99235 *Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date* (work RVU = 3.24 and 50 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 3.25 for CPT code 90792.**

90832 ***Psychotherapy, 30 minutes with patient and/or family member***
The RUC reviewed the survey results from 185 adult and child psychiatrists, psychologists and social workers for CPT code 90832 and determined that the median work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC determined 5 minutes pre-service, 30 minutes intra-service and 10 minutes post-service is appropriate to perform this service. Pre-time activities include completing checklists in anticipation of the service depending on the type of therapy and post-service activities include documenting the visit, documentation of therapy notes and treatment plans, follow-up with the primary care physician or therapists and setting up the next visit. The RUC compared the surveyed service to key reference service 96152 *Health and behavior intervention, each 15 minutes, face-to-face; individual* (work RVU = 0.46 and 15 minutes intra-service time) and agreed with the survey respondents that 90832 requires more time and is more intense and complex to perform than 96152. For additional support, the RUC also compared the surveyed service to similar services 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 1.50 and 25 minutes intra-service time) and 94005 *Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more* (work RVU = 1.50 and 25 minutes intra-service time) and determined that the recommended work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 1.50 for CPT code 90832.**

90833 ***Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and Management service***
The specialty societies reiterated that there are specific guidelines that indicate the Evaluation and Management service is to be billed separately with this service. The RUC reviewed the survey results from 114 adult and child psychiatrists for CPT code 90833 and determined that the median work RVU of 1.50 appropriately accounts for the physician work required to perform this service. The RUC determined 0 minutes pre-service, 30 minutes intra-service and 3 minutes post-service is appropriate to perform this service. The specialty indicated and the RUC agreed that any pre-time work will be captured in the separately reported Evaluation and Management service and the 3 minutes of post-service include activities specific to documentation of the symptoms and

behaviors that are the focus of the treatment as well as documentation of the specific psychotherapeutic intervention performed. The RUC compared the surveyed service to key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 1.50 and 25 minutes intra-service time) and agreed with the survey respondents that 90833 requires the same physician work, slightly more physician time and similar intensity and complexity to perform compared to 99214. For additional support, the RUC also compared the surveyed service to similar service 94005 *Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more* (work RVU = 1.50 and 25 minutes intra-service time) and determined that the recommended work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 1.50 for CPT code 90833.**

90834 ***Psychotherapy, 45 minutes with patient and/or family member***
The RUC reviewed the survey results from 183 adult and child psychiatrists, psychologists and social workers for CPT code 90834 and determined that the median work RVU of 2.00 appropriately accounts for the work required to perform this service. The RUC determined 5 minutes pre-service, 45 minutes intra-service and 10 minutes post-service is appropriate to perform this service. Pre-time activities include completing checklists in anticipation of the service depending on the type of therapy and post-service activities include documenting the visit, documentation of therapy notes and treatment plans, follow-up with the primary care physician or therapists and setting up the next visit. The RUC compared the surveyed service to similar services 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 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 and 30 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 2.00 for CPT code 90834.**

90836 ***Psychotherapy, 45 minutes with patient and/or family member when performed with an Evaluation and Management service***
The specialty societies reiterated that there are specific guidelines that indicate the Evaluation and Management service is to be billed separately with this service. The RUC reviewed the survey results from 114 adult and child psychiatrists for CPT code 90836 and determined that the median work RVU of 1.90 appropriately accounts for the physician work required to perform this service. The RUC determined 0 minutes pre-service, 45 minutes intra-service and 3 minutes post-service is appropriate to perform this service. The specialty indicated and the RUC agreed that any pre-time work will be captured in the separately reported Evaluation and Management service and the 3 minutes of post-service include activities specific to documentation of the symptoms and behaviors that are the focus of the treatment as well as documentation of the specific psychotherapeutic intervention performed. The RUC compared the surveyed service to key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 1.50 and 25 minutes intra-service time) and agreed with the survey respondents that 90836 requires more physician work and time and is more intense and complex to perform compared to 99214. For additional

support, the RUC also compared the surveyed service to similar service 99221 *Initial hospital care, per day, for the evaluation and management of a patient* (work RVU = 1.92 and 30 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 1.90 for CPT code 90836.**

90837 ***Psychotherapy, 60 minutes with patient and/or family member***
The RUC reviewed the survey results from 185 adult and child psychiatrists, psychologists and social workers for CPT code 90837 and determined that the survey 75th percentile work RVU of 3.00 appropriately accounts for the work required to perform this service. The RUC determined that the survey median work RVU of 2.25 would be too low in relation to 90834 and 0.25 difference in work RVU would not appropriately account for an additional 15 minutes of intra-service time and additional intensity and complexity required to perform 90837. The RUC determined 5 minutes pre-service, 60 minutes intra-service and 10 minutes post-service is appropriate to perform this service. Pre-time activities include completing checklists in anticipation of the service depending on the type of therapy and post-service activities include documenting the visit, documentation of therapy notes and treatment plans, follow-up with the primary care physician or therapists and setting up the next visit. The RUC compared the surveyed service to similar services 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), 96111 *Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report* (work RVU = 2.60 and 60 minutes intra-service time) and 99222 *Initial hospital care, per day, for the evaluation and management of a patient* (work RVU = 2.61 and 40 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 3.00 for CPT code 90837.**

90838 ***Psychotherapy, 60 minutes with patient and/or family member when performed with an Evaluation and Management service***
The specialty societies reiterated that there are specific guidelines that indicate the Evaluation and Management service is to be billed separately with this service. The RUC reviewed the survey results from 114 adult and child psychiatrists for CPT code 90838 and determined that the survey 75th percentile work RVU of 2.50 appropriately accounts for the physician work required to perform this service. The RUC determined that the survey median work RVU of 2.10 would be too low in relation to 90836 and 0.20 difference in work RVU would not appropriately account for an additional 15 minutes of intra-service time and additional intensity and complexity required to perform 90838. The RUC determined 0 minutes pre-service, 60 minutes intra-service and 3 minutes post-service is appropriate to perform this service. The specialty indicated and the RUC agreed that any pre-time work will be captured in the separately reported Evaluation and Management service and the 3 minutes of post-service include activities specific to documentation of the symptoms and behaviors that are the focus of the treatment as well as documentation of the specific psychotherapeutic intervention performed. The RUC compared the surveyed service to key reference

service 99354 *Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour* (work RVU = 1.77 and 60 minutes intra-service time) and agreed with the survey respondents that 90838 requires more physician work and is more intense and complex to perform compared to 99354. For additional support, the RUC also compared the surveyed service to similar service 96111 *Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report* (work RVU = 2.60 and 60 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 2.50 for CPT code 90838.**

90785 ***Interactive Complexity (List separately in addition to the code for primary procedure)***
90839 ***Psychotherapy for crisis, first 60 minutes;***
90840 ***Psychotherapy for crisis, first 60 minutes; each additional 30 minutes***
The specialty societies indicated and the RUC agreed that codes 90785, 90839 and 90840 be carrier priced to allow for education and experience with a significantly different coding structure. This will allow providers to gain experience with the codes prior to conducting a RUC survey. After a year of experience with the new coding structure the specialties will conduct RUC surveys for these services.

90845 ***Psychoanalysis***
October 2011 RUC recommendation
Multiple specialty societies submitted public comment to CMS to review code 90845 *Psychoanalysis* as part of the 4th Five-Year Review. In September 2010, recommendations regarding code 90845 were submitted along with 16 additional codes. During that presentation the specialties requested that the entire tab be referred to the CPT Editorial Panel to revised the code descriptors to more accurately describe these services. During the CPT review process, CPT recommended to remove psychoanalysis, as revisions to the descriptor were unnecessary because the work inherent in providing this service was the same regardless of the provider.

In September 2011, the RUC reviewed 90845 and agreed with the specialty society that there is compelling evidence that the patient population has changed and that the technique employed in psychoanalytic practice has changed. Psychoanalysis traditionally treated a wide variety of conditions which included a considerable number of high functioning patients who were treated for relatively minor psychological problems by current standards. Patients with these conditions are now often treated in a variety of newer treatment modalities rather than psychoanalysis. Given this, patients now receiving psychoanalysis are more complex and typically require a more active approach on part of the psychoanalyst due to the increased number of co-morbidities. In addition, in the past psychoanalysts tended to be silent during the treatment, intervening infrequently. Current practice emphasizes the importance of interaction between the psychoanalyst and the patient. As a result of this technical change the psychoanalyst is required to be much more intently focused on the minute to minute interaction during the session and considerably more active during the session. This substantially increases the psychoanalyst's intensity and complexity effort during the session, when compared with the earlier model.

The RUC reviewed CPT code 90845 and agreed with the specialty societies that the typical service is one hour, 5 minute pre-service, 50 minutes intra-service and 5 minutes immediate post-service time. The RUC reviewed the survey results and agreed that the median survey work RVU of 2.10 accurately values the typical physician work involved in the procedure. To justify this value, the RUC compared CPT code 90845 to key reference service 99404 *Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes* (work RVU = 1.95, total time = 60 minutes). Although the reference code has greater intra service time compared to the surveyed code, the survey respondents indicated and the RUC agreed that intensity and complexity to perform 90845 is greater in every measure compared to reference service 99404. The RUC also compared 90845 to reference code 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 2.11, total time = 55 minutes). The respondents indicated 90845 was more intense and complex than 99215, specifically the technical skill required to perform 90845 indicated the greatest difference. Finally, the RUC compared 90845 to MPC code 99233 *Subsequent hospital care, per day, for the evaluation and management of a patient* (work RVU = 2.00, total time = 55 minutes). The RUC determined that these comparison codes coupled with the median survey results support a recommendation of 2.10 work RVUs for CPT code 90845. **The RUC recommends a work RVU of 2.10 for CPT code 90845.**

90846 ***Family psychotherapy (without the patient present)***
The RUC reviewed the survey results from 123 adult and child psychiatrists, psychologists and social workers for CPT code 90846 and determined that the survey median work RVU of 2.40 appropriately accounts for the work required to perform this service. The RUC determined 5 minutes pre-service, 50 minutes intra-service and 10 minutes post-service is appropriate to perform this service. Pre-time activities include completing checklists in anticipation of the service depending on the type of therapy and post-service activities include documenting the visit, documentation of therapy notes and treatment plans, follow-up with the primary care physician or therapists and setting up the next visit. The RUC compared the surveyed service to 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 agreed with the survey respondents that 90846 requires more work and time and to perform than 99215. For additional support, the RUC also compared the surveyed service to similar services 99204 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 2.43 and 30 minutes intra-service time) and 99349 *Home visit for the evaluation and management of an established patient* (work RVU = 2.33 and 40 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 2.40 for CPT code 90846.**

90847 ***Family psychotherapy (conjoint psychotherapy) (with patient present)***
The RUC reviewed the survey results from 123 adult and child psychiatrists, psychologists and social workers for CPT code 90847 and determined that the survey median work RVU of 2.50 appropriately accounts for the work required to perform this service. The RUC determined 5 minutes pre-service, 55 minutes intra-service and 10 minutes post-service is appropriate to perform this service. Pre-time activities include completing checklists in anticipation of the service depending on the type of therapy and post-service activities include documenting the visit, documentation of therapy notes and

treatment plans, follow-up with the primary care physician or therapists and setting up the next visit. The RUC compared the surveyed service to 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) and agreed with the survey respondents that although 90847 requires 10 more minutes of intra-service time, it requires slightly less work to perform than 99205. For additional support, the RUC also compared the surveyed service to similar services 99222 *Initial hospital care, per day, for the evaluation and management of a patient* (work RVU = 2.61 and 40 minutes intra-service time) and 99336 *Domiciliary or rest home visit for the evaluation and management of an established patient* (work RVU = 2.46 and 40 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 2.50 for CPT code 90847.**

90853 ***Group psychotherapy (other than of a multiple-family group)***
The RUC reviewed the survey results from 82 adult and child psychiatrists, psychologists and social workers for CPT code 90853 and determined that the current work RVU of 0.59 be maintained. The survey median work RVU of 3.00, for the entire group session divided by 5 the typical number of patients in a group equals 0.60 and maintaining the value appropriately accounts for the work required to perform this service. The RUC agreed with the survey times divided by the typical number of patients resulting in 3 minutes pre-service, 10 minutes intra-service and 3 minutes post-service is appropriate to perform this service. The RUC compared the surveyed service to key reference service 96153 *Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)* (work RVU = 0.10 and 5 minutes total time) and agreed with the survey respondents that 90853 requires more work, time, intensity and complexity to perform than 96153. For additional support, the RUC also compared the surveyed service to MPC code 97002 *Physical therapy re-evaluation* (work RVU = 0.60 and 18 minutes intra-service time) and 76881 *Ultrasound, extremity, nonvascular, real-time with image documentation; complete* (work RVU = 0.63 and 15 minutes intra-service time) and determined that the recommended physician work and time place this service in the proper rank order relative to other services on the physician payment schedule. **The RUC recommends a work RVU of 0.59 for CPT code 90853.**

Practice Expense
The RUC reviewed the direct practice expense inputs submitted by the specialty societies and recommends no modifications.

Wireless Motility Capsule (Tab 27)
Nicholas Nickl, MD (ASGE); Edward Bentley, MD (ASGE)

In February 2012, the CPT Editorial Panel deleted Category III code (0242T) and created a Category I code to describe gastrointestinal tract transit and pressure measurement from the stomach to the colon via wireless capsule.

The RUC reviewed the survey results from 41 gastroenterologists for CPT code 91112 *Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report* and determined that a work RVU of 2.10, the survey's 25th percentile, appropriately accounts for the physician work required to perform this service. The RUC agreed with the survey time of 5 minutes pre-service, 40 minutes intra-service and 15 minutes post-service. The RUC compared 91112 to key

reference service CPT code 91110 *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with physician interpretation and report* (work RVU=3.64) and determined that while code 91112 is a XXX code, 5 minutes of pre service time to capture the face-to-face patient encounter work including informed consent is appropriate for this code and is consistent with other XXX gastrointestinal diagnostic services. The reference service requires twice as much time to perform than 91112, 80 and 40 minutes intra-service time, respectively. The RUC noted that while the quantity of data to be reviewed for 91112 is less than that for 91110, the complexity of the data is greater. For further support the RUC compared 91112 to CPT code 88189 *Flow cytometry, interpretation; 16 or more markers* (work RVU=2.23) and noted that the codes had identical intra-service time. **The RUC recommends a work RVU of 2.10 for CPT code 91112.**

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

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

Anterior Segment Imaging (Tab 28)
Stephen A. Kamenetzky, MD (AAO); David B. Glasser, MD (AAO); Michael Chaglasian, OD (AOA)

In April 2011, the RUC identified CPT code 92286 *Anterior segment imaging with interpretation and report; with specular microscopy and cell analysis* through the Harvard-Valued utilization over 30,000 screen. The utilization for this service was just below 100,000 for the initial Harvard-Valued – Utilization over 100,000 screen based on 2007 Medicare claims data. The specialty society submitted a coding proposal to revise the existing code descriptor to better describe the service. CPT code 92287 *segment imaging with interpretation and report; with fluorescein angiography* is to be reviewed as part of this family of services.

92286
The RUC reviewed the survey data from 51 ophthalmologists and optometrists for CPT code 92286 and determined that the survey median work RVU of 0.40, which is below the current work RVU, and survey pre-time of 5 minutes and intra-service time of 10 minutes appropriately account for the physician work and time required to perform this service. The specialty society indicated and the RUC agreed that the interpretation and report are included as part of the intra-service work. The RUC compared 92286 to 92025 *Computerized corneal topography, unilateral or bilateral, with interpretation and report* (work RVU = 0.35) and determined that although 92286 is inherently bilateral and requires 2 minutes less intra-service time to perform than 92025, the survey respondents indicated that it is more intense and complex. **The RUC recommends a work RVU of 0.40 for CPT code 92286.**

92287
The American Academy of Ophthalmology (AAO) indicated that apart from utilizing an image, codes 92286 and 92287 are completely different clinical indications and conditions. These services are also provided by different specialties within

ophthalmology. CPT code 92286 is used primarily to follow patients with corneal endothelial dystrophy for progression of their disease, pre-cataract surgery to assess the need for possible corneal transplant at the same time and for follow-up care of post corneal transplant patients. CPT code 92287 is rarely performed (less than 3000 in 2010) and obtaining valid survey responses would be difficult. AAO indicated that CPT code 92287 may be inadvertently being reported in lieu of CPT code 92235 *Fluorescein angiography (includes multiframe imaging) with interpretation and report* since it is designates that an image was made at the same time as the angiogram. Currently, there is no increased work when that is occurring as both have the same work value. The Academy believes that coding education and publication of a CPT Assistant article may help clarify the difference between codes 92287 and 92235. **The RUC recommends that the specialty society develop a CPT Assistant article to clarify the difference between CPT codes 92287 and 92235.**

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

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

Percutaneous Allergy Testing (Tab 29)
Gary Gross, MD (ACAAI); Donald Aaronson, MD (ACAAI); Jacqueline Pongracic, MD (ACAAI)

In 2011, CPT code 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* and 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* were identified as part of the Low Value-Billed in Multiple Units screen. In April 2011, the RUC reviewed survey data for 95010 and 95015 based on a typical patient that requires venom testing, but determined that both codes were reported on the same day by the same physician more than 80% of time and that a new bundled code was appropriate. As part of the process to develop a bundled code, the specialty society determined there to be little difference in physician work between percutaneous and intracutaneous testing on a "per test" basis, but a significant difference in practice expense inputs and typical number of tests required when comparing venom testing to drugs/biologic testing. Based on this information, the CPT Editorial Panel approved two new bundled codes, one code for percutaneous/intracutaneous venom testing and one code for percutaneous/intracutaneous drug/biologic testing. RUC surveys were conducted for each new code, using the typical patient and typical total number of tests required. The work RVU and times approved by the RUC would then be divided by the typical number of tests to determine the "per test" values.

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 by a physician, specify number of tests***

At the April 2011 RUC meeting CPT codes 95010 and 95015 (subsequently deleted) were thought to typically be billed with an Evaluation and Management service on the same day and at that time the RUC determined that pre- and post- time should be reduced from the recommended survey times. However, upon further review of claims data, the RUC determined that code 95017 is not typically reported on the same day as an E/M and therefore E/M time and work is bundled into the pre and post-work. The RUC reviewed the survey results from 72 allergists for CPT code 95017 and determined that the median pre-, intra-, and post-times (15, 20, 15, respectively) and the median work RVU of 1.80 are appropriate for the total physician work required for the typical patient who would have 27 venom tests. The RUC compared 95017 to key reference CPT code 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 providers 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. Physicians typically spend 45 minutes face-to-face with the patient and/or family* (work RVU=2.43) and 95017 to MPC code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 30 minutes face-to-face with the patient and/or family* (work RVU=1.42) and determined that the survey median work RVU of 1.80 appropriately placed 95017 between these two references. The RUC also compared 95017 to CPT code 95808 *Polysomnography; sleep staging with 1-3 additional parameters of sleep, attended by a technologist* (work RVU=1.74) and noted that this service has identical time with 15 minutes pre-service time, 20 minutes intra-service time and 15 minutes post-service time, and required slightly less intensity to perform, justifying the slightly higher work RVU for 95017. The approved total work RVU of 1.80 for the typical patient was divided by the typical number of tests (27) to arrive at 0.07 work RVUs "per test." The approved total pre-, intra-, and post-times (15, 20, 15, respectively) were divided by the typical number of tests (27) to arrive at the "per test" pre-, intra-, and post-times (0.556, 0.741, 0.556, respectively). This calculation allows for correct work valuation for the typical patient who will undergo 27 venom tests. **The RUC recommends a work RVU of 0.07 per test for CPT code 95017**.

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 by a physician, specify number of tests***

At the April 2011 RUC meeting CPT codes 95010 and 95015 (subsequently deleted) were thought to typically be billed with an Evaluation and Management service on the same day and at that time the RUC determined that pre- and post- time should be reduced from the recommended survey times. However, upon further review of claims data, the RUC determined that code 95018 is not typically reported on the same day as an E/M and therefore E/M time and work is bundled into the pre and post-work. The RUC reviewed the survey results from 69 allergists for CPT code 95018 and determined that the median pre-, intra-, and post-times (15, 15, 15, respectively) and the 25th percentile work RVU of 1.25 are appropriate for the total physician work required for the typical patient who would have 9 drug tests. The RUC compared 95018 with key reference CPT code 99214

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers 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. Physicians typically spend 25 minutes face-to-face with the patient and/or family (work RVU=1.50) and CPT code 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU=0.97) and determined that the survey 25th percentile work RVU of 1.25 appropriately placed 95018 between these two references. The RUC also compared 95018 to CPT code 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 physician analysis, review and report; multiple lead implantable cardioverter-defibrillator system* (work RVU=1.25) and noted that this service requires the same intra-service time of 15 minutes and would require the same total physician work. The approved total work RVU of 1.25 for the typical patient was divided by the typical number of tests (9) to arrive at 0.14 work RVUs "per test." The approved total pre-, intra-, and post-times (15, 15, 15, respectively) were divided by the typical number of tests (9) to arrive at the "per test" pre-, intra-, and post-times (1.667, 1.667, 1.667, respectively). This calculation allows for correct work valuation for the typical patient who will undergo 9 drug tests. **The RUC recommends a work RVU of 0.14 per test for CPT code 95018**.

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

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

Allergen Ingestion Test (Tab 30)
Gary Gross, MD (ACAAI); Donald Aaronson, MD (ACAAI); Jacqueline Pongracic, MD (ACAAI)

In 1995, the RUC reviewed CPT code 95075 *Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance such as metabisulfite)* and recommended to maintain the 1993 work RVUs, which were not based on a RUC survey. The code has not been reviewed since 1995 and the RUC determined that the dominant specialty at that time (otolaryngology) is no longer the dominant specialty (currently, Allergy/Immunology). In February 2012, the CPT Editorial Panel deleted 95075 and created CPT code 95076 *Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); initial 120 minutes of testing* and CPT code 95079 *Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); each additional 60 minutes of testing (List separately in addition to code for primary procedure),* to establish time based codes to report ingestion challenge tests. The RUC agreed with the specialty society that there is compelling evidence to increase the value of these codes based on a change in the patient population and related physician work. The patient population and severity of food allergies is vastly different than it was in 1995. The 1995 typical patient reacted to wheat with nasal congestion symptoms in comparison to current population. Food allergies (most typically peanuts) now result in anaphylaxis and potentially death

(ie, not just nasal congestion). Although not typical in the office setting during testing, anaphylaxis and death is a serious concern, requiring close monitoring by the physician throughout the testing period.

Medicare data indicate an E/M is typically performed on the same day. Although the specialty society experts could not be certain, they believe if a Medicare patient receives this test it would likely be for a speculative antibiotic allergy. These Medicare patients would not undergo incremental dosing and extended monitoring and moving forward would not likely report the new time based code. In addition, Medicare patients comprise a fraction of the national utilization of this code. The RUC agreed with the specialty society and the typical patient is a pediatric patient. A CPT Assistant article will be developed to explain that these codes are to be used to report incremental challenges that require monitoring between dosing and that anything less is to be reported with an Evaluation and Management Service.

95076

The RUC reviewed the survey results from 107 allergists and determined that the work RVU of 1.50, the survey's 25th percentile appropriately accounts for the physicians work required to perform this service. The RUC agreed with the survey times of 7 minutes pre-service, 30 minutes intra-service and 5 minutes post-service. The RUC compared 95076 to key reference CPT code 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU=2.11) which has slightly less intra-service time at 30 and 35 minutes, respectively and less total time at 42 and 55 minutes, respectively. The RUC agreed with the specialty that 95076 requires less time and intensity to perform compared with 99215 and therefore should have a lower work RVU. The RUC also compared 95076 to a second reference code cited by the specialty, CPT code 99214 *Office or other outpatient visit for the evaluation and management of an established* (work RVU=1.50) which has slightly less intra-time and almost identical total time. The RUC agreed that 95076 and 99214 would require similar total physician work and similar intensity, and therefore agreed with the specialty that the 25th percentile work RVU of 1.50 was appropriate. As additional support, the RUC compared 95076 to 99393 *Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)* (work RVU=1.50), with identical physician work. **The RUC recommends a work RVU of 1.50 for CPT code 95076.**

95079

The RUC reviewed the survey results from 104 allergists and determined that the work RVU of 1.38, the survey's 25th percentile, appropriately accounts for the physicians work required to perform this service. The RUC agreed with the survey time of 30 minutes intra-service. The RUC compared 95079 to key reference CPT code 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU=2.11) and determined 99215 required more work than 95079, but was not a good reference because of the difference in global period. The RUC determined 95079 should be compared to other codes which have a ZZZ-global, including 13102 *Repair, complex, trunk; each additional 5 cm or less* (work-RVU=1.24) and 13122 *Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less* (work RVU=1.44). Codes 13102 and 13122 bracket code 95079 in time and support the 25th percentile work RVU of 1.38. The RUC also compared the surveyed service to CPT code 99355 *Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual*

service; each additional 30 minutes (List separately in addition to code for prolonged service) (work RVU=1.77) with identical intra-service time. **The RUC recommends a work RVU of 1.38 for CPT code 95079.**

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

Pediatric Polysomnography (Tab 31)
Amy Aronsky, DO (AASM); Burt Lesnick, MD (ACCP); Steven Krug, MD (AAP); Marianna Spanaki, MD, PhD (AAN)

In February 2012, the CPT Editorial Panel created 95782 *Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist* and 95783 *Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist* to describe the physician work involved in pediatric polysomnography for children 5 years of age or younger. These tests were previously reported using CPT codes 95810 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist* and 95811 *Polysomnography; 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.* The RUC noted that although age distribution was not available for the original survey, the specialty society did survey their members and determined that the "under 6" age band indicated the point where physician work and intensity changed. The RUC survey vignettes for CPT codes 95810 and 95811 describe adult patients.

95782
The RUC reviewed the survey results from 89 physicians for 95782 *Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist* and determined that the physician work is accurately valued at the survey median work RVU of 3.00. The physician work involved is primarily in the interpretation of data which has become more intense due to a shift in patient population. The RUC noted that pediatric patients sleep longer (9 hours versus 8), are more prone to movement which causes leads to fall off and introduces artifacts and more likely to experience hypopnea which is more difficult to identify and review. The RUC compared 95782 to key reference service 95810 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU=2.50) and determined that the surveyed code required more time and intensity, as discussed above, and should be valued higher. The RUC also reviewed CPT codes 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)(work RVU=2.78)* and agreed that with 15 minutes more time, 95782 should be valued higher. The RUC also reviewed 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* (work RVU=3.08) and determined that the two services have identical intra-service time, 45 minutes, and are comparable in work. **The RUC recommends a work RVU of 3.00 for CPT Code 95782.**

95783
The RUC reviewed the survey results from 86 physicians for 95783 *Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist* and determined that physician work is accurately valued at the survey median work RVU of 3.20. The RUC noted that this sleep study is an hour longer than 95782 and includes a capnography and CPAP mask which increases the intensity of the procedure and interpretation of the data. Typically, there are 90-120 additional epochs to review in each pediatric polysomnogram. The RUC compared 95783 to key reference service 95811 *Polysomnography; 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* (work RVU=2.60) and determined that 95783 requires 20 more minutes to perform and is more intense, therefore, necessitating a higher value than the reference code. The RUC also reviewed 94012 *Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age (*work RVU=3.10) and agreed that although 94012 requires more time, the physician work of 95783 is more intense. In addition, a work RVU of 3.20 will maintain proper rank order for this family of services. **The RUC recommends a work RVU of 3.20 for CPT Code 95783.**

Practice Expense:
The RUC reviewed and approved practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

<u>EMG in Conjunction with Nerve Testing (Tab 32)</u>
Marianna Spanaki, MD, PhD (AAN); James Selwa, MD, MBA (AAN); Joe Zuhosky, MD (AAPMR); Andrea Boon, MD (AANEM); John Palazzo, DSc, PT, ECS (APTA)
Facilitation Committee #2

In February 2010, CPT codes 95860, 95861, 95863 and 95864 were identified by the Relativity Assessment Workgroup through the Codes Reported Together 75% or More Screen. These codes are billed commonly with 95904. In February 2011, the specialties submitted a code change proposal to the CPT Editorial Panel to bundle the services commonly reported together. The Panel created three new ZZZ global codes to be reviewed at the RUC in April 2011. The CPT Editorial Panel noted, and the RUC agreed, that these three new codes were approved with the intent that the specialties will take additional time and bring forward a more comprehensive coding solution which bundles services commonly performed together during the CPT 2013 cycle. In February 2012, the CPT Editorial Panel created seven new codes that bundle the work of multiple nerve conduction studies into each individual code.

95860 ***Needle electromyography; 1 extremity with or without related paraspinal areas***
The RUC reviewed the survey results from 93 physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 20 minutes and post-service time= 10 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that while the survey supports a higher value, there is no compelling evidence to change the current value, 0.96 work RVUs, for this service. To justify this value, the RUC reviewed the key reference service CPT code 99213 *Office or other outpatient visit*

for the evaluation and management of an established patient (work RVU= 0.97) and agreed that while 95860 has greater intra-service time compared to the reference code, 20 minutes and 15 minutes, respectively, the two services have analogous physician work and should be valued similarly. **The RUC recommends a work RVU of 0.96 for CPT code 95860.**

95861 ***Needle electromyography; 2 extremities with or without related paraspinal areas***
The RUC reviewed the survey results from 46 physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 29 minutes and post-service time= 10 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that the current work RVU of 1.54, slightly above the survey 25th percentile, accurately reflects the physician work involved in this service. To justify this value, the RUC reviewed the key reference service CPT code 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 1.50) and agreed that 95861 should be valued slightly higher than the reference code due to slightly greater intra-service time, 29 minutes and 25 minutes, respectively. **The RUC recommends a work RVU of 1.54 for CPT code 95861.**

95863 ***Needle electromyography; 3 extremities with or without related paraspinal areas***
The RUC reviewed the survey results from 46 physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 40 minutes and post-service time= 11 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that while the survey supports a higher value, there is no compelling evidence to change the current value, 1.87 work RVUs, for this service. To justify this value, the RUC reviewed the key reference service CPT code 99215 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 2.11) and agreed that 95863 has analogous total physician time compared to the reference code, 61 minutes and 55 minutes, respectively, and should be valued slightly less. **The RUC recommends a work RVU of 1.87 for CPT code 95863.**

95864 ***Needle electromyography; 4 extremities with or without related paraspinal areas***
The RUC reviewed the survey results from 46 physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 50 minutes and post-service time= 13.5 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that while the survey supports a higher value, there is no compelling evidence to change the current value, 1.99 work RVUs, for this service. To justify this value, the RUC reviewed the key reference service CPT code 95810 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU= 2.50) and agreed that while 95864 should be valued less because it is a less involved, complex service. **The RUC recommends a work RVU of 1.99 for CPT code 95864.**

95865 ***Needle electromyography; larynx***
The RUC reviewed the survey results from practicing physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 15 minutes and post-service time= 6.5 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that the current value of 1.57 work RVUs accurately reflects the physician work involved in the service. To justify this value, the RUC reviewed the key reference service CPT code 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 1.50) and agreed that 95865 should be valued slightly higher because that it is a much more intense service compared to the reference code, as shown by the survey respondents' intensity/complexity measures. In addition, the RUC reviewed CPT code 70542 *Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)* (work RVU= 1.62) and agreed that since the two services have identical intra-service times, 15 minutes, and comparable physician work, the work values should be similar. **The RUC recommends a work RVU of 1.57 for CPT code 95865.**

95866 ***Needle electromyography; hemidiaphragm***
The RUC reviewed the survey results from practicing physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 15 minutes and post-service time= 10 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that while the survey supports a higher value, there is no compelling evidence to change the current value, 1.25 work RVUs, for this service. To justify this value, the RUC reviewed the key reference service CPT code 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 1.50) and agreed that the reference code should be valued slightly higher than 95866 due to greater total time, 40 minutes compared to 35 minutes. **The RUC recommends a work RVU of 1.25 for CPT code 95866.**

95867 ***Needle electromyography; cranial nerve supplied muscle(s), unilateral***
The RUC reviewed the survey results from 39 practicing physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 15 minutes and post-service time= 10 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that while the survey supports a higher value, there is no compelling evidence to change the current value, 0.79 work RVUs, for this service. To justify this value, the RUC reviewed CPT code 76816 *Ultrasound, pregnant uterus, real time with image documentation, follow-up, transabdominal approach, per fetus* (work RVU= 0.85) and agreed that the two services should be valued similarly because they have identical intra-service times of 15 minutes and analogous total time. Additionally, the RUC compared 95867 to 95866 and noted that while both services have the same physician times, the survey respondents rated 95866 as a more intense and complex service compared to 95867. **The RUC recommends a work RVU of 0.79 for CPT code 95867.**

95868 ***Needle electromyography; cranial nerve supplied muscles, bilateral***
The RUC reviewed the survey results from 40 practicing physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 20 minutes and post-service time= 10 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that while the survey supports a higher value, there is no compelling evidence to change the current value, 1.18 work RVUs, for this service. To justify this value, the RUC reviewed key reference service CPT code 99214 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 1.50) and agreed that reference code should be valued higher because of greater intra-service time compared to 95868, 25 minutes and 20 minutes, respectively. **The RUC recommends a work RVU of 1.18 for CPT code 95868.**

95869 ***Needle electromyography; thoracic paraspinal muscles (excluding T1 or T12)***
The RUC reviewed the survey results from 43 practicing physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 15 minutes and post-service time= 10 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that while the survey supports a higher value, there is no compelling evidence to change the current value, 0.37 work RVUs, for this service. To justify this value, the RUC reviewed CPT code 94452 *High altitude simulation test (HAST), with physician interpretation and report* (work RVU= 0.31) and agreed that the two services have comparable physician work, but 95869 should be valued higher due to greater total time compared to the reference code, 35 minutes and 30 minutes, respectively. **The RUC recommends a work RVU of 0.37 for CPT code 95869.**

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***
The RUC reviewed the survey results from 43 practicing physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 15 minutes and post-service time= 10 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that while the survey supports a higher value, there is no compelling evidence to change the current value, 0.37 work RVUs, for this service. To justify this value, the RUC reviewed CPT code 94452 *High altitude simulation test (HAST), with physician interpretation and report* (work RVU= 0.31) and agreed that the two services have comparable physician work, but 95869 should be valued higher due to greater total time compared to the reference code, 35 minutes and 30 minutes, respectively. The RUC also compared 95870 to 95869 and agreed that with identical physician time components the two services should be valued identically. **The RUC recommends a work RVU of 0.37 for CPT code 95870.**

95907 ***1-2 nerve conduction studies***
The RUC reviewed the survey results from 52 practicing physicians and recommends the following median survey times: pre-service time= 10 minutes, intra-service time= 15 minutes and post-service time= 10 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service. The RUC reviewed the respondents' estimated physician work values and agreed with the specialty that the median work RVU of 1.00 accurately reflects the physician work of this bundled code. To justify this value, the RUC compared the surveyed code to CPT code 93890 *Transcranial Doppler study of the intracranial arteries; vasoreactivity study* (work RVU= 1.00) and agreed that the two services have comparable physician work, with identical time components, and should be valued identically. The RUC also reviewed CPT code 94004 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; nursing facility, per day* (work RVU= 1.00) and agreed that 95907 should have the same work value to ensure relativity to this reference code because they have identical time. **The RUC recommends a work RVU of 1,00 for CPT code 95907.**

95908 ***3-4 nerve conduction studies***
The RUC reviewed the survey results from 52 practicing physicians and agreed that the intra-service time for this code did not fit in proper relativity within the family. To determine more accurate intra-service time, the Committee noted that nerve conduction studies are typically done in pairs, thus using the approved physician time from the base code 95907, 15 minutes, the RUC agreed that 7.5 minutes per nerve was a reasonable increment to assess the physician work of 95908. The RUC then conservatively assumed an increase of 1.5 nerves per bundled code, resulting in an additional 10 minutes, from the base code, of intra-service time for 95908. The recommended physician time components are: pre-service time= 10 minutes, intra-service time= 25 minutes and post-service time= 10 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service.
The RUC also noted that the survey's estimated work value was overestimated at the median level, 1.68 work RVUs. To determine an appropriate value, the RUC compared the physician work of 95908 to CPT code 62270 *Spinal puncture, lumbar, diagnostic* (work RVU= 1.37) and agreed that the two services have comparable physician work and physician total time, 40 minutes and 45 minutes, respectively. Given this close comparison, the RUC agreed to directly crosswalk the work RVU of 95908 to CPT code 62270. To justify this value, the RUC noted that the surveyed code has identical intensity to the base code, 95907. Valuing 95908 at the same intensity factor results in a work RVU of 1.37, identical to the reference code. The RUC agreed that this value places 95908 in proper rank order within the family of services and within the RBRVS. **The RUC recommends a work RVU of 1.37 for CPT code 95908.**

95909 5-*6 nerve conduction studies***
The RUC reviewed the survey results from 52 practicing physicians and agreed that the intra-service time for this code did not fit in proper relativity within the family. To determine more accurate intra-service time, the Committee noted that nerve conduction studies are typically done in pairs, thus using the approved physician time from the base code 95907, 15 minutes, the RUC agreed that 7.5 minutes per nerve was a reasonable increment to assess the physician work of 95909. The RUC then conservatively assumed an increase of 1.5 nerves per bundled code, resulting in an additional 10 minutes, from

the 3-4 bundled nerve code, of intra-service time for 95909. The recommended physician time components are: pre-service time= 10 minutes, intra-service time= 35 minutes and post-service time= 11 minutes. The RUC agreed that pre-service time of 10 minutes accurately reflects the work to evaluate the patient, given that Evaluation and Management services are not typically billed on the same date of service.

The RUC also noted that the survey's estimated work value was overestimated at the median level, 2.28. To determine an appropriate value, the RUC compared the physician work of 95909 to CPT code 95813 *Electroencephalogram (EEG) extended monitoring; greater than 1 hour* (work RVU= 1.73) and agreed that the two services have comparable physician work and physician total time, 60 minutes and 56 minutes, respectively. Given this close comparison, the RUC agreed that the two services should have almost identical work values. To justify this relativity, the RUC noted that the surveyed code has identical intensity to the base code, 95907. Valuing 95909 at the same intensity factor results in a work RVU of 1.77, almost identical to the reference code. The RUC agreed that this value places 95909 in proper rank order within the family of services and within the RBRVS. **The RUC recommends a work RVU of 1.77 for CPT code 95909.**

95910 ***7-8 nerve conduction studies***
The RUC reviewed the survey results from 52 practicing physicians and agreed that the median physician time components accurately reflect the physician work inherent in this procedure. The recommended physician time components are as follows: pre-service time= 13 minutes, intra-service time= 40 minutes and post-service time= 12.50 minutes. The RUC agreed that pre-service time of 13 minutes accurately reflects the work to evaluate the patient, and is an appropriate increase over the lower bundled codes because of the increased complexity in performing more nerve conduction studies, given that Evaluation and Management services are not typically billed on the same date of service.

The RUC reviewed the survey's estimated work value and agreed that the survey median work RVU of 2.80 is an accurate value for CPT code 95910. To justify this value the RUC compared 95910 to CPT code 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU= 2.40) and agreed that while the reference code has slightly greater total time compared to 95910, 70 minutes and 65.5 minutes, respectively, the surveyed code should be valued higher because it is a more complex and involved procedure. For additional validation, the RUC noted that the physician work involved in performing more than 7 nerve conduction studies in the same setting is a more intense and complex compared to performing less than 7 studies. Therefore, the RUC calculated the time components by the surveyed intensity factor of 95910 and arrived at a work value of 2.80. With a robust survey and validation by a strong reference code and an approved alternative methodology, a work RVU of 2.81 is relative across the RBRVS. **The RUC recommends a work RVU of 2.80 for CPT code 95910.**

95911 ***9-10 nerve conduction studies***
The RUC reviewed the survey results from 52 practicing physicians and agreed that the median physician time components accurately reflect the physician work inherent in this procedure. The recommended physician time components are as follows: pre-service time= 15 minutes, intra-service time= 50 minutes and post-service time= 15 minutes. The RUC agreed that pre-service time of 15 minutes accurately reflects the work to evaluate the patient, and is an appropriate increase over the lower bundled codes because of the

increased complexity in performing more nerve conduction studies, given that Evaluation and Management services are not typically billed on the same date of service.

The RUC reviewed the survey's estimated work value and agreed that the survey median work RVU of 3.34 is an accurate value for CPT code 95911. To justify this value the RUC compared 95911 to CPT code 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* (work RVU= 3.08) and agreed that the surveyed code should be valued higher than the reference code because 95911 has five more minutes of intra-service time. For additional validation, the RUC noted that the physician work involved in performing more than 7 nerve conduction studies in the same setting is a more intense and complex compared to performing less than 7 studies. Therefore, the RUC calculated the time components by the surveyed intensity factor of 95911 and arrived at a work value of 3.47. With a robust survey and validation by a strong reference code and an approved alternative methodology, a work RVU of 3.34 is relative across the RBRVS. **The RUC recommends a work RVU of 3.34 for CPT code 95911.**

95912 ***11-12 nerve conduction studies***
The RUC reviewed the survey results from 52 practicing physicians and agreed that the median physician time components accurately reflect the physician work inherent in this procedure. The recommended physician time components are as follows: pre-service time= 15 minutes, intra-service time= 60 minutes and post-service time= 15 minutes. The RUC agreed that pre-service time of 15 minutes accurately reflects the work to evaluate the patient, and is an appropriate increase over the lower bundled codes because of the increased complexity in performing more nerve conduction studies, given that Evaluation and Management services are not typically billed on the same date of service.

The RUC reviewed the survey's estimated work value and agreed that the survey median work RVU of 4.00 is an accurate value for CPT code 95912. To justify this value the RUC compared 95912 to CPT code 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* (work RVU= 3.50) and agreed that while the two service have identical intra-service time the surveyed code should have a higher value due to greater total time, 90 minutes compared to 70 minutes. For additional validation, the RUC noted that the physician work involved in performing more than 7 nerve conduction studies in the same setting is a more intense and complex compared to performing less than 7 studies. Therefore, the RUC calculated the time components by the surveyed intensity factor of 95912 and arrived at a work value of 4.03. With a robust survey and validation by a strong reference code and an approved alternative methodology, a work RVU of 4.00 is relative across the RBRVS. **The RUC recommends a work RVU of 4.00 for CPT code 95912.**

95913 ***13 or more nerve conduction studies***
The RUC reviewed the survey results from 52 practicing physicians and agreed that the median physician time components accurately reflect the physician work inherent in this procedure. The recommended physician time components are as follows: pre-service time= 15 minutes, intra-service time= 70 minutes and post-service time= 20 minutes. The RUC agreed that pre-service time of 15 minutes accurately reflects the work to evaluate

the patient, and is an appropriate increase over the lower bundled codes because of the increased complexity in performing more nerve conduction studies, given that Evaluation and Management services are not typically billed on the same date of service.

The RUC reviewed the survey's estimated work value and agreed that the survey median work RVU of 4.20 is an accurate value for CPT code 95913. To justify this value the RUC compared 95913 to CPT code 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* (work RVU= 3.61) and agreed that the surveyed code should be valued higher due to greater intra-service time, 70 minutes compared to 60 minutes. For additional validation, the RUC noted that the physician work involved in performing more than 7 nerve conduction studies in the same setting is a more intense and complex compared to performing less than 7 studies. Therefore, the RUC calculated the time components by the surveyed intensity factor of 95913 and arrived at a work value of 4.70. With a robust survey and validation by a strong reference code and an approved alternative methodology, a work RVU of 4.20 is relative across the RBRVS. **The RUC recommends a work RVU of 4.20 for CPT code 95913.**

The RUC reviewed the RUC recommendations from April 2011 for the add-on EMG codes 95885 *Needle electromyography each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited*, 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* and 95887 *Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study* and agreed to reaffirm the established values, as they are relative to the family of services reviewed at the April 2012 RUC meeting. In addition, the RUC reviewed the recent October 2009 RUC recommendation for CPT code 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* and agreed that the physician work is limited for this service, 5 minutes intra-service time, and would not benefit from an additional review only two cycles later. **The RUC reaffirms a work RVU of 0.35 for CPT code 95885, a work RVU of 0.92 for CPT code 95886, a work RVU of 0.73 for CPT code 95887 and a work RVU of 0.05 for CPT code 95905.**

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

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

Autonomic Function Testing (Tab 33)
Kevin Kerber, MD (AAN); Andrea Boon, MD (AANEM)

CPT codes 95921 and 95922 were identified through the Codes Reported Together 75% or More screen as well as the Different Performing Specialty from the Survey screen. In February 2012, the CPT Editorial Panel created a new code 95924 which combines the procedures currently described in 95921 and 95922 as these are currently reported

together more than 75% of the time. Additionally, the dominant specialties now performing these services are Family Medicine and Internal Medicine, specialties that were not part of the 1996 survey. Lastly, the utilization for 95921 and 95922 has dramatically increased and from 2008 to 2009 and continue to rise, which the specialties attribute to incorrect reporting of these services for the use of a device for an automated nervous system test. Therefore, the CPT Editorial Panel created CPT 95943 to describe the automated nervous system test, in which providers do not use a tilt table during autonomic testing.

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
The RUC reviewed the survey results from 33 neurologists, neuromuscular and electrodiagnostic medicine physicians and determined that the current work RVU of 0.90 appropriately accounts for the work required to perform this service. The RUC agreed with the median survey results of 8 minutes pre-service time, 15 minutes intra-service time and 10 minute immediate post-service time. The specialties indicated and the RUC agreed that the key reference service 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* (work RVU = 0.54) is not an appropriate comparison for this service because the physician is not present during the test, it is much less intense and there is very little risk compared 95921 in which the physician is present and patients are fainting and have arrhythmias. The RUC compared the surveyed code to MPC codes 99202 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 0.93 and 15 minutes intra-service time) and determined that these services required similar physician work and the same intra-service time to perform. For additional support, the RUC compared the surveyed code to the secondary key reference service 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08 and 15 minutes intra-service time) and determined 95921 requires slightly less physician work to perform and MPC code 20551 *Injection(s); single tendon origin/insertion* (work RVU = 0.75 and 20 minutes total time) and determined that 95921 requires more physician work and time to perform. **The RUC recommends a work RVU of 0.90 for CPT code 95921.**

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
The specialty societies indicated that 20 minutes of tilt is the new standard to perform this service; abnormalities may go undetected in less time. However, depending on the specific conditions of the patient the tilt table time may be less than 20 minutes. The RUC indicated that once physicians are practicing the new standard for this service and 20 minutes of tilt table is typical, at their discretion, the specialties may go to CPT to change the descriptor to “at least 20 minutes”.

The RUC reviewed the survey results from neurologists, neuromuscular and electrodiagnostic medicine physicians and determined that the current work RVU of 0.96 appropriately accounts for the work required to perform this service. The RUC agreed with the median survey results of 10 minutes pre-service time, 20 minutes intra-service time and 10 minute immediate post-service time. The RUC compared the surveyed code to MPC codes 95805 *Multiple sleep latency or maintenance of wakefulness testing,*

recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness (work RVU = 1.20 and 20 minutes intra-service time) and determined that 95805 services requires slightly more physician work to perform. For additional support, the RUC compared the surveyed code to MPC code 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.97 and 23 minutes total time) and determined that 95922 requires similar physician work to perform. **The RUC recommends a work RVU of 0.96 for CPT code 95922.**

95924 Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt
The specialty societies indicated that 20 minutes of tilt is the new standard to perform this service; abnormalities may go undetected in less time. However, depending on the specific conditions of the patient the tilt table time may be less than 20 minutes. The RUC indicated that once physicians are practicing the new standard for this service and 20 minutes of tilt table is typical, at their discretion, the specialties may go to CPT to change the descriptor to "at least 20 minutes".

The specialty societies indicated that 95924 combines the services currently described in 95921 and 95922. The typical patient that will receive the combined tests 95924 is more complex and the testing is more intense than the patient that will just have one test (95921 or 95922). The RUC reviewed the survey results for 95924 and determined that the survey response rate was too low (26 responses). There was also confusion about what is described in 95943 which may have resulted in invalid physician time for this service. As an interim recommendation, the RUC recommends that the physician work and intra-service time for 95921 and 95922 be added together to account for the physician work and time required to perform this service (0.90 + 0.96 = 1.86 and 15 minutes + 20 minutes = 35 minutes intra-service time). The RUC recommends interim pre-service time of 10 minutes, intra-service time of 35 minutes and post-service time of 15 minutes. **The RUC recommends an interim work RVU of 1.86 for CPT code 95924 until this service is resurveyed for the October 2012 RUC meeting.**

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
The RUC reviewed the survey results from neurologists, neuromuscular and electrodiagnostic medicine physicians and determined that the current work RVU of 0.90 appropriately accounts for the work required to perform this service. The RUC agreed with the survey 5 minutes pre-service time, 15 minutes intra-service time and 10 minute immediate post-service time, which are the current times. The RUC compared the surveyed code to key reference code 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.97 and 23 minutes total time) and determined that 95923 requires similar physician work and intensity and complexity to perform. The RUC also compared 95923 to 95921 and determined that the physician work and intra-service time is the same for these services. **The RUC recommends a work RVU of 0.90 for CPT code 95923.**

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
The American College of Physicians will survey 95943 once the physicians that use this "small box" technology are identified and matched as members of these societies in order to survey. AMA staff will also provide Medicare claims data by state to the specialty societies to indicate that 40% of the volume for code 95921 is from Florida and Texas. This code is scheduled for the October 2012 RUC meeting.

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

XI. Relativity Assessment – CMS/Other Time Screen – Utilization over 500,000

CT Abdomen (Tab 34)
Geraldine McGinty, MD (ACR); Zeke Silva, MD (ACR); David Rosman, MD (ACR)

In February 2008, CPT Code 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* was identified in the CMS/Other-Utilization over 500,000 screen.

The RUC reviewed the survey results from 75 radiologists and recommends that the current work RVU of 1.40, which is below the survey 25th percentile, be maintained. The RUC noted that in April 2010, three codes were created to report the combination of computed tomography of the abdomen and pelvis. As a result, Medicare utilization has significantly decreased from 859,320 in 2010 to 145,235 in 2011 for code 74170. The RUC reviewed key reference service 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=2.10) and agreed that although intensity components are similar, 74178 requires 12 more minutes of intra-service time and should be valued higher. The RUC compared 74170 to 73718 *Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)* (work RVU=1.35) and determined that these two services require the same physician work and time and therefore should be valued similarly. The RUC also agreed that a work RVU of 1.40 will maintain proper rank order within the family of CT codes, including 74160 *Computed tomography, abdomen; with contrast material(s)* (work RVU=1.27) and 74150 *Computed tomography, abdomen; without contrast material* (work RVU=1.19). **The RUC recommends a work RVU of 1.40 for CPT Code 74170.**

Practice Expense:
The RUC reviewed and approved practice expense inputs as recommended by the Practice Expense Subcommittee.

Extremity Studies (Tab 35)
Gary Seabrook, MD (SVS); Robert Zwolak, MD (SVS); Mathew Sideman, MD (SVS); Michael Sutherland, MD (SVS); Sean Roddy, MD (SVS); Geraldine McGinty, MD (ACR); Zeke Silva, MD (ACR); Richard Wright, MD (ACC)

In April 2011, CPT codes 93925, 93926, 93970 were identified review by the RUC through the CMS/Other - utilization over 500,000 screen. At the February 2011 RUC meeting, a survey was requested by the Relativity Assessment Workgroup since the codes had "CMS/Other" inputs.

The RUC discussed the compelling evidence that the technology and patient population has changed significantly since the last review of these services. The fundamental physician work for these services has increased due to new technology that was not available in 1995, at the last review. All the arteries below the knee can now be reviewed. In addition, this has led to an increase in the amount of images to be reviewed by the physician. The typical interventions were essentially never performed almost 20 years ago, but are now essential to the procedure. The increased work is also detailed in practice guidelines from accrediting agencies that now show clinical necessity for the additional work of reviewing the tibial arteries. Finally, there has been a change in patient population. The percentage of diabetics has increased in the U.S. since the last review. The typical patient is now a diabetic with heavily calcified vessels which are more complex and take more time to review. The RUC agreed that there is compelling evidence that the physician work has significantly changed since the last valuation.

93925 ***Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study***
The RUC reviewed the survey results from 63 physicians and recommends the median survey physician time components: pre-service time= 5 minutes, intra-service time= 15 minutes, and post-service time= 5 minutes. The RUC agreed that 5 minutes of pre-service time is appropriate to evaluate the patient because an Evaluation and Management service is not typically performed on the same date and same physician. The RUC reviewed the survey respondents' estimated physician work value for this service and agree with the specialty that 0.90 work RVU, the survey median, accurately values this service. To justify this value, the RUC reviewed the key reference service 93306 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography* (work RVU= 1.30) and agreed that while the physician work is similar, the reference code should be valued higher due to greater intra-service time, 20 minutes compared to 15 minutes. In addition, the RUC reviewed CPT code 92012 *Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient* (work RVU= 0.92) and noted that the two service have analogous physician work and identical time components. Given this, the two services should be valued similarly. Finally the RUC reviewed CPT code 73700 *Computed tomography, lower extremity; without contrast material* (work RVU= 1.00) and agreed that the two services should be valued similarly, given the analogous physician work and time components. **The RUC recommends a work RVU of 0.90 for CPT code 93925.**

93926 ***Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study***
The RUC reviewed the survey results from 59 physicians and recommends the median survey physician time components: pre-service time= 5 minutes, intra-service time= 10 minutes, and post-service time= 5 minutes. The RUC agreed that 5 minutes of pre-service time is appropriate to evaluate the patient because a Evaluation and Management service is not typically performed on the same date and same physician. The RUC reviewed the survey respondents' estimated physician work value for this service and agree with the specialty that 0.70 work RVU, the survey median, accurately values this service. To justify this value, the RUC reviewed the key reference code 76776 *Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation* (work RVU= 0.76) and agreed that the two services have identical physician time components and both describe the same spectrum of work. Given this, the surveyed code is correctly valued similar to 76776. In addition, the RUC compared 93926 to reference code 76817 *Ultrasound, pregnant uterus, real time with image documentation, transvaginal* (work RVU= 0.75) and agree that because the two services employ the same technology and have almost identical physician time components, the two service should be valued similarly. **The RUC recommends a work RVU of 0.70 for CPT code 93926.**

93970 ***Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study***
The RUC reviewed the survey results from 53 physicians and recommends the median survey physician time components: pre-service time= 3 minutes, intra-service time= 15 minutes, and post-service time= 5 minutes. The RUC agreed that 3 minutes of pre-service time is appropriate to evaluate the patient because a Evaluation and Management service is not typically performed on the same date and same physician. The RUC reviewed the survey respondents' estimated physician work value for this service and agree with the specialty that 0.70 work RVU, the survey median, accurately values this service. To justify this value, the RUC compared 93970 to key reference code 93971 *Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study* (work RVU= 0.45) and agreed that while the physician work is comparable, the surveyed code should be valued higher due to greater intra-service time compared to the reference code, 15 minutes and 10 minutes, respectively. In addition, the RUC reviewed CPT code 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU= 0.81) and noted that while the surveyed code has five more minutes of intra-service time, 76700 is a more intense procedure and should be valued higher than 93970. **The RUC recommends a work RVU of 0.70 for CPT code 93970.**

Practice Expense: The RUC reviewed and accepted the direct practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

XII. CMS Request – July 19th NPRM

<u>Cholecystectomy (Tab 36)</u>
Christopher Senkowski, MD (ACS); Charles Mabry, MD (ACS); Don Selzer, MD (ACS)

In the Notice for Proposed Rulemaking, CMS indicated that the agency received comments regarding a potential relativity problem between CPT codes 47600 *Cholecystectomy*; and 47605 *Cholecystectomy; with cholangiography*. It appears that the visits do not appropriately reflect the relativity of these two services, and 47600 should

not have more time and visits associated with the service than 47605. The specialty society recognized that the value for code 47605 may be incorrect. The RUC recommended that codes 47600 and 47605 be resurveyed for physician work and practice expense.

The specialty societies indicated and the RUC agreed that there is compelling evidence that the typical patient receiving these services have changed. In current practice, the typical patient undergoing an open procedure has been converted from a laparoscopic approach due to severity of disease, difficult adhesions from prior abdominal surgery and/or difficulties with defining ductal and other anatomy. The specialty societies indicated that more than 80% of Medicare patients undergoing open cholecystectomy are scheduled and started as laparoscopic and are then converted to open. Per Medicare guidelines, only the definitive procedure can be reported, and in this instance, it would be the open procedures 47600 or 47605. The physician reports the open procedure and ICD-9 code V64.41 *Laparoscopic surgical procedure converted to open procedure*. The American College of Surgeons summarizes the rationale and approval process for the vignettes for 47600 and 47605 in the attached memorandum.

47600 *Cholecystectomy*
In April 2012, the RUC reviewed the survey results from 50 general surgeons and determined that the survey median work RVU of 20.00 and intra-service time of 120 minutes appropriately account for the physician work and time required to perform this service. The survey respondents indicated and the RUC agreed that 2-99232 *Subsequent hospital care visits* are appropriate to care for this typical patient who has had been converted to an open procedure. The RUC compared 47600 to the key reference service 44140 *Colectomy, partial; with anastomosis* (work RVU = 22.59 and 150 minutes intra-service time) and determined that 44140 requires 30 minutes more intra-service time and more physician work to perform. For further support, the RUC compared 47600 to similar MPC code 38100 *Splenectomy; total (separate procedure)* (work RVU = 19.55 and 120 intra-service time) and 49203 *Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 1 or more peritoneal, mesenteric, or retroperitoneal primary or secondary tumors; largest tumor 5 cm diameter or less* (work RVU = 20.13 and 120 minutes intra-service time) and determined that a work RVU of 20.00 for 47600 places this service in proper rank order. **The RUC recommends a work RVU of 20.00 for CPT code 47600.**

47605 *Cholecystectomy; with cholangiography*
In April 2012, the RUC reviewed the survey results from 50 general surgeons and determined that the survey median work RVU of 21.00 and intra-service time of 135 minutes appropriately account for the physician work and time required to perform this service. The survey respondents indicated and the RUC agreed that two 99232 *Subsequent hospital care visits* are appropriate to care for this typical patient who has had been converted to an open procedure. The RUC compared 47605 to the key reference service 44140 *Colectomy, partial; with anastomosis* (work RVU = 22.59 and 150 minutes intra-service time) and determined that 44140 requires 15 minutes more intra-service time and more physician work to perform. The RUC noted that the median value of 21.00 for CPT code 47605 and significant increases to intra-time and post-op work addresses the current rank order anomaly and places this service in the proper rank order with 47600. For further support, the RUC compared 47605 to similar MPC code 38100 *Splenectomy; total (separate procedure)* (work RVU = 19.55 and 120 intra-service time) and 33883 *Placement of proximal extension prosthesis for endovascular repair of*

descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension (work RVU = 21.09 and 120 minutes intra-service time), which is more intense and complex to perform, but requires less post-operative visits than 47605. **The RUC recommends a work RVU of 21.00 for CPT code 47605.**

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

Complex Wound Repair (Tab 37)
Glenn Goldman, MD (ACMS); Brett Coldiron, MD (AAD); Melissa Crosby, MD (ASPS); Mark Villa, MD (ASPS)
Facilitation Committee #1

In April 2011, the RUC identified codes 13131 and 13152 as part of the Harvard Valued – Utilization Over 30,000 screen for survey at the September 2011 meeting. CPT codes 13100 and 13101 were reviewed as part of the 4th Five-Year Review. However, in the June 6, 2011 *Proposed Rule* for the 4th Five-Year Review of the RBRVS, CMS requested that the RUC review the entire family of complex wound repair codes to ensure consistency and appropriate gradation of work value. The RUC recommended that the *specialty society re-survey codes 13100-13152 for the April 2012 RUC meeting.*

13100 ***Repair, complex, trunk; 1.1 cm to 2.5 cm***
The RUC reviewed the survey results from 101 dermatologists and plastic surgeons for 13100 and recommends the survey 25th percentile work RVU of 3.00, which is lower than the current value. The RUC compared 13100, with 32 minutes of intra-service time to CPT codes 11603 *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 2.1 to 3.0 cm* (work RVU = 2.82 and intra-time = 30 minutes) and 11444 *Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm* (work RVU = 3.19 and intra-service time = 40 minutes), and determined that using magnitude estimation, the work required to perform 13100 is appropriately placed between these two services. The RUC determined that CPT code 13100 requires more physician time to perform to apply anesthesia to a larger area using a regional block, to undermine tissue and requires more cosmetic detail to repair compared to excision code *11603.* ***The RUC recommends a work RVU of 3.00 for CPT code 13100.***

13101 ***Repair, complex, trunk; 2.6 cm to 7.5 cm***
The RUC reviewed the survey results from 95 dermatologists and plastic surgeons for 13101 and recommends the survey 25th percentile work RVU of 3.50, which is lower than the current value. The RUC determined that survey 25th percentile appropriately places this service in the proper rank order relative to code 13100 which requires 32 minutes of intra-service time compared to 45 minutes of intra-service time required to perform 13101, as well as accounts for the larger area repaired. For additional support the RUC compared 13101 to key reference service 12032 *Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm* (work RVU = 2.52 and 30 minutes intra-service time) and MPC code 11644 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm* (work RVU = 4.34 and 45 minutes intra-service time) and determined the physician work

and time required to perform 13101 appropriately places this service in the proper rank order. **The RUC recommends a work RVU of 3.50 for CPT code 13101.**

13102 ***Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 128 dermatologists and plastic surgeons for 13102 and recommends the survey median intra-service time of 30 minutes and that the current work RVU of 1.24 be maintained. The RUC compared 13102 to key reference 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 MPC code 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)* (work RVU = 1.11 and 25 minutes intra-service time) and determined that a work RVU of 1.24 appropriately places this service in the proper rank order. **The RUC recommends a work RVU of 1.24 for CPT code 13102.**

13120 ***Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm***
The RUC reviewed the survey results from 82 dermatologists and plastic surgeons for 13120 and recommends the survey median intra-service time of 35 minutes and survey 25th percentile work RVU of 3.23. The RUC compared 13120 to the recommended value for 13100 *Repair, complex, trunk; 1.1 cm to 2.5 cm* (recommended work RVU = 3.00 and 32 minutes intra-service time) and determined that 13120 requires slightly more intra-service time and it is more intense and complex to repair these body regions versus repairing a wound of the same size on the trunk. The RUC also compared 13120 to key reference service 12031 *Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less* (work RVU = 2.00 and 20 minutes intra-service time) and MPC code 11643 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm* (work RVU = 3.42 and 30 minutes intra-service time) and determined that a work RVU of 3.23 appropriately places this service in the proper rank order. **The RUC recommends 3.23 work RVUs for CPT code 13120.**

13121 ***Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm***
The RUC reviewed the survey results from 94 dermatologists and plastic surgeons for 13121 and recommends the survey intra-service time of 45 minutes and the survey 25th percentile work RVU of 4.00. The specialty society recommended and the RUC agreed that the intra-service time is 45 minutes and 1-99212 Office visit is typically required, not two as is currently included in this global period. Therefore, the decrease in work RVUs from the current work RVU of 4.42 is appropriate. The RUC also compared 13121 to CPT code 11010 *Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues* (work RVU = 4.19 and 50 minutes intra-service time) and MPC code 11644 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm (work RVU = 4.34 and 45 minutes intra-service time) and determined that a work RVU of 4.00 places this service in the proper rank order. **The RUC recommends a work RVU of 4.00 for CPT code 13121.**

13122 ***Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 96 dermatologists and plastic surgeons for 13122 and recommends the survey median intra-service time of 30 minutes and that the current work RVU of 1.44 be maintained. The RUC compared 13122 to the recommended value for 13102 *Repair, complex, trunk; each additional 5 cm or less* (recommended work RVU = 1.24 and 30 minutes intra-service time) and determined that 13122 requires the same intra-service time, but is more intense and complex to repair these body regions versus repairing a wound of the same size on the trunk. The RUC also compared 13122 to key reference service 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 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 determined that the 13122 requires less physician work to perform. **The RUC recommends a work RVU of 1.44 for CPT code 13122.**

13131 ***Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm***
The RUC reviewed the survey results from 87 dermatologists and plastic surgeons for 13131 and recommends the survey intra-service time of 45 minutes and the survey 25th percentile work RVU of 3.73. The RUC compared 13131 to the recommended value for 13120 *Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm* (recommended work RVU = 3.23 and 35 minutes intra-service time) and determined that 13131 requires 10 more intra-service time and it is more intense and complex to repair these body regions versus repairing a wound of the same size on the scalp, arms and/or legs. The RUC also compared 13131 to MPC code 11644 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm* (work RVU = 4.34 and intra-service time = 45 minutes) and determined that a work RVU of 3.73 places this service in the proper rank order. **The RUC recommends 3.73 work RVUs for CPT code 13131.**

13132 ***Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm***
The RUC reviewed the survey results from 115 dermatologists and plastic surgeons for 13132 and recommends the survey 25th percentile work RVU of 4.78. The specialty society recommended and the RUC agreed that the intra-service time is 50 minutes and 1-99212 Office visit is typically required, not two as is currently included in this global period. Therefore, the decrease in work RVUs from the current work RVU of 6.58 is appropriate. The RUC also compared 13132 to similar service 11446 *Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm* (work RVU = 4.80 and 60 minutes intra-service time) and determined this a work RVU of 4.78 places this service in the proper rank order. **The RUC recommends a work RVU of 4.78 for CPT code 13132.**

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)***
The RUC reviewed the survey results from 93 dermatologists and plastic surgeons for 13133 and recommends the survey median intra-service time of 35 minutes and that the

survey 25th percentile work RVU of 2.19. The RUC compared 13133 to the recommended value for 13122 *Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less* (recommended work RVU = 1.44 and 30 minutes intra-service time) and determined that 13133 requires more physician time to perform and is more intense and complex to repair these body regions versus repairing a wound of the same size on the scalp, arms and/or legs. The RUC also compared 13133 to 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 determined that 13133 requires more physician work and time to perform. **The RUC recommends a work RVU of 2.19 for CPT code 13133.**

13150 ***Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less***
The RUC reveiwed the speiclaties request to delete CPT 13150. The RUC determined that the 1.0 cm or less size of this repair makes it a medically unlikely complex repair due to the small size of the repair. The specialty will submit a CPT proposal requesting deletion of this code for consideration at the October 2012 CPT meeting. **The RUC recommends deletion of CPT code 13150.**

13151 ***Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm***
The RUC reviewed the survey results from 144 dermatologists and plastic surgeons for CPT 13151 and determined that the survey 25th percentile work RVU of 3.50 was too low and would cause a rank order anomaly compared to less intense code 13131 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm* (recommended work RVU = 3.73). CPT code 13151 is more intense and complex to perform than 13131. CPT code 13151 has a higher risk of complication, requires finer smaller sutures in a delicate area, is more challenging to repair with underlying tissue planes and adjacent structures, has a more cosmetic impact and involves repair on mobile areas. Therefore, the RUC recommends a direct crosswalk to CPT code 11644 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm* (work RVU = 4.34 and intra-service time = 45 minutes) in order to maintain rank order among this family of services. **The RUC recommends a work RVU of 4.34 for CPT code 13151.**

13152 ***Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm***
The RUC reviewed the survey results from 107 dermatologists and plastic surgeons for CPT 13152 and determined that the survey 25th percentile work RVU of 4.90 was too low and would cause a rank order anomaly compared to less intense code 13132 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm* (recommended work RVU = 4.78). CPT code 13152 is more intense and complex to perform than 13132. CPT code 13152 has a higher risk of complication, requires finer smaller sutures in a delicate area, is more challenging to repair with underlying tissue planes and adjacent structures, has a more cosmetic impact and involves repair on mobile areas. Therefore, the RUC recommends a direct crosswalk to CPT code 36571 *Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older* (work RVU = 5.34 and intra-service time = 50 minutes) in order to maintain rank order among this family of services. **The RUC recommends a work RVU of 5.34 for CPT code 13152.**

13153 ***Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 92 dermatologists and plastic surgeons for CPT 13153 and determined that the survey 25th percentile work RVU of 2.20 too low and would cause a rank order anomaly compared 13133 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less* (recommended work RVU = 2.19 and intra-service time 35 minutes), which is less intense and requires 10 minutes less intra-service time to perform. The RUC compared 13153 to key reference service 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 similar service 22116 *Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure)* (work RVU = 2.32 and 45 minutes intra-service time) and determined that a work RVU of 2.38 places this service in the proper rank order. **The RUC recommends the survey median and current RVU of 2.38 for CPT code 13153.**

XIII. CMS Request – CMS High Expenditure Procedure Codes

Shaving of Epidermal or Dermal Lesions (Tab 38)
Mark Kaufmann, MD (AAD); Brett Coldiron, MD (AAD)
Facilitation Committee #1

At the January 2012 RUC meeting, the specialty society requested that shaving of epidermal or dermal lesions codes 11300-11313 be validated for physician time and work prior to surveying the Mohs surgery codes 17311 and 17312. CPT Mohs surgery codes 17311 and 17312 were identified through the CMS High Expenditure Procedural screen and are scheduled to be reviewed by the RUC at the April 2013 meeting. The RUC recommended review to validate physician time for codes 11300-11313 at the April 2012 meeting.

The RUC agreed with the specialty society that the previous CMS valuation of assigning these codes an RVU based on a percentage of another code was flawed. This flawed methodology provides compelling evidence to review the work RVUs.

11300 ***Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less***
The RUC reviewed the survey results from 76 dermatologists for 11300 and determined that the 25th percentile work RVU of 0.60 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 9 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC used magnitude estimation and compared 11300 to reference code key reference service 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU = 0.84) and MPC code 11721 Debridement *of nail(s) by any method(s); 6 or more* (work RVU = 0.54) and determined

that the work required to perform this service is appropriate relative to these two services. **The RUC recommends a work RVU of 0.60 for CPT code 11300.**

11301 ***Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm***
The RUC reviewed the survey results from 76 dermatologists for 11301 and determined that the 25th percentile work RVU of 0.90 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 10 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11301 to 11300 which requires 5 minutes less intra-service time to shave a smaller size lesion and determined the 0.90 maintains the proper rank order for this family of services. The RUC compared 11301 to reference code key reference service 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), which requires slightly less physician work and time, 10 versus 15 minutes respectively, to perform than 11301. **The RUC recommends a work RVU of 0.90 for CPT code 11301.**

11302 ***Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 1.1 to 2.0 cm***
The RUC reviewed the survey results from 76 dermatologists for 11302 and determined that the median work RVU of 1.16 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 10 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11302 to 11301 which requires 5 minutes less intra-service time to shave a smaller size lesion and determined the 1.16 maintains the proper rank order for this family of services. The RUC also compared 11302 to 12002 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm* (work RVU = 1.14), which requires slightly less physician work and time, 15 versus 20 minutes respectively, to perform than 11302. **The RUC recommends a work RVU of 1.16 for CPT code 11302.**

11303 ***Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter over 2.0 cm***
The RUC reviewed the survey results from 76 dermatologists for 11303 and determined that the 25th percentile work RVU of 1.25 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 10 minutes to 5 minutes to account only for the immediate post-

operative services related to treatment of the lesion. The RUC compared 11303 to 11302 which requires 2 minutes less intra-service time to shave a smaller size lesion and determined the 1.25 maintains the proper rank order for this family of services. The RUC compared 11303 to key 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* (work RVU = 1.14 and 15 minutes intra service time) and MPC code 11755 *Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)* (work RVU = 1.31 and 25 minutes intra-service time) to support the recommended value. **The RUC recommends a work RVU of 1.25 for CPT code 11303.**

11305 ***Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less***
The RUC noted that podiatry is the dominant provider of this service. APMA determined not to participate in the survey process, however, sent a letter of support for these work RVU recommendations.

The RUC reviewed the survey results from 66 dermatologists for 11305 and determined that the 25th percentile work RVU of 0.80 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 10 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11305 to 11300, and determined that 11305 requires 4 more minutes of intra-service time and is more intense and complex to perform than on the trunk, arms or legs. The RUC also compared 11305 to key 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* (work RVU = 1.14) and determined that 11305 requires less physician work and time to perform, 14 and 15 minutes intra-service time, respectively. The RUC determined a work RVU of 0.80 maintains the proper rank order for this family of services. **The RUC recommends a work RVU of 0.80 for CPT code 11305.**

11306 ***Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm***
The RUC reviewed the survey results from 66 dermatologists for 11306 and determined that the survey median work RVU of 1.18 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 10 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11306 to 11301, and determined that 11306 requires 3 minutes more intra-service time and is more intense and complex to perform than on the trunk, arms or legs. The RUC compared 11306 to key 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* (work RVU = 1.14), which requires less physician work and time to perform, 18 and 15

minutes intra-service time, respectively. The RUC determined a work RVU of 1.18 maintains the proper rank order for this family of services. **The RUC recommends a work RVU of 1.18 for CPT code 11306.**

11307 ***Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm***
The RUC reviewed the survey results from 66 dermatologists for 11307 and determined that the 25th percentile work RVU of 1.20 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 10 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11307 to 11302, and determined that 11307 requires 1 minute more intra-service time and is more intense and complex to perform than on the trunk, arms or legs. The RUC compared 11307 to key 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* (work RVU = 1.14), which requires less physician work and time to perform, 21 and 15 minutes intra-service time, respectively. The RUC determined a work RVU of 1.20 maintains the proper rank order for this family of services. **The RUC recommends a work RVU of 1.20 for CPT code 11307.**

11308 ***Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 2.0 cm***
The RUC noted that podiatry is the dominant provider of this service. APMA determined not to participate in the survey process, however, sent a letter of support for these work RVU recommendations.

The RUC reviewed the survey results from 66 dermatologists for 11308 and determined that the 25th percentile work RVU of 1.46 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate any duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 10 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11308 to 11303, and determined that 11308 requires 4 more minutes intra-service time and is more intense and complex to perform than on the trunk, arms or legs. For additional support the RUC compared 11308 to similar services 12014 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm* (work RVU = 1.57 and 20 minutes intra-service time) and MPC code 29445 *Application of rigid total contact leg cast* (work RVU = 1.78 and 30 minutes intra-service time) and determined that 11308 was less intense and complex to perform. The RUC determined a work RVU of 1.46 maintains the proper rank order for this family of services. **The RUC recommends a work RVU of 1.46 for CPT code 11308.**

11310 Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less
The RUC reviewed the survey results from 68 dermatologists for 11310 and determined that the median work RVU of 1.19 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate any duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 10 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11310 to 11305 and determined that 11310 requires 6 minutes more minutes of intra-service time and is more intense and complex to perform than on the scalp, neck, hands, feet, genitalia. The RUC determined a work RVU of 1.19 maintains the proper rank order for this family of services. The RUC compared 11310 to key reference code 11440 *Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less* (work RVU = 1.05) which requires less physician work and time to perform, 20 minutes and 10 minutes intra-service time, respectively. **The RUC recommends a work RVU of 1.19 for CPT code 11310.**

11311 ***Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm***
The RUC reviewed the survey results from 68 dermatologists for 11311 and determined that the median work RVU of 1.43 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 10 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11311 to 11306, and determined 11311 requires 7 more minutes of intra-service time and is more intense and complex to perform than on the scalp, neck, hands, feet and genitalia. The RUC also compared 11311 to key reference code 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 determined 11311 requires more physician work and 10 more minutes of intra-service time to perform. The RUC determined a work RVU of 1.43 maintains the proper rank order for this family of services**. The RUC recommends a work RVU of 1.43 for CPT code 11311.**

11312 Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm
The RUC reviewed the survey results from 68 dermatologists for 11312 and determined that the median work RVU of 1.80 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 11 minutes to 5 minutes to account only for the immediate post-

operative services related to treatment of the lesion. The RUC compared 11312 to 11307, and determined 11312 requires 9 more minutes of intra-service time and is more intense and complex to perform than on the scalp, neck, hands, feet and genitalia. The RUC compared 11312 to MPC code 29445 *Application of rigid total contact leg cast* (work RVU=1.78) which requires similar physician work and 30 minutes of intra-service time to perform. The RUC determined a work RVU of 1.80 maintains the proper rank order for this family of services. **The RUC recommends a work RVU of 1.80 for CPT code 11312.**

11313 ***Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm***
The RUC reviewed the survey results from 68 dermatologists for 11313 and determined that the median work RVU of 2.00 appropriately accounts for the physician work required to perform this service. The RUC reduced the pre-service time to eliminate duplication of services already performed in the Evaluation and Management service. The RUC recommends 1 minute of pre-time positioning the patient and 5 minutes of scrub, dress, wait time to administer local anesthesia. Additionally, the specialty recommended and the RUC agreed to reduce the survey respondents immediate post-service time from 12 minutes to 5 minutes to account only for the immediate post-operative services related to treatment of the lesion. The RUC compared 11313 to 11308, and determined 11313 requires 9 more minutes of intra-service time and is more intense and complex to perform than on the scalp, neck, hands, feet and genitalia. The RUC noted that the survey 25th percentile work RVU of 1.68 would not appropriately account for the physician work required to perform this service and would cause a rank order anomaly with the smaller shave code for this same body region, CPT code 11312. The RUC also compared 11313 to similar service 12015 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm* (work RVU = 1.98 and 25 minutes intra-service time). The RUC determined a work RVU of 2.00 maintains the proper rank order for this family of services. **The RUC recommends a work RVU of 2.00 for CPT code 11313.**

Shaving of epidermal or dermal lesion, single lesion

CPT Code	Pre-Eval	Pre-Posit	Pre-SDW	Intra	Imm Post	Survey Value	Rec wRVU
Trunk, arms or legs							
11300	0	1	5	10	5	25th	0.60
11301	0	1	5	15	5	25th	0.90
11302	0	1	5	20	5	Median	1.16
11303	0	1	5	22	5	25th	1.25
Scalp, neck, hands, feet, genitalia							
11305	0	1	5	14	5	25th	0.80
11306	0	1	5	18	5	Median	1.18
11307	0	1	5	21	5	25th	1.20
11308	0	1	5	26	5	25th	1.46
Face, ears, eyelids, nose, lips, mucous membrane							
11310	0	1	5	20	5	Median	1.19
11311	0	1	5	25	5	Median	1.43
11312	0	1	5	30	5	Median	1.80
11313	0	1	5	35	5	Median	2.00

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

Arthrocentesis – PE Only (Tab 39)

This service was identified by CMS in July 2011 through the CMS High Expenditure Procedural Codes screen. Surveys for physician work were reviewed recently for the 2011 Medicare physician payment schedule, but practice expense was not reviewed at that time. In January 2012, the RUC recommended that the practice expense only be reviewed at the April 2012 meeting. The Practice Expense Subcommittee removed three minutes for *provide pre-service education/obtain consent* from each code because they are commonly billed with an Evaluation and Management service. **The RUC reviewed and approved the direct practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.**

Valve Replacement and CABG Procedures (Tab 40)
Jim Levett, MD (STS); Stephen Lahey, MD (STS); Jeff Jacobs, MD (STS)

In July 2011, these services were identified as part of the CMS High Expenditure Procedural Codes screen. In January 2012, the RUC recommended that the specialty societies survey this service for work and practice expense. Rather than conduct a RUC survey the specialty society utilized data from the STS National Adult Cardiac Database, which meets the criteria established by the RUC for the use of extant data. It was also confirmed that the mean is the appropriate data point for analysis of the STS database. While the median is useful for analyzing smaller samples, the STS data has tens of thousands of data points and a mean is therefore more appropriate. The specialty society queried the years 2006-2010 to compare to data obtained from 2000-2004. The RUC reviewed the results of an intensity survey from 76 cardiac surgeons, whom indicated that the intensity of physician work has increased significantly since the codes were last reviewed in 2005 for the 3rd Five-Year Review. The RVU recommendations were calculated by multiplying the intensity measures and the service time, which is the same methodology that was used for valuation for the last review. The RUC did not employ the intensity survey submitted because its use in conjunction with extant data is not clearly permitted outside of the 5 year review under the current RUC policies and procedures.

CPT codes 33405 ***Replacement, aortic valve, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve***
The RUC reviewed the data from 78,332 patients and agreed with the specialty society that the work RVU of 41.32, the current value and below the computed value based on STS database time, appropriately accounts for the physician work required to perform this service. The RUC agreed with the specialty society recommended physician time of 95 minutes pre-service, 197 minutes intra-service and 40 minutes post-service. The RUC agreed that pre-service time equivalent to a pre-service package 4 (difficult patient, difficult procedure), with additional time for evaluation and positioning of the patient, was appropriate for this service. The RUC agreed that an additional 20 minutes of evaluation time was appropriate to review the echocardiogram and angiogram, confirm the set up for the cardiopulmonary bypass and conduct a review of patient and planned procedure with qualified healthcare professionals involved in the service. An additional 12 minutes of positioning is also needed to adequately position the patient and position external equipment on the patient to ensure appropriate nerve protection and comfort.

The STS data showed that the intra-service time remained relatively the same (198 to 197 minutes), and the intensity measures have increased. The specialty society indicated and the RUC agreed that the pre-service and post-service, as well as post-operative visits have not changed. The RUC reviewed reference codes with similar time and intensity and noted that CPT code 33031 *Pericardiectomy, subtotal or complete; with cardiopulmonary bypass* (work RVU=45.00) has similar intra-service time at 205 minutes and CPT code 35082 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta* (work RVU=42.09), has similar intra-service time at 180 minutes and similar physician work. The RUC concurred that this service is valued appropriately and should maintain its value. **The RUC recommends a work RVU of 41.32 for CPT code 33405.**

CPT code 33430 *Replacement, mitral valve, with cardiopulmonary bypass*
The RUC reviewed the data set of 15,374 patients and agreed with the specialty society that the work RVU of 50.93, the current value and below the computed value based on STS database time, appropriately accounts for the physician work required to perform this service. The RUC agreed with specialty society recommended physician time of 95 minutes pre-service, 232 minutes intra-service and 40 minutes post-service. The RUC agreed that pre-service time equivalent to a pre-service package 4 (difficult patient, difficult procedure), with additional time for evaluation and positioning of the patient, was appropriate for this service. The RUC agreed that an additional 20 minutes of evaluation time was appropriate to review the echocardiogram and angiogram, confirm the set up for the cardiopulmonary bypass and conduct a review of patient and planned procedure with qualified healthcare professionals involved in the service. An additional 12 minutes of positioning is also needed to adequately position the patient and position external equipment on the patient to ensure appropriate nerve protection and comfort. The STS data showed that the intra-service time has increased from 223 to 232 minutes, and the intensity measures have increased. However, the specialty did not feel that a request for an increase could be justified at this time because the patients have not changed. The specialty society indicated and the RUC agreed that the pre-service and post-service, as well as post-operative visits have not changed. The RUC reviewed comparator codes with similar time and intensity and noted that CPT code 33465 *Replacement, tricuspid valve, with cardiopulmonary bypass* (work RVU=50.72) has similar physician time at 95 minutes pre-service, 211 minutes intra-service and 40 minutes post-service and CPT code 33875 *Descending thoracic aorta graft, with or without bypass* (work RVU=50.72), has similar intra-service time at 240 minutes and similar physician work. The RUC concurred that this service is valued appropriately and should maintain its value. **The RUC recommends a work RVU of 50.93 for CPT code 33430.**

CPT code 33533 *Coronary artery bypass using arterial graft(s); single arterial graft*
The RUC agreed with the specialty society that there is compelling evidence to increase the value of this code based on an increase in intra-service time, a change in patient population and increased work intensity. Although the overall length of hospital stay was unchanged, there have been increases in the incidence of diabetes, heart failure, cerebrovascular disease and peripheral vascular disease. Most of the composite variables that predict increased morbidity have increased and the use of preoperative ADP blockers has increased. The patient population undergoing surgical myocardial revascularization has changed dramatically due to two factors. First, the drug eluting coronary stent was introduced in 2002-2003 and became prevalent at the very end of the 2000-2004 period

used in establishing the current work values. This device has led to dramatic shifts in the surgical population towards patients having severe and diffuse coronary artery disease (and those with diabetes) toward percutaneous intervention. The second major change in the patient population is the prevalence of dual antiplatelet drug therapy that occurred in 2004 when the an FDA panel recommended at least 12 months of such therapy to minimize the occurrence of fatal drug eluting stent thrombosis. Increasing prevalence of dual antiplatelet therapy and the introduction of other agents such as direct thrombin inhibitors and irreversible fractionated heparin products have increased complexity and intensity of obtaining hemostasis during cardiac surgery. This has been compounded by the withdrawal of aprotinin from the marketplace in 2006. This was the only effective hemostatic agent in this anti-platelet drug environment, and was in widespread use during the 2000-2004 index time period.

The RUC reviewed the data set of 29,250 patients and agreed with the specialty recommended physician time of 95 minutes pre-service, 158 minutes intra-service and 40 minutes post-service. The RUC agreed that pre-service time equivalent to a pre-service package 4 (difficult patient, difficult procedure), with additional time for evaluation and positioning of the patient, was appropriate for this service. The RUC agreed that an additional 20 minutes of evaluation time was appropriate to review the echocardiogram and angiogram, confirm the set up for the cardiopulmonary bypass and conduct a review of patient and planned procedure with qualified healthcare professionals involved in the service. An additional 12 minutes of positioning is also needed to adequately position the patient and position external equipment on the patient to ensure appropriate nerve protection and comfort. The STS data showed that the intra-service time has increased from 151 to 158 minutes, and the and the intensity measures have increased The specialty society indicated and the RUC agreed that the pre-service and post-service, as well as post-operative visits have not changed.

The RUC reviewed the results of an intensity survey from 76 cardiac surgeons, but did not employ the intensity survey submitted because its use in conjunction with extant data is not clearly permitted outside of the 5 year review under the current RUC policies and procedures. The RUC noted that this method should be further considered by the Research Subcommittee. The RUC used magnitude estimation and determined that a direct crosswalk to CPT code 33510 *Coronary artery bypass, vein only; single coronary venous graft* (work RVU = 34.98, intra-service time = 154 minutes), is appropriate. The RUC agreed with the specialty society that 33510 is less intense to perform than 33533, since an arterial graft is more complex than a vein graft. However, 33510 has one more post-operative visit than the surveyed code, thus validating the same value for these services. **The RUC recommends a work RVU of 34.98 for CPT code 33533, a direct crosswalk to CPT code 33510.**

Practice Expense

The RUC discussed that the staff type included in practice expense is an RN rather than the more common RN/LPN/MTA blend. The RUC agreed with the specialty society that during past reviews of cardiothoracic services, compelling evidence was accepted to justify the designation of RN as the clinical staff type. The RUC reviewed and approved the direct practice expense inputs as recommended by the Practice Expense Subcommittee.

Repair of Arterial and Venous Blockage (Tab 41)
Geraldine McGinty, MD (ACR); Zeke Silva, MD (ACR); Sean Tutton, MD (SIR); Michael Hall, MD (SIR); Robert L Vogelzang, MD (SIR); Gerald A. Niedzwiecki, MD (SIR); Robert Kossmann, MD (RPA); and Chet Amedia, MD (RPA)
Facilitation Committee #2

In September 2011, CPT Codes 35475 *Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel* and 35476 *Transluminal balloon angioplasty, percutaneous; venous* were identified in the CMS High Expenditure Procedure Codes screen.

35475
The RUC reviewed survey results of 84 diagnostic and interventional radiologists and interventional nephrologists and determined that physician work values were overestimated at the 25th percentile, 7.00 work RVUs. The RUC confirmed that 35475 is also reported with 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* (work RVU=3.72) and 75962 *Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation* (work RVU=0.54) and that the Multiple Procedure Payment Reduction rule is applied to 36147 when performed with another service. Therefore, there is no duplication of physician work when these services are performed on the same day. To obtain an accurate value for this service, the RUC reviewed CPT code 37224 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty (work RVU=9.00)* and determined that by removing 1.86 work RVUs to account for the multiple procedure reduction and 0.54 work RVUs accounting for the radiologic supervision and interpretation included in code 37224, the resulting value would be 6.60 work RVUs. The RUC agreed that this value accurately describes the physician work inherent in code 35475. To justify a work RVU of 6.60 for this service, the RUC reviewed CPT code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral* (work RVU=6.74, pre-75, intra-45, post-30) and determined that these services required similar physician work, time and intensity components. **The RUC recommends a work RVU of 6.60 for CPT Code 35475.**

35476
The RUC reviewed the survey results from 85 diagnostic and interventional radiologists and interventional nephrologists and determined that the 25th percentile work RVU of 5.10 appropriately accounts for the physician work required to perform this service. This code is also reported with 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* (work RVU=3.72) and 75962 *Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation* (work RVU=0.54). The RUC noted that the Multiple Procedure Payment Reduction rule is applied to 36147 when performed with another service. Therefore, there is no duplication of physician work when these services are performed on the same day. The RUC compared 35476 to CPT code 37220 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 8.15) and determined that removing 1.86 to account for the multiple procedure

payment rule and 0.54 for supervision and interpretation would appropriately derive a comparable work RVU of 5.75 to the recommended value for 35476. The RUC also reviewed CPT Code 52276 *Cystourethroscopy with direct vision internal urethrotomy* (work RVU=4.99) and agreed that with identical intra-service time of 35 minutes these services should be valued similarly. **The RUC recommends a work RVU of 5.10 for CPT code 35476.**

Practice Expense:
The RUC reviewed and approved practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

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

Lithotripsy (Tab 42)
Thomas Cooper, MD (AUA); Christopher Gonzalez, MD (AUA); Thomas Turk, MD (AUA); Martin Dineen, MD (AUA)

In September 2011, CPT Code 50590 *Lithotripsy, extracorporeal shock wave* was identified in the CMS High Expenditure Procedure Codes screen.

The RUC reviewed the survey results from 39 urologists and recommends that the current work RVU of 9.77, which is below the survey 25th percentile, be maintained. The specialty society recommended and the RUC agreed that three office visits (one 99212 and two 99213s) and a half-day discharge management service (99238) accurately describe the post operative physician work to clinically evaluate the patient and order diagnostic tests to reduce the risk of capillary damage, parenchymalor or subcapsular hemorrhage following the procedure. The RUC compared 50590 to key reference service 52648 *Laser vaporization of prostate, including control of postoperative bleeding, complete* (work RVU=12.15) and noted that although intra service times were identical, 52648 is a more intense procedure, with greater total time, compared to the surveyed code. The RUC also compared 50590 to CPT code 29891 *Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect* (work RVU=9.67) and determined that physician time and intensity components were analogous and thus the codes should be valued similarly**. The RUC recommends a work RVU of 9.77 for CPT code 50590.**

Practice Expense:
The RUC reviewed and approved practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

Transurethral Destruction of Prostate Tissue (Tab 43)
Thomas Cooper, MD (AUA); Christopher Gonzalez, MD (AUA); Thomas Turk, MD (AUA); Martin Dineen, MD (AUA)
Facilitation Committee #2

In September 2011, CPT Code 53850 *Transurethral destruction of prostate tissue; by microwave thermotherapy* was identified in the CMS High Expenditure Procedure Codes screen.

The RUC reviewed the survey results from 33 urologists and recommends that the current work RVU of 10.08 should be maintained. The RUC noted that while the surveyed intra service time of 60 minutes is a reduction from current intra service time of 90 minutes, the post operative visits have increased from two 99213 visits currently assigned to this code to four visits, per the survey data. The RUC noted that there has been a change in technology which now delivers the therapy at a higher temperature putting patients more at risk for clots. The RUC agreed that the increased intensity due to new technology and patients who are more at risk for clots following the procedure does warrant an increase in post operative visits; however, they determined that one 99212, two 99213s and one 99214 visits were more appropriate compared to the survey results.

To justify the current value, the RUC wanted to ensure the reduction in intra-service time was equal to the increase in post operative visits warranted by the change in patient population. The RUC calculated the difference between the current and surveyed intra service time (30 minutes) and multiplied by the current IWPUT (.0643), resulting in a work RVU of 1.93. The current post operative visits include 1.94 work RVUs (two 99213s). The RUC recommended post operative visits result in a work RVU of 3.92. The difference between the current and recommended post operative visits is a work RVU of 1.98. Therefore, the RUC noted that the difference between intra service time and post operative visits was roughly the same. To further support this value, the RUC reviewed CPT code 45190 *Destruction of rectal tumor (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach* (work RVU=10.42, pre-80, intra-60, post-45) and determined that these two services require the same intra-service time of 60 minutes and are similar in work. The RUC also reviewed codes 53852 *Transurethral destruction of prostate tissue; by radiofrequency thermotherapy* (work RVU=10.83, pre-60, intra-58, post-45) and 52647 (work RVU=11.30, pre-60, intra-45, post-45) and determined that the intra service times and work are similar. **Therefore, the RUC recommends a work RVU of 10.08 for CPT code 53850.**

Practice Expense:
The Practice Expense Subcommittee understood that previously 2/3 of physician time was allocated to assist physician in performing the procedure. However, the new technology delivers higher intensity/temperature and now requires the nurse to assist 100% of the time.

Transvaginal and Transrectal Ultrasound (Tab 44)
Geraldine McGinty, MD (ACR); Zeke Silva, MD (ACR); George Hill, MD (ACOG)

In September 2011, CPT Codes 76830 *Ultrasound, transvaginal* and 76872 *Ultrasound, transrectal* were identified in the CMS High Expenditure Procedure Codes screen.

76830 *Ultrasound, transvaginal*
The RUC reviewed the survey results from 120 radiologists and obstetricians/gynecologists and recommends that the current work RVU of 0.69, which is below the survey 25th percentile, be maintained for CPT Code 76830. The RUC noted that 76830 is billed with 76856 *Ultrasound, pelvic (nonobstetric), real time with image documentation; complete* and determined that there is no overlap of physician work when the services are performed on the same date of service. The RUC reviewed physician time and recommends the survey median times of 5 minutes of pre-time, 10 minutes of intra-service time and 10 minutes of post-time. The RUC noted that post-service time increased from 5 minutes in 2005 to 10 minutes in this survey and agreed that since there

is an increased rate of sepsis following the procedure, there should be more time allocated for patient discussion. The RUC compared 76830 to the key reference code 76817 *Ultrasound, pregnant uterus, real time with image documentation, transvaginal* (work RVU=0.75 and intra-time=10 minutes) and determined that the urgency of medical decision making and risk of malpractice with poor outcomes is greater in 76817 compared to the surveyed code. Thus, the reference code should be valued higher. The RUC also reviewed 20600 *Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)* (work RVU=0.66 pre-11, intra-5 and post-5) and determined that these two services require similar intensity and total time. Finally, to further justify a work RVU of 0.69, the RUC reviewed CPT Code 65205 *Removal of foreign body, external eye; conjunctival superficial* (work RVU=0.71, pre-5, intra-5, post-5) and agreed that the overall work is similar. **The RUC recommends a work RVU of 0.69 for CPT Code 76830.**

76872 ***Ultrasound, transrectal***
The RUC reviewed the results of 69 radiologists and urologists and recommends that the current work RVU of 0.69 be maintained, which is below the survey 25th percentile for CPT Code 76872. The RUC noted that although 76872 is also billed with 55700 *Biopsy, prostate; needle or punch, single or multiple, any approach* and 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision*, this procedure is typically not used for cancer, but rather to determine therapy to relieve patients of primary bladder neck obstruction. Therefore, there is no duplication of physician work when these services are reported on the same day. The RUC reviewed CPT Code 76881 *Ultrasound, extremity, nonvascular, real-time with image documentation; complete* (work RVU=0.63) and agreed that 76872 requires 10 more minutes and should be valued higher. In addition, the RUC reviewed 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU=0.81) and determined that although 76700 requires less time, it is a more intense procedure and should be valued higher than the surveyed code. A work RVU of 0.69 maintains proper rank within this family of services. **The RUC recommends a work RVU of 0.69 for CPT Code 76872.**

Practice Expense:
The RUC reviewed and approved practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

<u>Radiotherapy Dose Plan IMRT (Tab 45)</u>
Najeeb Mohideen, MD (ASTRO); Michael Kuettel, MD, PhD (ASTRO); Dwight Heron, MD (ASTRO) and Gerald White (ASTRO)

In the July 19, 2011, Proposed Rule for 2012, CMS requested that the RUC review high expenditure services. CPT code 77301 was selected because it had not been reviewed in almost ten years. In September 2011, the Relativity Assessment Workgroup reviewed this service and recommended that the specialty societies submit action plans for January 2012. In January 2012 the RUC recommended that this service be surveyed for physician work and practice expense in April 2012.

77301 ***Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications***
The RUC reviewed the survey results from 90 radiation oncologists and agreed with the specialty society that the survey respondents accurately estimated the physician work

involved in this service: intra-service time= 160 minutes and post-service time= 35 minutes. Currently, 77301 has 30 minutes of pre-service time, however, the specialty explained that the three primary work components involved in this service, image acquisition, contouring and dose prescription are all performed in the intra-service time. The survey was modified and approved by the Research Subcommittee to preclude pre-service physician work and add a more robust description of intra-service work. The RUC agreed that this reallocation more accurately apportions the time required to complete this service. Finally, the RUC noted that while this procedure is intensive and completed over several hours, CPT code 77301 is only reported once per course of therapy.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the current work RVU of 7.99, just below the survey's 25th percentile, accurately reflects the physician work involved in the service. To justify this value, the RUC compared the surveyed code to key reference service 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* (work RVU= 11.87) and agreed that while the services are fundamentally similar with a high degree of complex planning, imaging evaluation and clinical correlation, the reference code has greater intra-service time compared to 77301, 201 minutes and 160 minutes, respectively. In addition, the RUC reviewed MPC 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* (work RVU= 5.99) and agreed that the two services have similar physician work. However, 77301 has 45 more minutes of physician time compared to the reference code and thus should be valued higher. **The RUC recommends a work RVU of 7.99 for CPT code 77301.**

Practice Expense: The RUC reviewed and approved the direct practice expense inputs as recommended by the Practice Expense Subcommittee.

Visual Field Exams (Tab 46)
Stephen A Kamenetzky, MD (AAO); Michael Chaglasian, OD (AOA)

In July 2011, CPT code 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVU=0.50), was identified through the CMS High Expenditure Procedural Codes screen. In January 2012, the RUC recommended that the specialty societies survey this service. CPT codes 92081 and 92082, which are part of this family of services were recently reviewed in April 2010 and were not resurveyed.

In April 2012, the RUC reviewed the survey results from 116 ophthalmologists and optometrists for CPT code 92083 and determined that the work RVU of 0.50, the survey's 25th percentile accounts for the physician work required to perform this service. The RUC discussed that survey respondents included post-service time which should not be included based on the RUC guidelines developed for 92081 and 92082 in 2005. The RUC also agreed that the respondents underestimated the physician work involved in the intra-service time because they did not recognize that the interpretation and creation of

the report is included in the intra-service time, as stated in the descriptor. Nothing has changed about the service since it was last reviewed in 2005 so for consistency and recognition of the interpretation and creation of the report being part of intra-service work, the RUC agreed that times should be modified from the survey to 3 minutes pre-service, 10 minutes intra-service and 0 minutes post-service. The RUC compared 92083 to key reference CPT code 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)* (work RVU=0.40) and determined that 92083 requires slightly more physician time and is more intense to perform, justifying the higher RVU value. **The RUC recommends a work RVU of 0.50 for CPT code 92083.**

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

Cardiovascular Stress Tests (Tab 47)
Richard Wright, MD (ACC); Bill Van Decker, MD (ACC); Diane Wallis, MD (ACC)

CMS identified code 93015 for cardiovascular stress test for review in the 2012 Medicare Proposed Rule because it had not been reviewed since before 2006 and had CY 2010 allowed charges of greater than $10 million at the specialty level. Related codes 93016 and 93018 were also surveyed and RUC reviewed in April 2012, as part of the Agency's request to review the entire family of services.

93015 ***Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report***
The RUC reviewed the survey data from 76 cardiologists and agreed with the specialty societies that there is no compelling evidence that the physician work has changed since the last valuation and recommends to maintain the current value of 0.75, below the survey's 25th percentile. The RUC reviewed the median survey physician times and noted that the respondents overestimated the pre and post time as it is not an accurate reflection of the physician time involved in the service. The RUC agreed that the current pre and post times are more appropriate for this service and recommends the following physician time components: pre-service time= 2 minutes, intra-service time= 20 minutes, post-service time= 4 minutes.

To justify the current work RVU of 0.75, the RUC reviewed CPT codes 76885 *Ultrasound, infant hips, real time with imaging documentation; dynamic (requiring physician manipulation)* (work RVU= 0.74) and CPT code 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* (work RVU= 0.78) and agreed that both had comparable physician work and identical intra-service times compared to the surveyed code. Therefore, the recommended value is

appropriately aligned relative to similar services. **The RUC recommends a work RVU of 0.75 for CPT code 93015.**

93016 ***Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, without interpretation and report***
The RUC reviewed the survey data from 53 cardiologists and agreed with the specialty societies that there is no compelling evidence that the physician work has changed since the last valuation and recommends to maintain the current value of 0.45, below the survey's 25th percentile. The RUC noted that while the current total time of 58 minutes, is overstated, the proposed median survey times were also too high. The RUC agreed that CPT codes 93016, physician supervision only, and 93018, physician interpretation and report only, should have times that are similar to that of CPT code 93015. Therefore, the RUC recommends the following physician time components for 93016: pre-service time= 2 minutes, intra-service time= 15 minutes, post-service time= 2 minutes.

To justify the current work RVU of 0.45, the RUC reviewed CPT code 93784 *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report* (work RVU= 0.38) and agreed that while the two services have identical intra-service time of 15 minutes, the surveyed code has pre and post time and thus should be valued slightly higher. In addition, the RUC reviewed CPT code 94620 *Pulmonary stress testing; simple (eg, 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)* (work RVU= 0.64) and noted that while both services have the same intra-service times, the reference code should be valued higher than 93016 because of greater total time, 40 minutes compared to 19 minutes. **The RUC recommends a work RVU of 0.45 for CPT code 93016.**

93018 ***Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only***
The RUC reviewed the survey data from 61 cardiologists and agreed with the specialty societies that there is no compelling evidence that the physician work has changed since the last valuation and recommends to maintain the current value of 0.30, below the survey's 25th percentile. However, the RUC disagreed with the proposed median survey time values for this service as it is an increase over the current times for this service. The RUC agreed that CPT codes 93016, physician supervision only, and 93018, physician interpretation and report only, should have times that are similar to that of CPT code 93015. Therefore, the RUC recommends the following physician time components for 93018: pre-service time= 2 minute, intra-service time= 5 minutes, post-service time= 4 minutes.

To justify the current work RVU of 0.30, the RUC reviewed CPT code 72114 *Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views* (work RVU= 0.32) and agreed that the two services have analogous physician work and times and should be valued similarly. In addition, the RUC compared 93018 to the work RVUs of 93015 and 93016 and agreed that a work RVU of 0.30 was appropriate because when it is added to 93016 the work RVU is the same, 0.75, as 93015. **The RUC recommends a work RVU of 0.30 for CPT code 93018.**

Practice Expense: The RUC reviewed and accepted the direct practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.

Immunotherapy Injections - PE Only (Tab 48)

This service was identified by CMS in July 2011 through the CMS High Expenditure Procedural Codes screen. In January 2012, the RUC noted that this service has not been reviewed in the last 6 years and recommended the practice expense be reviewed for the family of services at the April 2012 meeting. The time for administration of injections was reduced from 2 minutes to 1 minute for 1 injection and 4 minutes to 2 minutes for 2 or more injections. **The RUC reviewed and approved the direct practice expense inputs with minor modifications as recommended by the Practice Expense Subcommittee.**

XIV. CMS Request to Re-Review Families of New/Revised Codes (PE Only)

CT Angiography - PE Only (Tab 49)
American College of Radiology

These services were most recently identified in the Nov. 28, 2011 Final Rule for 2012. CMS requested that the RUC re-review specific codes in a family of CT angiography services that were recently reviewed and bundled. In January 2012, the RUC reviewed the CMS identified family of services and recommended that CPT codes 72191 *Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing* and 74175 *Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing* be referred to the PE Subcommittee to review in April 2012 to determine if any practice expense anomalies exist between the new bundled code 74174 *Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing* and these individual codes. The RUC determined that review of physician work is not necessary at this time. The PE Subcommittee reviewed the practice expense inputs and noted that the expert panel overestimated the clinical staff time needed for the CT tech to *Assist the physician in performing procedure/computer post processing,* recommending 57 minutes rather than the 33 minutes needed for the same input for 74174. Practice expense inputs were revised to align with the 30 minutes of physician work intraservice time typical for the family of codes. An additional clinical staff time of 3 minutes was added for computer post processing, resulting in a total of 33 minutes for *Assist the physician in performing procedure/computer post processing***. The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.**

Evoked Potentials and Reflex Studies – PE Only (Tab 50)
AAN, AANEM, AAPM&R, ACNS

These services were most recently identified in the Nov 28, 2011 Final Rule for 2012. CMS requested that the RUC re-review specific codes in a family of services that were recently reviewed. In January 2012, the RUC reviewed the CMS identified family of services and recommended that codes 95925 and 95926 be referred to the PE Subcommittee to review in April 2012 to determine if any practice expense anomalies exist between 95938 or 95939 and these codes. The RUC determined that review of

physician work is not necessary at this time. Practice expense inputs were revised to align with accepted standards and the intra-service time for *Assist the physician in performing procedure* was revised to reflect the typical time needed when a patient is being tested for one limb as compared to two limbs. **The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.**

XV. Practice Expense Subcommittee (Tab 51)

Doctor Bill Moran, Chair, provided a summary of the Practice Expense Subcommittee report. The Subcommittee reviewed a letter submitted by the American College of Physicians (ACP) with assistance from American College of Radiology (ACR) regarding CPT codes utilizing ultrasound equipment that are potentially misreported by internal medicine physicians. The letter explained that according to 2010 utilization data, Internal Medicine is the dominant specialty on only 2 of the 14 codes, CPT codes 59074 and 93314. ACP and ACR recommend that coding education be directed towards the physicians misreporting these codes and that the PE Subcommittee review the codes after 2 years (May 2014), to verify that coding education will alleviate the improper coding. The **PE Subcommittee accepted the recommendation of ACP and ACR.**

The ACR presented to the PE Subcommittee regarding migration of radiologic images from film to digital (PACS) and discussed formation of a multi-specialty workgroup. Doctor Moran noted that this is an urgent issue as the use of film surrogates in place of digital for practice expense inputs has created problems for the Subcommittee. **The Chair will establish a workgroup to address this concern. The workgroup should include representation from ACR and other appropriate specialty societies.**

The Subcommittee reviewed the recommendation of the American Society for Gastrointestinal Endoscopy (ASGE) to add irrigation basin, CMS code SJ009, to Endoscope Cleaning and Disinfecting Pack, CMS code SA042. **The PE Subcommittee agreed that the basin should be added to the cleaning and disinfecting pack and will submit the recommendation to CMS.**

The Subcommittee reviewed the recommendations of the Pre-Service Time for 000 Day Globals Workgroup. The Workgroup recommends to the PE Subcommittee that the standard pre-service time for 000 day global codes should remain zero. The Workgroup acknowledges that pre-service time is required for some of these codes. It therefore recommends that assignment of any pre-service time to 000 day global codes must include appropriate justification and compelling evidence. When appropriate justification is provided the Workgroup proposes the following pre-service standards for clinical staff time for 000 and 010 day global period codes: 0 minutes for standard use of clinical staff, 15 minutes for minimal use of clinical staff and 30 minutes for extensive use of clinical staff. The proposed times are meant to be guidelines and are not predetermined for any code. Specialties can recommend 1-15 minutes of pre-service time, distributed in whatever way is typical, for codes that make minimal use of clinical staff. Specialties can recommend 16-30 minutes of pre-service time, distributed in whichever way is typical, for codes that make extensive use of clinical staff.

In addition, the Workgroup identified 48 codes 000 day global codes that have greater than 30 minutes of pre-service time in the facility setting. The Workgroup recommends that the Subcommittee provide the opportunity for specialty societies to comment on the

allocation of time to these 48 codes. The Workgroup will review the codes as well as the comments to determine if the time should be reduced to 30 minutes of pre-service time. **The results of this review will be considered at the October RUC Meeting.**

There was concern amongst the PE Subcommittee members that the maximum pre-service time of 30 minutes is arbitrary. It was noted that many 090 day globals that are less complex than some of the 000 day globals codes are assigned pre-service time without scrutiny, and that many of the 000 day globals codes have legitimate reason for having significant pre-service time allocations. Some members stated that defining a maximum time of 30 minutes of pre-service time for 000 day globals will not result in any standardization for the PE Subcommittee as each code will continue to need individual review. The Chair stated that the pre-service time for 090 day globals should be reviewed by the PE Subcommittee in the future. These concerns were noted, and the Subcommittee moved to a vote on the issue. **There was some dissent, however the Subcommittee voted to recommend the policy established by the Workgroup to the RUC.**

Doctor Moran noted that the PE Subcommittee is concerned about the volume of codes in this and future meetings.

The RUC approved the Practice Expense Subcommittee report and it is attached to these minutes.

XVI. Research Subcommittee (Tab 52)

Doctor Brenda Lewis, Chair, provided a summary of the Research Subcommittee report. The Research Subcommittee Report from the February 2012 Conference Call is included in Tab 52 of the April 2012 agenda materials and was reviewed and approved by the RUC. The AGA, ACG and ASGE submitted a request to refine the survey process for GI endoscopy procedures which will be surveyed between the October 2012 and January 2014 RUC meetings. In summary the changes would survey moderate sedation separately from the physician work involved from scope-in, scope-out. The first option would ask survey respondents to provide time and RVW value for the administration of sedation for a base code and also ask respondents to value the incremental work over the base code for performing scope-in, scope-out procedure. The total "Work RVU" would be calculated using the following formula:

(Moderate Sedation Value) + (Base Code Value) + (Incremental Procedure Value) =Total "Work RVU"

The second option reviewed would adjust the survey instrument so that each code in the family is surveyed independently with moderate sedation separate from the scope-in, scope-out procedure. The "Work RVU" for each code would be calculated using the following formula:

(Moderate Sedation Value) + (Procedure Work Value) = Total "Work RVU"

The Research Subcommittee members were not supportive of either option. They expressed concern that separating moderate sedation could lead to a biased survey and also could make it difficult to capture an overlap in work specific to the administration of moderate sedation. The specialty societies noted, and the Subcommittee members agreed

that the second option would be complex and time-consuming for survey respondents and could negatively impact the response rate. In addition, this could create rank-order anomalies. During the discussion, it was also noted that the base code for esophagoscopy procedures, 43200, is a service predominantly performed by otolaryngologists. It is advised that the specialties collaborate on a plan to address CPT Code 43200. **The Research Subcommittee recommends that the specialty societies use either the 000 day survey instrument for each code within the family or survey a base code with the standard survey instrument and then use a mini-survey for intra-service time for each other code within the family.**

The RUC approved the Research Subcommittee report and it is attached to these minutes.

XVII. Multi-Specialty Points of Comparison Workgroup (Tab 53)

Doctor Ronald Burd, Chair, provided the Multi-Specialty Points of Comparison Workgroup (MPC) Workgroup Conference Call Report. The MPC Workgroup has created a revised Multi-Specialty Points of Comparison (MPC) list and submits it for the RUC for approval. The revised list is comprised of 221 codes, 65 of the codes were on the old list, the rest of the codes are new. The MPC Workgroup has worked steadily for close to two years to critically review the current MPC list and how it is maintained. From this analysis, the MPC Workgroup has systematically restructured the MPC list through several objective criteria. The primary purpose of this restructuring is to create a list of cross-specialty codes that are useful in valuation both within a specialty and between specialties.

The process of refinement of the MPC list will be an ongoing process. Following adoption by the RUC, the Workgroup members will consider how to further improve the function of the MPC Workgroup and list, including processes for adding additional services. The MPC Workgroup recognizes two issues that will continue to be monitored and reviewed to ensure the MPC list is most useful. First, the list has very few services over 10.00 work RVUs. Second, specialties that bill services with high RVUs (e.g. Cardiothoracic Surgeons) or have low utilization in the Medicare population (pediatric medicine) have little representation on the list. The MPC Workgroup members will continue to monitor these issues and work with the relevant specialty societies to determine the appropriate method to address these issues.

All MPC codes may require periodic confirmation of the appropriateness for continuance on the list, but should not require formal revaluations. Finally, specialty societies are encouraged to review the new list and submit formal requests to the MPC Workgroup to add services that are widely performed by multiple specialties or are otherwise good comparators for assessing inter or intra specialty valuation.

The RUC approved the Multi-Specialty Points of Comparison Workgroup report including the revised MPC list and it is attached to these minutes.

XVIII. HCPAC Review Board (Tab 55)

Jane White, PhD, provided the HCPAC Review Board report. The American Occupational Therapy Association (AOTA) and American Physical Therapy Association

(APTA) indicated that they intend to submit a coding proposal to revise many of the physical medicine and rehabilitation codes.

APTA indicated that of 48 codes in this family, 23 remain time-based codes, describing "each 15 minutes" of service. APTA's proposed revisions will describe "sessions" instead of "time units". Additionally, the code set will collapse significantly to approximately 12 codes to describe different levels of interventions: patient severity at the time of the visit and intensity of the visit.

AOTA indicated they are working with APTA to revise this code set and that one of the challenges will be development of vignettes to describe both the OT and PT service. AOTA and APTA intend to submit a coding proposal in Fall 2012.

The HCPAC reviewed the following code and will submit the recommendation to CMS or the 2013 Medicare Physician Payment Schedule:

Pharmacologic Management with Psychotherapy (90863)

In February 2012, as part of the new psychotherapy coding framework, the CPT Editorial Panel created code 90863 *Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)* to allow psychologists who perform pharmacologic management services for their patients as an add-on to psychotherapy to report these services.

The American Psychological Association recommended that code 90863 be carrier priced as this service is being reported by approximately 100 individuals in two states and it would be difficult to survey at this time. **The HCPAC agreed and recommends that CPT code 90863 be carrier priced.**

The RUC approved the HCPAC Review Board report and it is attached to these minutes.

XIX. Election of Rotating Seats (Tab 56)

The RUC considered the election of the internal medicine subspecialty rotating seat and elected Larry Martinelli, MD, Infectious Diseases Society of America.

The RUC considered the election of the primary care rotating seat. The RUC elected M. Douglas Leahy, MD, MACP, American College of Physicians.

The terms for the rotating seats are two years, beginning with the October 2012 RUC meeting and ending in May 2014, with the provision of final recommendations to the Centers for Medicare and Medicaid Services.

XX. Other Issues

The Chronic Care Coordination Workgroup (C3W) met before the start of the RUC meeting. Doctor Ellington briefed the RUC attendees on new Transitional Care Management Services (TCM) and Complex Chronic Care Coordination Services (CCCC)

CPT codes. The RUC will review these codes at the October 2012 RUC meeting in time for the 2013 Medicare Physicians Payment Schedule.

Doctor Vates informed the RUC that there are concerns about a proposed changes to the wording of the introduction section in the CPT book. Currently it states that all proposed changes of the CPT code book will be considered by the CPT Editorial Panel with consultation of appropriate medical specialty societies. It has been proposed to strike that sentence, with the implication being that the CPT Editorial Panel can consider CPT codes without the input of medical specialty societies.

Staff Note: AMA staff clarifies that this was a propsoal and this language has not been removed from CPT.

Doctor Williams inquired about the progress of making the RUC database more Mac friendly and Sherry Smith reported that the AMA is in the process of developing this capability.

Doctor Levy adjourned the meeting at 7:38pm on Saturday, April 28, 2012.