AMA/Specialty RVS Update Committee
Meeting Minutes
April 25-27, 2013

I. Welcome and Call to Order

Doctor Barbara Levy called the meeting to order on Friday, April 26, 2013 at 8:00 am. The following RUC Members were in attendance:

Barbara Levy, MD
Margie C. Andreae, MD
Michael D. Bishop, MD
James Blankenship, MD
Dale Blasier, MD
Albert Bothe, MD
Ronald Burd, MD
Scott Collins, MD
John O. Gage, MD
William F. Gee, MD
Anthony Hamm, DC
David C. Han, MD
David F. Hitzeman, DO
Charles F. Koopmann, Jr., MD
Timothy Laing, MD
Walt Larimore, MD
Alan Lazaroff, MD
M. Douglas Leahy, MD, MACP
Brenda Lewis, DO
J. Leonard Lichtenfeld, MD
Scott Manaker, MD, PhD
William J. Mangold, Jr., MD
Larry Martinelli, MD
Geraldine B. McGinty, MD
Gregory Przybylski, MD
Marc Raphaelson, MD
Sandra B. Reed, MD
Peter Smith, MD
J. Allan Tucker, MD
James C. Waldorf, MD
George Williams, MD
Allan A. Anderson, MD*
Gregory L. Barkley, MD*
Gregory DeMeo, MD*
Verdi DiSesa, MD*
William D. Donovan, MD, MPH, FACR*
Jeffrey Paul Edelstein, MD*
Yul Ejnes, MD*
William E. Fox, MD, FACP*
Daniel McQuillen, MD*
Eileen Moynihan, MD
Daniel Nagle, MD*
Margaret Neal, MD*
Chad A. Rubin, MD, FACS*
M. Eugene Sherman, MD*
Daniel Mark Siegel, MD*
Fredrica E. Smith, MD*
Norman Smith, MD*
Holly Stanley, MD*
Stanley W. Stead, MD, MBA*
Robert J. Stomel, DO*
G. Edward Vates, MD*
Thomas J. Weida, MD*
Jane White, PhD, RD, FADA, LDN*
Jennifer L. Wiler, 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:
    - Edith Hambrick, MD – CMS Medical Officer
    - Steve E. Phurrough, MD – CMS Medical Officer
    - *Via Conference Call*
        - Kathy Bryant - Director of the Division of Practitioner Services
        - Ryan Howe – Senior Policy Analyst

- Doctor Levy welcomed the following Contractor Medical Director:
    - Richard W. Whitten, MD, MBA, FACP
- On February 28th, 2013 Doctors Levy, Smith and Leahy from the RUC and Doctors Hollmann, Synovec and Brin from CPT met with John Blum, Deputy Administrator at the Center for Medicare & Medicaid Services (CMS) and other CMS staff to discuss enhancing the relationship and communication between CPT/RUC and CMS. Multiple issues were discussed including transparency. It was a positive meeting. It was clear that there are policy pressures on CMS that determine the final rule, however the group had a frank discussion about expectations that misvalued services that CPT/RUC identifies are not only targeted for decreases in value, but that increases would also be considered when appropriate. Mr. Blum was very forthcoming, accommodating and thoughtful in his comments. The group committed to meeting more frequently in order to keep communication open and to understand where each group is coming from and the work that we are each doing.
- On March 29th, 2013 Doctor Levy met with Grant Rodkey, the first Chair of the RUC. They met with John Goodson and Miriam Laugesen, who is a researcher at Columbia University and has attended the RUC in the past, in Doctor Rodkey's office at the VA Hospital in West Roxbury, MA and reviewed the history of the RBRVS.
- Doctor Levy thanked the following RUC members whom are retiring or rotating off the RUC:
    - Joel Bradley, Jr., MD - American Academy of Pediatrics
    - William F. Gee, MD - American Urological Association
    - Timothy Laing, MD - American College of Rheumatology
    - Brenda Lewis, DO - American Society of Anesthesiologists
    - David C. Han, MD - Society for Vascular Surgery
- Doctor Levy congratulated Doctor Gee who is the President-elect of the American Urology Association (AUA)
- Doctor Levy laid out the following guidelines related to RUC proceedings:
    - There is a confidentiality policy that needs to be signed at the registration table for all RUC members and alternates.
    - Proceedings are recorded in order for RUC staff to create the meeting minutes.
    - RUC members must state if they have a conflict of interest before a presentation That RUC member will not discuss or vote on the issue.
- Doctor Levy shared the sad news that Carolyn Mullen passed away this year. A remembrance from her memorial service was passed around to RUC members.
- Doctor Levy laid out the additional following guidelines related to RUC proceedings:
    - 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.
    - RUC members should state their conflict of interest, if applicable, and the member will not discuss or vote on the issue. This will be reflected in our minutes.
- Doctor Levy laid out the following guidelines related to voting:
    - The RUC vote count will be published as previously outlined by the Administrative Subcommittee. The votes will be published following the November 2013 Final Rule for the 2014 Medicare Physician Payment Schedule
    - Voting will occur on every work RVU, including facilitation reports and practice expense.
    - RUC members should share voting clickers with alternates if unable to be at the table.

  - To ensure 28 votes are collected for each code, re-voting may be necessary throughout the meeting.
  - If members abstain from voting or leave the table, please notify AMA staff so we may account for all 28 votes
- Doctor Levy conducted the following financial disclosure review:
  - Tab 22: Percutaneous Implantation of Neurostimulator – PE Only
    - Doctor Tucker explained that the Financial Disclosure Review Workgroup reviewed this tab and found a financial conflict.
    - When there is a financial conflict there are three options:
      1. No restriction
      2. Limited presentation
      3. No presentation
    - The Workgroup reviewed minutes of the last six meetings of the Financial Disclosure Review Workgroup to make sure the conclusion was consistent with past decisions.
    - There are three manufacturers that make this device and the individual in question had financial interests in two. The Workgroup decided this was too great a conflict and decided on option 3. The report of the Financial Disclosure Review Workgroup can be found in your handouts.

III. Director's Report

- The AMA has engaged with a consultant to update the RUC database including making it Mac compatible and allowing downloading online through a password protected site. We will also be able to distribute the agenda through this password protected site.

IV. Approval of Minutes of the January 24-27, 2013 RUC Meeting

The RUC approved the January 2013 RUC Meeting Minutes as submitted.

V. CPT Editorial Panel Update (Informational)

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

- The CPT Panel met in January/February in Tampa, Florida. Doctor Laing attended the meeting as the RUC representative.
- A question was raised at the House of Delegates regarding whether or not an issue was in the surgery section and how various payers looked at services depending on where they are placed in the CPT book. As a result, new language is in the introductory section stating, "listing of a service or procedure in a specific section of the book should not be interpreted as classifying a service or procedure as surgery or not surgery".
- Based on the questions of RUC members and a Workgroup, the CPT Editorial Panel looked at use of appendix C and determined it still had utility. However, introductory language was added at the beginning of appendix C stating, "examples included in this section are not appropriately used for any review of correct coding or estimating physicians work."
- The Panel reviewed category II codes. With the increased use of electronic reporting of performance metrics, the use of category 2 codes is declining. A Workgroup has looked at converting performance measures to registry reporting. Also, the Workgroup discussed

a category II maintenance plan over the next 5-8 years depending on when there is a complete conversion to electronic reporting.

- At the upcoming May meeting, the CPT Editorial Panel will have its annual review of strategic issues. The topics largely came from the summit that CPT leadership held with a variety of stakeholders over the last two months. The emphasis will be increased transparency and access of the CPT deliberations and input from the public.
- Finally, Doctor Bothe requested that specialty society staff encourage their CPT Advisors to complete the Advisor Comment Form. It would help deliberations of the Panel if more advisors submitted their comments.

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

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

- Marilyn Tavenner, Acting Administrator of CMS had her Senate hearing. Currently she is awaiting confirmation as Senator Harkin has placed a hold on her nomination.
- Joanna Baldwin is the new Acting Deputy Director in the Division of Practitioner Services.
    - She is previously from the Coverage and Analysis group within CMS.
- At this meeting and previously the RUC has approved adding a visit on the same day as surgery.
    - The result is there are more visits listed in the global period than the length of stay.
    - The Agency wonders whether more visits than the length of stay should be included in the valuation for these procedures.
    - In the context of the 23+ hour stay discussion, the RUC added subsequent inpatient hospital visits and then later when subsequent observation days were created they added subsequent observation days. CMS did not allow the inclusion of this visit. However, the Agency allowed the intra-service time to be included and its value was added to the post-service period.
- RUC Staff clarified that, in regard to the issue of more visits than the length of stay, the RUC acknowledged that for some major surgical procedures, physicians would return the same evening to round on the patient. This is not duplicative visits, it just happens to be on the day of surgery.
- A RUC member commented that, this isn't just a surgical-only issue. There are many patients in regular hospital beds that require intensive care with multiple visits per day that are not adequately covered by the current inpatient codes.
- A RUC member commented that, we should be looking at a solution in which 000 day globals are allowed for current surgical procedures, so that the visits can be collected in order to ascertain whether there is indeed more work and in some cases less work. This would provide transparency so the work of the physician is properly captured.

VII. Contractor Medical Director Update (Informational)

Doctor Richard W. Whitten, MD, FACP provided the contractor medical director update:

- All 4 Durable Medical Equipment (DME) contracts were awarded, so they will likely be stable for a period of 4 years. The Contractor Management Group has requested legislation to extend the contracts for a period greater than 5 years. This is a low priority

legislative item; however, CMS has acknowledged that the transitions need to be less frequent than they have been.

- The A/B MAC contracts – CMS is on track with the time table they planned for full conversion of this set of A/B MACS. They have been delayed because of protests, which continue to be resolved. All should be resolved within two years of being on time, in 2014. Jurisdiction E A/B MAC has been held up in an unusual protest that went to the court level and is now resolved and Jurisdiction G A/B MAC protest was resolved, so all should be in place within the year.
- ZPICs have taken over from the program safeguard contractors. The ZPICs deal with fraud. If a member receives a letter it should be treated seriously. The specialties may want to communicate to their members that they should consider instituting an office ZPIC policy along the lines of notifying all physicians if a ZPIC note is received.
- Sections 6407 of Affordable Care Act will result in a separate issue for DME Prosthetics, Orthotics and Supplies.
    - A physician must document that he/she, PA, NP or CNS has had a face-to-face exam with a beneficiary in the 6 months before a written Rx.
    - 155 items covered under the requirement.
    - A physician documenting a PA, NP or CNS' visit will be able to bill a separate G code. There will also be a code for a physician to document if they have reviewed the exam done by a PA, NP or CNS.
    - This is scheduled to go into effect in on July 1.
- One of the most confusing areas for the contractors in terms of questions and errors is the transitional care management services.
    - Transitional Care Management Services 99495 (Moderate Complexity) requires:
        - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days post-discharge (or documentation of 2 unsuccessful attempts).
        - Documented medical and/or psychosocial problems require medical decision making of at least moderate complexity during the service period.
        - Face-to-face visit, within 14 calendar days post-discharge
        - Medication reconciliation and management must be documented no later than the date of the face-to-face visit
    - Transitional Care Management Services 99496 (High Complexity) requires:
        - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days post-discharge (or documentation of 2 unsuccessful attempts)
        - Documented medical and/or psychosocial problems require medical decision making of high complexity during the service period.
        - Face-to-face visit, within 7 calendar days post-discharge
        - Medication reconciliation and management must be documented no later than the date of the face-to-face visit
    - Both 99495 & 99496: transition in care is from:
        - An inpatient hospital setting
        - Partial hospital
        - Observation status in a hospital
        - Skilled nursing/nursing facility
    - The transition in care is to the patient's community setting (NOT to SNF):
        - Home
        - Domiciliary

        - Rest home or assisted living
        - The provider of service is not a hospitalist
    - Both 99495 & 99496:
        - Payable only once in the 30 days following a discharge, per patient per discharge, to a single community physician or qualified non-physician practitioner (or group practice) who assumes responsibility for the patient's post-discharge TCM services.
        - Billing to be after the 30 day period
- "LCD Writers" now meeting regularly
- LCD Writers Workgroups consist of the following members:
    - Pain Management
        - Gary R. Oakes, MD; Bernice R. Hecker, MD; Michael F. Montijo, MD; Arthur N. Lurvey, MD
    - Molecular Pathology Codes
        - Elaine K. Jeter, MD; Mitchell I. Burken, MD; Earl Berman, MD
    - EMG/NCS
        - Cheryl Ray, DO; Eileen Moynihan, MD
    - Radiation (including Radiation Oncology)
        - Sidney Hayes, MD; Edward L. Humpert, MD
    - Skin Substitutes
        - Steve Boren, MD; Craig Haug, MD; Juan L Schaening-Perez, MD
    - T Codes (Cat II Codes) Coverage Issues
        - Laurence Clark, MD; James J. Corchran, Jr., MD; Olatokunbo Awodele, MD; Carolyn Cunningham, MD; Greg McKinney, MD
- All LCD Writers and Contractor Medical Director have a usually self-administered drugs policy.
    - If you are not happy with the policy suggestions, guidance especially data is appreciated.
    - For example, SYLATRON™ (peginterferon alfa-2b) is a current topic we are seeking data on.
- The CMS website has resources to find your local contractor medical directors.

VIII. Washington Update (Informational)

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

- Sustainable Growth Rate (SGR) Status Report
    - January 1st, 2013 began the 15th year under SGR
- Calls for repeal of the SGR continue to grow:
    - President's 2014 budget
    - Medicare Payment Commission
    - Two commissions
        - National Commission on Fiscal Responsibility & Reform (Simpson-Bowles II)
        - Bipartisan Policy Center (formed in 2007 by 4 former senate leaders)
- CBO has reduced 10-yr score and it is now $138 billion
- Physician-Endorsed Principles – endorsed by over 100 physician organizations, including state societies.

  - Pay updates should reflect costs +quality & efficiency.
  - Transition should provide choices, incremental change & way to measure progress.
  - Physicians should be rewarded for savings across health care spectrum.
  - Physicians adopting new models should have enhanced updates.
  - Plan should encourage systems of care but preserve choice.
  - State and specialty initiatives should be counted as delivery improvements.
  - Hardship exemptions should be available for some physicians.
- AMA Draft Transition Proposal
  - Step 1: Repeal SGR
  - Step 2: CMS develops accountable payment models (APMs)
  - Step 3: CMS assigns 3 levels of points (high, medium and low)
  - Step 4: Future updates tied to points
  - Step 5: CMS reports & recommendations
- House Medicare Committees: Ways and Means & Energy and Commerce
  - Physicians would have a choice:
    - Performance-based FFS
    - Alternative models
- AMA's response to House Medicare Committees' proposal:
  - There is a lot that we like:
    - 3 ways to meet quality goals
  - What we do not like:
    - 10-year freeze is not stability
    - Concern about withhold
- Prognosis
  - Prospects for SGR repeal clearer by August

IX. SGR Spending and Utilization Growth for 2012 (Informational)

Kurt Gillis, AMA, provided the RUC with the following information regarding SGR spending and utilization growth:

- Data and Methods
  - Estimates based on claims processed through Dec 31, 2012. They are not exact as they do not include claims that continue to come in at the beginning of the year. (>92% complete). Numbers can change, but the estimates have proven to be very accurate. Last year's estimates did not change at all.
  - Use Medicare Physician/Supplier Procedure Summary file (PSPS)
  - Spending changes broken down into changes in pay, utilization, site of service affects.
- Medicare Physician Fee Schedule (MFS) spending:
  - Accounts for 89% of SGR spending. The other 11% is mostly clinical lab fee schedule spending.
  - Accounts for 29% of Medicare Part B spending (2012)
    - SGR and Part B are not the same. The rest of Part B is Medicare Advantage payment, hospital outpatient payments, durable medical equipment and physician administered drugs.
  - Accounts for 12% of total Medicare spending
- Results for 2012 – Overall
  - SGR spending is up 0.3%, basically flat.

  - MFS spending change is -0.3%, this is low by historical standards the average growth from 1997 to 2011 has been 6% per year.
  - Change in MFS spending was due to:
    - Increase in FFS enrollment (0.9%)
    - Decrease in MFS pay (-1.1%), this happened despite the conversion factor freeze for 2012. A provision in the ACA that boosted PE GPCIs for rural areas in 2010 and 2011 and that provision expired.
    - Utilization growth (per enrollee) of 0.0%, this is extremely low, historically the average is 3.5%.
- Results for 2012 – Imaging
  - Spending change for imaging is -6%, 650 million reduction in spending due to:
    - -4% pay change
    - -2% change in utilization per enrollee
    - Shift to facility setting reduced spending by 1%
      - For SGR spending a shift to facility setting generally causes spending to go down, but for overall Medicare spending it causes a spending increase.
  - Utilization change is low or negative across all detailed categories (table 6a)
  - Nuclear medicine stands out for decline in utilization and site of service shift (CPT 78452)
  - Advanced imaging – site of service shift for all categories (to facility)
- Results for 2012 – E&M
  - Very low growth
  - 1% increase in spending with 0% change in utilization per enrollee
  - 1% increase in utilization of office visits, counting volume and intensity
  - 2% decrease in utilization of hospital visits
  - 18% increase in utilization of wellness visits (new in 2011), this is the only major increase
- Procedures
  - Very low growth in spending and utilization, as we have seen in previous years
  - 1% increase in spending with 1% increase in utilization per enrollee
  - Decline in utilization for cardiovascular and orthopedic procedures
  - Something that stands out is the 5% decline in utilization of oncology – radiation therapy
- Other notable results
  - Physical therapy, previously there has been a lot of growth (10% average for 2008, 2009). In last three years there is no growth in utilization per enrollee.
  - Lab tests: 8% increase in utilization of non-MFS lab tests. Spending in this category was up $500 million dollars for this year.
- Change in utilization of MFS services 2012
  - Stable and declining utilization across the board, especially in the last 3 years. This is only Medicare fee schedule. Very different from years past.
- Impacts
  - SGR cliff is shrinking (a little): was -27.4% for 2012, projected at -24.4% for 2014
  - 10 year cost to repeal SGR drops:
    - Now it is $138 billion (Feb 2013) for a 10 year freeze
    - Just a year and half ago it was $290 billion (Nov 2011)

Questions for Sharon and Kurt

Q: Sharon you said there has been an increase for non-facility of 4% since 2001, what is the impact in terms of the increase among the hospitals (facility)?
A: Hospitals regularly get 2% to 3% a year. They have to report on quality and efficiency and outcome measures, but the percent increase is much higher. This has led to many physicians switching to a hospital-based setting and MedPAC is now suggesting that the payments in the facility and nonfacility should be equalized.
Q: What work is being done on risk adjustment?
A: The Congressional Medicare Committees know this has to be addressed and proposals ask questions about this. The AMA comments address that changes need to be made to the risk adjustors for both quality and efficiency measures. The current data being used is a year old and we have suggested, updating data on a quarterly basis. There is work being done on incorporating chronic conditions as well.
Q: Kurt, are services in the outpatient setting included in this data?
A: Professional component is included in this data and always has been, but other components such as facility fee are not.
Q: Kurt, you mentioned that imaging spending is going down, partially based on site of service, yet we hear that change in site of service from nonfacility to facility causes increased spending?
A: The facility is often a more expensive site of service; however the technical component if performed in the facility setting will not be counted in this data. It is not part of the SGR spending.

X. Relative Value Recommendations for CPT 2014:

Breast Biopsy (Tab 4)
Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); Mark Alson, MD (ACR); Jan Jeske, MD (ACR); Eric Whitacre, MD FACS (SIR); Christopher Senkowski, MD FACS (ACS); Charles Mabry, MD FACS (ACS)

In January 2012, the RUC identified codes 77031 *Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation*, 19103 *Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance*, 77032 *Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation* and 19290 *Preoperative placement of needle localization wire, breast* through the Codes Reported Together 75% or More screen. In October 2012, the CPT Editorial Panel established six new bundled codes to report breast biopsy with imaging guidance and established eight new bundled codes to report placement of breast location devices with imaging guidance. The six breast lesion biopsy codes include marker placement and specimen radiography if performed and are categorized by stereotactic guidance, ultrasound guidance and MRI guidance, each with an add-on code to describe additional lesions subject to biopsy. The eight breast marker placement codes are reported in the absence of breast biopsy and are categorized by mammographic guidance, stereotactic guidance, ultrasound guidance and MRI guidance, each with an add-one code to describe additional lesions localized.

The RUC noted that the recommendations for these two families of services, breast lesion biopsy and breast marker placement, maintain the proper rank order relative to one another in regards to physician work as follows: (1) magnetic resonance guidance; (2) stereotactic guidance; (3) mammographic guidance; and (4) ultrasound guidance.

Breast Lesion Biopsy

The specialty society indicated and the RUC agreed that for the breast lesion biopsy family of services, imaging of the biopsy specimen is bundled into these services when performed. For example, the physician would use radiography for a specimen from the patient to identify calcification and confirm it is in the specimen prior to sending it to the pathologist for further analysis.

19081 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance

The RUC reviewed the survey results from 99 physicians for CPT code 19081 and determined that the survey respondents slightly overestimated the work required to perform this service. The respondents indicated CPT code 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU = 4.71) as the key reference service which is more intense and complex and may have caused the respondents to overestimate the work for 19081. Additionally, the RUC determined that the 25th percentile work RVU was too low for this service and would cause a rank order anomaly within this family and other similar services. Therefore, the RUC recommended a direct crosswalk to CPT code 31296 *Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)* (work RVU = 3.29 and 30 minutes intra-service time). The RUC determined that for stereotactic guidance service, the patient is typically in the prone position, therefore 2 additional minutes for positioning time is warranted. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* with the positioning adjustment for 13 minutes evaluation, 3 minute positioning and 6 minutes scrub, dress and wait pre-service time is appropriate. The RUC determined the physician time of 22 minutes pre-service, 30 minutes intra-service and 15 minutes immediate post-service time were appropriate to perform this procedure. For additional support the RUC compared 19081 to 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU = 3.30) and determined that each require similar physician work and the same intra-service time of 30 minutes. **The RUC recommends a work RVU of 3.29 for CPT code 19081.**

19082 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 52 physicians for CPT code 19082 and determined that the physician work may have been overestimated in relation to the base code 19081. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned; re-draped and additional anesthesia must be administered for each subsequent lesion biopsied. The specialty society indicated and the RUC agreed that the physician work required to biopsy each additional lesion is half that of the primary code. Therefore, the RUC determined a work value of 1.65 appropriately values this procedure. For support the RUC referenced similar service 76812 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal*

evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure) (work RVU = 1.78), which requires similar physician work and time. **The RUC recommends a work RVU of 1.65 for CPT code 19082.**

19083 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance
The RUC reviewed the survey results from 97 physicians for CPT code 19083 and determined that the median work RVU of 3.10 appropriately accounts for the work required to perform this service and is appropriate in relation to this code family. The RUC determined that for this ultrasound guided service, the patient is typically in the supine position; therefore, no additional positioning time is warranted. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* with an adjustment in the scrub, dress and wait time to match the survey respondents for 13 minutes evaluation, 1 minute positioning and 5 minutes scrub, dress and wait pre-service time is appropriate. The RUC recommends 19 minutes of pre-service, 25 minutes of intra-service and 15 minutes of immediate post-service time for this service. The RUC compared 19083 to key reference service 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU = 4.71) and agreed that the key reference service is more intense and complex and requires 5 more minutes intra-service to perform. For additional support the RUC reviewed MPC codes 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU = 2.78); 15002 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children* (work RVU = 3.65) and similar service 32557 *Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance* (work RVU = 3.12) and determined that the median work RVU of 3.10 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 3.10 for CPT code 19083.**

19084 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)
The RUC reviewed the survey results from 52 physicians for CPT code 19084 and determined that the physician work may have been overestimated in relation to the survey responses related to the base code 19083. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned, re-draped and additional anesthesia must be administered for each subsequent lesion biopsied. The specialty society indicated and the RUC agreed that the physician work required to biopsy each additional lesion is half of that of the primary code. Therefore, the RUC determined a work value of 1.55 appropriately values this procedure. For support, the RUC referenced similar service 49412 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial*

markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure) (work RVU = 1.50), which requires similar physician work and time. **The RUC recommends a work RVU of 1.55 for CPT code 19084.**

19085 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance
The RUC reviewed the survey results from 64 physicians for CPT code 19085 and determined that the median work RVU of 3.64 accounts for the work required to perform this service and maintains appropriate relativity within this family. The RUC determined that for MRI guidance service, the patient is typically in the prone position, therefore 2 additional minutes for positioning time is warranted. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* with the positioning adjustment for 13 minutes evaluation, 3 minute positioning and 6 minutes scrub, dress and wait pre-service time is appropriate. The RUC recommends 22 minutes of pre-service, 45 minutes of intra-service and 15 minutes of immediate post-service time for this service. The RUC compared 19085 to key reference service 49411 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple* (work RVU = 3.82) and noted that the respondents indicated variation in the intensity and complexity measures for both of these services, which reflects the unique nature of breast interventions. Although reference code 49411 requires 5 minutes less intra-service than 19085, 40 and 45 minutes, respectively, it is a more intense service. For additional support the RUC reviewed MPC codes 15002 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children* (work RVU = 3.65) and 31628 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe* (work RVU = 3.80) and determined that the median work RVU of 3.64 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 3.64 for CPT code 19085.**

19086 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)
The RUC reviewed the survey results from 40 physicians for CPT code 19086 and determined that the survey 25th percentile work RVU of 1.80 was appropriate. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned; re-draped and additional anesthesia must be administered for each subsequent lesion. The specialty society indicated and the RUC agreed that the physician work required to biopsy each additional lesion is half of that of the primary code. Therefore, the RUC determined a work value of 1.82 appropriately values this procedure. For support, the RUC referenced similar service 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) (work RVU = 2.19), which has slightly higher total time and, hence, a slightly higher RVU. **The RUC recommends a work RVU of 1.82 for CPT code 19086.**

Breast Marker Placement

19281 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance

The RUC reviewed the survey results from 62 physicians and determined that the median work RVU of 2.00 appropriately accounts for the work required to perform this service and maintains appropriate relativity within this code family. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* for 13 minutes evaluation, 1 minute positioning and 6 minutes scrub, dress and wait pre-service time is appropriate. The RUC agreed that 20 minutes of pre-service, 30 minutes of intra-service and 15 minutes of immediate post-service time are appropriate for this service. The RUC compared 19281 to key reference service 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 2.50) and noted that the respondents indicated higher intensity and complexity for the surveyed service, however, 36556 requires 15 minutes of intra-service time compared to 30 minutes. The RUC agreed that this reflects the unique nature of breast interventions. The breast marker placement services are associated with very high patient and family anxiety, which tend to increase the psychological stress of the physician. Although the reference code requires less time, the physician work is higher, rendering it a more intense service. For additional support, the RUC reviewed MPC codes 64483 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU = 1.90) and 90937 *Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription* (work RVU = 2.11) and determined that the median work RVU of 2.00 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 2.00 for CPT code 19281.**

19282 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 37 physicians for CPT code 19282 and determined that the physician work may have been overestimated in relation to the survey responses related to the base code 19281. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned; re-draped and additional anesthesia must be administered for each subsequent lesion. The specialty society indicated and the RUC agreed that the physician work required for each additional lesion is half of that of the primary code. Therefore, the RUC determined a work value of 1.00 appropriately values this procedure. For further support the RUC referenced similar service 11046 *Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 1.03), which requires similar physician work and time. **The RUC recommends a work RVU of 1.00 for CPT code 19282.**

19283 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance
The RUC reviewed the survey results from 93 physicians and determined that the survey 25th percentile work RVU of 2.00 appropriately accounts for the work required to perform this service and maintains appropriate relativity within this code family. The RUC determined that for this stereotactic guidance service, the patient is typically in the prone position, therefore 2 additional minutes for positioning time is warranted. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* with the positioning adjustment for 13 minutes evaluation, 3 minute positioning and 6 minutes scrub, dress and wait pre-service time is appropriate. The RUC agreed that 22 minutes of pre-service, 20 minutes of intra-service and 15 minutes of immediate post-service time are appropriate for this service. The survey respondents indicated that the intra-service time is 10 minutes less for 19283 compared to 19281. The RUC noted that the survey respondents may have only assumed one wire for 19283 as it is not specified as a dual-wire service in the vignette as it is for 19281, thus causing the time variation. The specialty societies indicated and the RUC agreed that two wires are typical to perform 19283, the same as 19281, therefore it is appropriate that the work RVU for these services to be the same. The RUC compared 19283 to key reference service 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 2.50) and noted that the respondents indicated higher intensity and complexity for the surveyed service, however, 36556 requires 15 minutes of intra-service time compared to 20 minutes. The RUC agreed that this reflects the unique nature of breast interventions. The breast marker placement services are associated with very high patient and family anxiety, which tend to increase the psychological stress of the physician. Although the reference code requires less time, the physician work is higher, rendering it a more intense service. For additional support, the RUC reviewed MPC codes 64483 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU = 1.90) and 90937 *Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription* (work RVU = 2.11) and determined that the 25th percentile work RVU of 2.00 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 2.00 for CPT code 19283.**

19284 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (List separately in addition to code for primary procedure)
The RUC reviewed the survey results from 48 physicians for CPT code 19284 and determined that the physician work may have been overestimated in relation to the survey responses related to the base code 19283. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned; re-draped and additional anesthesia must be administered for each subsequent lesion. The specialty society indicated and the RUC agreed that the physician work required for each additional lesion is half that of the primary code. Therefore, the RUC determined a work value of 1.00 appropriately values this procedure. Additionally, the RUC determined that this service requires the same physician work and time as 19282 and therefore should be valued the same. For further support the RUC referenced similar service 11046 *Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed);*

each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure) (work RVU = 1.03), which requires similar physician work and time. **The RUC recommends a work RVU of 1.00 for CPT code 19284.**

19285 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance
The RUC reviewed the survey results from 101 physicians and determined that the survey 25th percentile work RVU of 1.70 appropriately accounts for the work required to perform this service and maintains appropriate relativity within this code family. The RUC determined that for this ultrasound guidance service, the patient is typically in the supine position; therefore no additional positioning time is warranted. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* for 13 minutes evaluation, 1 minute positioning and 6 minutes scrub, dress and wait pre-service time is appropriate. The RUC agreed that 20 minutes of pre-service, 15 minutes of intra-service and 15 minutes of immediate post-service time are appropriate for this service. The RUC noted that 19285 typically requires one wire and less intra-service time than 19281 and 19283 and therefore should be valued lower. The RUC compared 19285 to key reference service 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 2.50) and noted that the respondents indicated higher intensity and complexity for the surveyed service, however, both services require 15 minutes of intra-service time. The RUC agreed that this reflects the unique nature of breast interventions. The breast marker placement services are associated with very high patient and family anxiety, which tend to increase the psychological stress of the physician. Although the reference code has the same intra-service time, the physician work is higher, rendering it a more intense service. For additional support, the RUC reviewed MPC code 64483 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU = 1.90) and determined that the 25th percentile work RVU of 1.70 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 1.70 for CPT code 19285.**

19286 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)
The RUC reviewed the survey results from 48 physicians for CPT code 19286 and determined that the physician work may have been overestimated in relation to the survey responses related to the base code 19285. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned; re-draped and additional anesthesia must be administered for each subsequent lesion. The specialty society indicated and the RUC agreed that the physician work required for each additional lesion is half of that of the primary code. Therefore, the RUC determined a work value of 0.85 appropriately values this procedure. For further support the RUC referenced similar service 93565 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)* (work RVU = 0.86), which requires similar physician work and time. **The RUC recommends a work RVU of 0.85 for CPT code 19286.**

19287 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance

The RUC reviewed the survey results from 64 physicians for CPT code 19287 and determined that the median work RVU of 3.02 appropriately accounts for the work required to perform this service and maintains appropriate relativity within this code family. The RUC determined that for this magnetic resonance guidance service, the patient is typically in the prone position; therefore 2 additional minutes for positioning time is warranted. The RUC agreed that the pre-service package 1A *Facility straightforward patient/procedure (no sedation/anesthesia)* with the positioning adjustment for 13 minutes evaluation, 3 minute positioning and 6 minutes scrub, dress and wait pre-service time is appropriate. The RUC recommends 22 minutes of pre-service, 37 minutes of intra-service and 15 minutes of immediate post-service time for this service. The RUC noted that 19287 is for the primary lesion with multiple clips, typically 3 clips. The RUC compared 19287 to key reference service 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 2.50 and 15 minutes intra-service time) and determined that the physician work is more intense and complex and requires an additional 22 minutes of intra-service time to complete than the key reference service. For additional support, the RUC reviewed MPC code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU = 2.78 and 30 minutes intra-service time) and determined that the median work RVU of 3.02 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 3.02 for CPT code 19287.**

19288 Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 40 physicians for CPT code 19288 and determined that the physician work may have been overestimated in relation to the survey responses related to the base code 19287. The RUC discussed the pre-service time associated with this add-on code and determined that 1 minute positioning and 4 minutes scrub, dress and wait of pre-service time are appropriate. The patient must come off of the table to be re-positioned; re-draped and additional anesthesia must be administered for each subsequent lesion. The specialty society indicated and the RUC agreed that the physician work required for each additional lesion is half of that of the primary code. Therefore, the RUC determined a work value of 1.51 appropriately values this procedure. For further support the RUC referenced similar service 31637 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; each additional major bronchus stented (List separately in addition to code for primary procedure)* (work RVU = 1.58), which requires similar physician work and time. **The RUC recommends a work RVU of 1.51 for CPT code 19288.**

Practice Expense

The RUC requested that the specialties clarify the contents of the stereotactic imaging system included as an equipment input in the practice expense. According to the CMS direct PE inputs the *breast biopsy imaging system, stereotactic (imager, table, software)* (EQ075) includes a table used for stereotactic services. The RUC noted a separate input, *table, power* (EF031) is also included in the equipment items and should be removed if a

separate table is not necessary to perform the service. Following the meeting, the specialty confirmed that a separate table is not needed and subsequently the *table, power* (EF031) has been removed from the stereotactic services codes. The RUC noted that a *table, exam* EF023) is included in the equipment inputs for the mammography codes because a table is not included in the *room, mammography* (EL013). The RUC recommends the direct practice expense inputs as modified 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.

Transcatheter Aortic Valve Replacement (Tab 5)
Jim Levett, MD (STS); Stephen Lahey, MD (STS); Jeff Jacobs, MD (ASCP); Richard Wright, MD (ACC); Clifford Kavinsky, MD (SCAI)

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.

In April 2012, the RUC thoroughly discussed the unique nature of these services to understand and assign the appropriate valuation. First, the members noted that 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 procedures 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 when implementing the new code family.

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.

In April 2012, the RUC reviewed and recommended a work RVU of 40.00 for CPT code 33366 *Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical approach (eg, left thoracotomy).* However, this service did not receive FDA approval prior to publication of CPT and it was carrier priced and published in CPT 2013 as Category III CPT code 0318T *Implantation of catheter-delivered prosthetic aortic heart valve, open thoracic approach, (eg, transapical, other transaortic).* FDA approval was received in November 2012, as a result, the Society of Thoracic Surgeons (STS), the American College of Cardiology (ACC) and the Society for Cardiac Angiography and Interventions (SCAI) submitted a coding proposal to CPT to convert Category III code

0318T to a Category I code, 33366 for CPT 2014. CPT code 33366 has the same descriptor, vignette and work descriptions that were surveyed and reviewed by the RUC at the April 2012 meeting. **In April 2013, the RUC reaffirmed its April 2012 recommendation of 40.00 work RVUs for CPT code 33366.**

April 2012 RUC Recommendation:

33366 ***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. 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, 0318T 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, 0318T is a much more intense procedure. In addition, 33366, 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 33366 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.**

Practice Expense
The RUC reviewed and approved the practice expense at the April 2012 RUC meeting.

<u>Fenestrated Endovascular Repair (Tab 6)</u>
Gary Seabrook, MD (SVS); Robert Zwolak, MD (SVS); Matthew Sideman, MD (SVS); Micheal Sutherland, MD (SVS)

In February 2013, the CPT Editorial Panel converted four Category III codes and created eight Category I codes to report fenestrated endovascular repair of the visceral aorta bundled with radiological supervision and interpretation, as well as revised the introductory language for these services.

The Society for Vascular Surgery (SVS) indicated that the RUC survey data revealed extensive pre-service time (120-195 minutes) for these procedures. SVS confirmed that these procedures do require extensive pre-service work that is not otherwise reportable and some of the most intensive work occurs days to weeks before the defined 090-day global period. SVS indicated that each of the currently FDA-approved main aortic endograft bodies are custom made by the vendor because every patient has a different arrangement and relative orientation of the renal and visceral artery origins. Each fenestrated endograft is anatomically specific for each patient. Additionally, the physician must spend a minimum of two hours reviewing CT angiograms and 3D reconstructions, constructing procedure planning models and completing sizing sheets. Ultimately, the appropriate fenestrated device is ordered. The physician work is conducted over the course of several days or weeks prior to the date of surgery and is outside the guidelines for the 090-day global period.

The RUC agreed with the specialty societies concerns and recommends that these services be carrier priced for CPT 2014 and that the specialty societies submit a coding proposal to describe the physician work provided prior to the 090-global period associated with these services.

Retrograde Treatment Open Carotid Stent (Tab 7)
Gary Seabrook, MD (SVS); Robert Zwolak, MD (SVS); Matthew Sideman, MD (SVS); Micheal Sutherland, MD (SVS); Alex Mason, MD (CNS); and John Ratliff, MD (AANS)

In February 2013, the CPT Editorial Panel established a new code, 37217 *Transcatheter placement of an intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, via open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation* to allow for reporting of open stent insertion. This procedure is currently reported using an unlisted code.

The RUC reviewed survey results from 32 vascular surgeons and neurosurgeons and agreed that a work RVU of 22.00, the survey median, appropriately accounts for the physician work. There was consensus among the RUC that the following physician time components are appropriate: pre-time of 74 minutes, intra service time of 120 minutes and post service time of 30 minutes. The RUC also agreed that an additional 11 minutes is appropriate to position the patient on the table in a beach chair position with the neck fully extended and rotated away from the operative side. In addition, the RUC agreed that time must be added to account for the placement of fluoroscopy compatible arm boards and safety restraints. To justify the work RVU, the RUC reviewed key reference code 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection* (work RVU=19.68, intra service time=103 minutes) and agreed that 37217 is a more intense procedure requiring additional physician work. Specifically, CPT code 37217 includes surgical exploration of the neck, dissection of the carotid sheath, dissection of the common artery and closure of the wound, in addition to the work of stent placement and angiography. Therefore, 37217 should be valued higher. The RUC also reviewed CPT code 35606 *Bypass graft, with other than vein; carotid-subclavian* (work RVU=22.46, intra service time=145 minutes) and concluded that these two services should be valued similarly since they require analogous physician work and intensity. However, since 35606 requires slightly more

time, it is appropriately valued higher. Further, the RUC compared 37217 to CPT code 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, intra service time=120 minutes) and noted that although these two require the same physician time, 37217 describes a slightly more intense procedure. **The RUC recommends a work RVU of 22.00 for CPT code 37217.**

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

Embolization and Occlusion Procedures (Tab 8)
Sean Tutton, MD (SIR); Robert Vogelzang, MD (SIR); Jerry Niedzwiecki, MD (SIR); Michael Hall, MD (SIR); Gary Seabrook, MD (SVS), Robert Zwolak, MD (SVS); Matthew Sideman, MD (SVS); Michael Sutherland, MD (SVS); Zeke Silva, MD (ACR) and Kurt Schoppe, MD (ACR)
Facilitation Committee #2

CPT code 37204 *Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck* was identified through the Codes Reported Together 75% or More screen. In April 2010, the RUC accepted the specialties' recommendation to submit a code change proposal that would address any duplication when these services are reported together on the same date by the same physician. In February 2013, the CPT Editorial Panel deleted 37204 *Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non head or neck* and 37210 *Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure* and established four bundled codes to report embolization and occlusion procedures.

37241 ***Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)*** The RUC reviewed the survey results from 75 vascular surgeons and radiologists and agreed that a work RVU of 9.00, the survey 25th percentile is appropriate, setting a proper base for this family of services. There was consensus among the RUC that the following physician time components are appropriate: pre-time of 27 minutes, intra service time of 90 minutes and post service time of 30 minutes. Furthermore, the RUC agreed that an additional 2 minutes of pre-time is appropriate to account for positioning of the patient on the angiographic table, as well as optimizing EKG monitoring lead placement to avoid obscuring imaging during embolization. The RUC compared 37241 to key reference code 37182 *Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)***(**work RVU=16.97) and agreed that the time and intensity of 37182 is greater. The RUC also reviewed CPT code 37211 *Transcatheter*

therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day (work RVU=8.00) and determined that since 37241 requires more physician work and intensity it should be valued higher. **The RUC recommends a work RVU of 9.00 for CPT code 37241.**

37242 ***Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)***

The RUC reviewed the survey results from 59 vascular surgeons and radiologists for CPT code 37242 and agreed that a direct crosswalk to CPT code 34833 *Open iliac artery exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral* (work RVU= 11.98 and 100 minutes intra-service time) is appropriate. Both services have identical intra times and should have identical values. There was consensus among the RUC that the following physician time components are appropriate: pre-time of 41 minutes, intra service time of 100 minutes and post service time of 30 minutes. Furthermore, the RUC agreed that an additional 2 minutes of pre-time is appropriate to account for positioning of the patient on the angiographic table, as well as optimizing EKG monitoring lead placement to avoid obscuring imaging during embolization. To validate this value, the Committee reviewed CPT codes 61640 *Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel* (work RVU= 12.32, and 90 minutes intra-service time/) and 37228 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 11.00, and 90 minutes intra-service time) and noted that while catheterization is included in both these reference codes, the resulting values provide an adequate level of relativity across similar services. **The RUC recommends a work RVU of 11.98 for CPT code 37242.**

37243 ***Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction***

The RUC reviewed survey results from 62 vascular surgeons and radiologists and compared the intra-service times from 37243, 120 minutes, to 37244, 90 minutes. The RUC noted that 37244 is a more intense procedure. CPT code 37244 typically describes a hemorrhaging patient after trauma, in which the patient must be treated expeditiously to prevent exsanguination. Therefore, the intra-service time is less, but the service is much more intense. Therefore, a work RVU of 14.00 is appropriate for CPT code 37243, given the intensity difference. There was consensus among the RUC that the following physician time components are appropriate: pre-time of 41 minutes, intra service time of 120 minutes and post service time of 45 minutes. Furthermore, the RUC agreed that an additional 2 minutes of pre-time is appropriate to account for positioning of the patient on the angiographic table, as well as optimizing EKG monitoring lead placement to avoid obscuring imaging during embolization. To validate a work RVU of 14.00, the RUC reviewed CPT code 11005 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure* (work RVU= 14.24 and intra-service time of 120 minutes) and agreed that the recommendation is relative to other services. **The RUC recommends a work RVU of 14.00 for CPT code 37243.**

37244 ***Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation***

The Committee reviewed the survey data for CPT code 37244 and agreed that the survey 25th percentile work RVU of 14.00 accurately values this service. While the intra-service time of 90 minutes, is lower than some of the other codes in this family, this is the most intense procedure in the family. CPT code 37244 typically describes a hemorrhaging patient after trauma, in which the patient must be treated expeditiously to prevent exsanguination. Therefore, the intra-service time is less, but the service is much more intense. There was consensus among the RUC that the following physician time components are appropriate: pre-time of 41 minutes, intra service time of 90 minutes and post service time of 45 minutes. Furthermore, the RUC agreed that an additional 2 minutes of pre-time is appropriate to account for positioning of the patient on the angiographic table, as well as optimizing EKG monitoring lead placement to avoid obscuring imaging during embolization. To validate this value, the Committee reviewed CPT code 37229 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed* (work RVU= 14.05 and 120 minutes intra-service time) and agreed that while the reference code has more intra time, the service includes catheterization and is therefore a less intense service compared to the surveyed code. **The RUC recommends a work RVU of 14.00 for CPT code 37244.**

Practice Expense:

The RUC accepted the direct PE inputs with minor modifications as recommended by the PE 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.

Transcatheter Placement of Intravascular Stent (Tab 9)

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In February 2010, the CPT Editorial Panel revised CPT codes 37208-37028 as part of the larger Endovascular Revascularization issue. Initially, the RUC requested review of these codes in tandem with the new lower extremity revascularization codes, but subsequently deferred review because it would be difficult to describe the typical patient given the removal of the lower extremity revascularization services. In April 2010, CPT code 37205 *Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel* was identified through the High Volume and Codes Reported Together 75% or More screens and the specialties were encouraged to create new bundled codes. In February 2013, the CPT Editorial Panel deleted four intravascular stent placement codes: 37205 *Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel*, 37206 *Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel*, 37207 *Transcatheter placement of an*

intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel and 37208 *Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel (List separately in addition to code for primary procedure)*and one radiological supervision and interpretation code, 75960 *Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel* and established four new bundled codes to describe transcatheter placement of intravascular stent.

37236 ***Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery***
The RUC reviewed the survey results from 77 vascular surgeons, radiologists and cardiologists and determined that a work RVU of 9.00, the survey median, appropriately accounts for the physician work of this procedure. The RUC noted that 37236 will be reported with a catheter placement code, 36200 *Introduction of catheter, aorta* (work RVU=3.02), 36215 *Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family* (work RVU=4.67), 36216 *Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family* (work RVU=5.27), 36217 *Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family* (work RVU=6.29), 36245 *Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU=4.67), 36246 *Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU=5.27) or 36247 *Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU=6.29), and the catheter code will be subject to the multiple procedure payment reduction. The retention of the catheter codes was necessary to account for variation in anatomical sites. To ensure the recommended value is relative to similar stenting procedures, the RUC reviewed several newly bundled services in the lower extremity revascularization family of services. Prior to comparing, the RUC noted that these codes have catheterization bundled in and appropriately applied the multiple procedure reduction in order to provide a useful comparison to 37236. The RUC reviewed the following CPT codes: 37221 *Iliac stent* (work RVU= 10.00) and removed the work of catheterization code 36245 (work RVU= 4.67/2 = 2.33) for a comparison value of 7.67; 37226 *Femoral stent* (work RVU= 10.49) and removed the work of catheterization code 36247 (work RVU= 6.29/2 = 3.15) for a comparison value of 7.34 and 37230 *Tibial stent* (work RVU= 13.80) and removed the work of catheterization code 36247 (work RVU= 6.29/2 = 3.15) for a comparison value of 10.65. The surveyed code describes intravascular stenting of any vessel other than lower extremity, coronary or carotid. The remaining vessels represent a wide variety of sizes, anatomies and locations; all of which are now described in 37236. Given this, the RUC agreed that the recommended value of 9.00 for 37236 is appropriately aligned between these three comparison codes.

For further comparison, the RUC compared 37236 to key reference code 37184 *Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological*

thrombolytic injection(s); initial vessel (work RVU=8.66) and noted that although these two codes have exact intra service time (90 minutes), and similar total time, (161 versus 160 minutes), the survey respondents indicated that 37236 is more intense and complex compared to the key reference code, 37184. The RUC agreed that the survey 25th percentile work RVU of 8.00 would create a rank order anomaly. The RUC also reviewed CPT code 52355 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor* (work RVU=9.00) and agreed that the physician work and complexity of these two procedures is similar. **The RUC recommends a work RVU of 9.00 for CPT code 37236.**

37237 ***Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 61 vascular surgeons, radiologists and cardiologists and determined that a work RVU of 4.25, the survey 25th percentile is appropriate. The RUC also agreed with the specialty society that 1 minute of pre and 1 minute of post time is appropriate for this add-on code to account for the additional evaluation time above the base code to assess placement of an additional stent in a separate vessel. This additional time is consistent with other ZZZ global codes in the vascular family (e.g. 37222, 37223 and 37232). To ensure relativity, the RUC reviewed two add-on codes: 35685 *Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit* (work RVU= 4.04) and 60512 *Parathyroid autotransplantation (List separately in addition to code for primary procedure)* (work RVU= 4.44) and noted that both have identical intra times as 37237, 45 minutes, and provide appropriate brackets to validate the recommended work RVU. **The RUC recommends a work RVU of 4.25 for CPT code 37237.**

37238 ***Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein***
The RUC reviewed survey results from 75 vascular surgeons, radiologists and cardiologists and determined that a direct crosswalk to CPT code 36247 *Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU= 6.29, and intra-service time of 60 minutes), is appropriate. A work value of 6.29 for 37238 is slightly higher than the survey 25th percentile. The RUC reviewed CPT code 35460 *Transluminal balloon angioplasty, open; venous* (work RVU= 6.03) and agreed that a work RVU lower than 6.29 would create a rank order anomaly since 37238 includes the physician work of an angioplasty and placement of a stent. To further support this value, the RUC reviewed CPT code 37197 *Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed* (work RVU=6.29, intra-service time=60 minutes) and agreed that both codes have the same intra-service time and similar complexity and should be valued the same. **The RUC recommends a work RVU of 6.29 for CPT code 37238.**

37239 ***Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within***

the same vessel, when performed; each additional vein (List separately in addition to code for primary procedure)

The RUC reviewed the survey results of 61 vascular surgeons, radiologists and cardiologists and determined that a direct crosswalk to CPT code 35686 *Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis) (List separately in addition to code for primary procedure)* (work RVU= 3.34 and intra-service time of 35 minutes) accurately accounts for the work involved in this service. The RUC also agreed with the specialty societies that 1 minute of pre-service and 1 minute of post-service time is appropriate to account for the additional evaluation time above the base code to assess placement of an additional stent in a separate vessel. The RUC also compared the work RVU of 3.34 to 37237 and agreed that since 37239 has 15 minutes less intra time, it is appropriately valued lower than 37237. To support this value, the RUC reviewed key reference code 37185 *Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure)* **(**work RVU=3.28, intra-service time=40 minutes) and determined that the physician work and intensity of 37239 is higher, justifying the higher work value. **The RUC recommends 3.34 work RVUs for CPT code 37239.**

Practice Expense:
The RUC accepted the direct PE inputs with minor modifications as recommended by the PE 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.

Esophasgoscopy (Tab 10)
Joel V. Brill, MD (AGA), Nicholas Nickl, MD (ASGE), Edward S. Bentley, MD (ASGE), Wayne M. Koch, MD (AAO-HNS), John Lanza, MD (AAO-HNS), Michael Edye, MD (SAGES), Don J. Selzer, MD (SAGES)

In September 2011, several esophagoscopy codes were identified through the CMS Multi-Specialty Points of Comparison (MPC) List screen as potentially misvalued. The specialties agreed to survey the entire family of codes (43200-43232). In developing vignettes, it was determined that the codes required revision at CPT to differentiate the approach (ie, rigid transoral, flexible transoral, flexible transnasal). In May 2012, the CPT Editorial Panel approved six new codes to report rigid transoral esophagoscopy (43191-6), two new codes to report flexible transnasal esophagoscopy (43197-8), revision to codes 43200-43232 to describe flexible transoral esophagoscopy and one new code for flexible transoral esophagoscopy (43206). In review of the family of esophagoscopy codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were needed so that the set of codes reflected current practice. In October 2012, the CPT Editorial Panel approved further revised guidelines along with an additional five codes within the esophagoscopy family of services. These five codes were reviewed at the January 2013 RUC meeting. Finally, in January 2013, the RUC agreed with the specialty societies that the survey data for 43231 and 43232 were anomalous and should be resurveyed and presented at the April 2013 RUC meeting.

After survey of the procedures for April, the specialty societies noted that the esophagoscopy with EUS procedures (43231 and 43232) are not inherently performed with moderate sedation by the same physician. However, due to CMS' consistent position, at the April meeting and in multiple Medicare Physician Payment Rules, that the Agency is looking for larger bundling of services, not unbundling of services, the moderate sedation for these services will remain bundled. Therefore, these two services will remain on Appendix G in the CPT codebook.

Rigid Esophagoscopy Services

The Otolaryngologists presented compelling evidence for the six rigid transoral esophagoscopy codes. There were two compelling evidence arguments given: a change in physician work due to technique and incorrect assumptions made at the time of the previous review. First, since these new procedures now refer only to rigid esophagoscopy procedures, the typical patient and typical provider of these services have changed from the previous codes that were either rigid or flexible. A service using a rigid scope is only performed by a surgeon in the facility setting, under general anesthesia, since the typical patient is either a cancer patient or has a foreign body or other stricture that requires more intense work compared to a patient receiving a flexible esophagoscopy. Second, incorrect assumptions were made in the initial valuation of these services because Otolaryngologists were not surveyed. For three of the previously reported codes (43200, 43202 and 43215) only Harvard values exist, which excluded Otolaryngologists in the review process. For two of the previously reported codes (43220 and 43226) a RUC survey was completed, but the vignette only specified flexible esophagoscopy. For the final previously reported service (43201), a RUC survey was completed only by Gastroenterologists. Therefore, these new services as described, have never been properly valued to account for the typical provider and equipment. The RUC agreed with the compelling evidence that there is potential misvaluation for these services.

43191 ***Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed***

The RUC reviewed the survey results from 59 Otolaryngologists and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 51 minutes, intra-service time of 20 minutes and immediate post-service time of 15 minutes. Package 4 Difficult patient/Difficult procedure was deemed appropriate for this code because the typical patient has cancer and is receiving this service under general anesthesia in the facility setting. Furthermore, 3 additional minutes for positioning is required to properly position the patient in the supine position, place a shoulder roll, ensure security and, working with the anesthetist, position the endotracheal tube.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the survey's 25th percentile, 2.78 work RVUs, is an accurate value for the physician work involved in this service. The RUC reviewed the key reference service CPT code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed* (work RVU= 2.78) and noted that while the reference code has 10 more minutes of intra-service time compared to 43191, the surveyed code has greater total time, 86 minutes compared to 65 minutes. Therefore, the RUC agreed that the recommended work RVU of 2.78 is appropriate for code 43191. To further justify this value, the RUC reviewed MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU= 2.70) and noted that both

the reference code and surveyed code have identical intra-service times and comparable physician work. Given these reference codes and compelling evidence that the previous work RVU for this service was misvalued, the RUC agreed that a work RVU of 2.78 accurately values 43191 relative to both the family of services and other similar services across the RBRVS. **The RUC recommends a work RVU of 2.78 for CPT code 43191.**

43192 ***Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance***

The RUC reviewed the survey results from 31 Otolaryngologists and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 56 minutes, intra-service time of 23 minutes and immediate post-service time of 20 minutes. Package 4 Difficult patient/Difficult procedure was deemed appropriate for this code because the typical patient has cancer and is receiving this service under general anesthesia in the facility setting. The RUC agreed that 3 additional minutes for positioning is required to properly position the patient in the supine position, place a shoulder roll, ensure security and, working with the anesthetist, position the endotracheal tube. The RUC agreed that 5 additional minutes of evaluation time to prepare the injection is required for CPT code 43192 compared to code 43191.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the survey's 25th percentile, 3.21 work RVUs, is an accurate value for the physician work involved in this service. The RUC reviewed the key reference service CPT code 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that the reference code has 7 more minutes of intra-service time compared to 43192, and is slightly more intense, thus substantiating a slightly higher work value. To further justify a work RVU of 3.21, the RUC reviewed CPT code 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open* (work RVU= 3.29) and noted that while the surveyed code has 3 additional minutes of intra-service time compared to the reference code, 32551 is a more intense procedure and should be valued slightly higher than 43192. Finally, the RUC compared 43192 to the diagnostic code 43191 and agreed that the increase of 3 minutes, 23 minutes compared to 20 minutes, in intra-service time for 43192 is accurate because of the additional time necessary to inject the wall of the esophagus. Furthermore, the addition of 5 minutes in the post-service period for 43192 is appropriate because these patients often have increased bleeding due to the injection and require more post-operative management compared to the diagnostic procedure. Given these reference codes and time differences, the RUC concurred that a work RVU of 3.21 accurately values 43192 relative to both the family of services and other similar services across the RBRVS. **The RUC recommends a work RVU of 3.21 for CPT code 43192.**

43193 ***Esophagoscopy, rigid, transoral; with biopsy, single or multiple***

The RUC reviewed the survey results from 35 Otolaryngologists and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 56 minutes, intra-service time of 30 minutes and immediate post-service time of 20 minutes. Package 4 Difficult patient/Difficult procedure was deemed appropriate for this code because the typical patient has cancer and is receiving this service under general anesthesia in the facility setting. The RUC agreed that 3 additional minutes for positioning is required to properly position the patient in the supine position, place a

shoulder roll, ensure security and, working with the anesthetist, position the endotracheal tube. The RUC agreed that 5 minutes of additional evaluation time to prepare the biopsy equipment is required for CPT code 43193 compared to code 43191.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the survey's 25th percentile, 3.36 work RVUs, is an accurate value for the physician work involved in this service. The RUC reviewed the key reference service CPT code 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that both the reference code and the surveyed code have identical intra-service times and should be valued identically. To further justify a work RVU of 3.36, the RUC reviewed CPT code 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU= 3.30) and agreed that with identical intra-service times the two services should be valued similarly. Finally, the RUC compared 43193 to the injection code 43192 and agreed that 7 additional minutes, 30 minutes compared to 23 minutes, of in intra-service time is accurate as several biopsies are taken to ensure an adequate sample and bleeding must be monitored. The specialty noted that this additional time is intense procedure time and not just waiting for an initial pathology report. Given these reference codes and time differences, the RUC concurred that a work RVU of 3.36 accurately values 43193 relative to both the family of services and other similar services across the RBRVS. **The RUC recommends a work RVU of 3.36 for CPT code 43193.**

43194 ***Esophagoscopy, rigid, transoral; with removal of foreign body***
The RUC reviewed the survey results from 34 Otolaryngologists and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 49 minutes, intra-service time of 30 minutes and immediate post-service time of 28 minutes. Package 3 Straightforward patient/Difficult procedure was deemed appropriate for this service because while the typical patient no longer has cancer, the procedure is very intense resulting from the emergent need to remove a large, sharp object from the patients' esophagus. The RUC agreed that 3 additional minutes for positioning is required to properly position the patient in the supine position, place a shoulder roll, ensure security and, working with the anesthetist, position the endotracheal tube.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the survey's 25th percentile, 3.99 work RVUs, is an accurate value for the physician work involved in this service. The RUC reviewed the key reference service CPT code 31638 *Bronchoscopy, rigid or flexible, with or without fluroscopic guidance; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required)* (work RVU= 4.88) and noted that while the reference code has more intra-service time than the surveyed code, 60 minutes compared to 30 minutes, the survey respondents indicated that code 43194 is more intense and complex procedure than code 31638. Therefore, the recommended work RVU of 3.99 for code 43194 is accurately valued in comparison to the reference code. To further justify this value, the RUC reviewed CPT code 20660 *Application of cranial tongs, caliper, or stereotactic frame, including removal* (work RVU= 4.00) and agreed that with identical intra-service time as the surveyed code, 30 minutes, the two codes should be valued similarly. Finally, the RUC compared 43194 to the other codes in the rigid esophagoscopy family and agreed that this emergent procedure requiring the removal of a

foreign body is the most intense and complex procedure in the family because there is relatively little ramp up or ramp down in the intensity of physician work for this service. Given these reference codes, the RUC concurred that a work RVU of 3.99 accurately values 43194 relative to both the family of services and other similar services across the RBRVS. **The RUC recommends a work RVU of 3.99 for CPT code 43194.**

43195 ***Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter)***
The RUC reviewed the survey results and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 49 minutes, intra-service time of 30 minutes and immediate post-service time of 15 minutes. Package 3 Straightforward patient/Difficult procedure was deemed appropriate for this service because while the typical patient no longer has cancer, the procedure is still intense and performed in the facility setting under general anesthesia. The RUC agreed that 3 additional minutes for positioning is required to properly position the patient in the supine position, place a shoulder roll, ensure security and, working with the anesthetist, position the endotracheal tube.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the respondents overestimated the work value of this service relative to similar services in the family of rigid esophagoscopy codes. To determine an appropriate value, the RUC compared code 43195 to 43192 (RUC recommended work RVU= 3.21) and noted that while 43195 has greater intra-service time compared to 43192, 30 minutes and 23 minutes, respectively, code 43195 has less total time in comparison. Therefore, the RUC agreed that these two services represent similar physician work and should both be valued at 3.21 work RVUs. To validate this work RVU, the RUC reviewed the key reference service CPT code 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that both services have identical intra-service time, 30 minutes, and should be valued similarly. The RUC also reviewed CPT code 31296 *Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)* (work RVU= 3.29) and agreed that with identical intra-service and analogous total times, both codes should be valued similarly. **The RUC recommends a work RVU of 3.21 for CPT code 43195.**

43196 ***Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire***
The RUC reviewed the survey results and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 49 minutes, intra-service time of 33 minutes and immediate post-service time of 20 minutes. Package 3 Straightforward patient/Difficult procedure was deemed appropriate for this service because while the typical patient no longer has cancer, the procedure is still intense and performed in the facility setting under general anesthesia. The RUC agreed that 3 additional minutes for positioning is required to properly position the patient in the supine position, place a shoulder roll, ensure security and, working with the anesthetist, position the endotracheal tube.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the respondents overestimated the work value of this service relative to similar services in the family of rigid esophagoscopy codes. To determine an appropriate

value, the RUC compared code 43196 to 43193 (RUC recommended work RVU= 3.36) and noted that while 43196 has slightly more intra-service time compared to 43192, 33 minutes and 30 minutes, respectively, code 43196 has less total time in comparison. Therefore, the RUC agreed that these two services represent similar physician work and should both be valued at 3.36 work RVUs. To validate this work RVU, the RUC compared 43196 to CPT code 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that both 31625 and the surveyed code have similar intra-service times, 30 and 33 minutes, respectively, and should be valued identically. To further justify a work RVU of 3.36, the RUC reviewed CPT code 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU= 3.30) and agreed that with similar intra-service times, 30 and 33 minutes respectively, the two services should be valued similarly. **The RUC recommends a work RVU of 3.36 for CPT code 43196.**

Flexible Esophagoscopy Services- Transnasal

43197 ***Esophagoscopy, flexible, transnasal; diagnostic, includes collection of specimen(s) by brushing or washing, when performed***
The RUC reviewed the survey results from 74 otolaryngologists and gastroenterologists and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 25 minutes, intra-service time of 15 minutes and immediate post-service time of 10 minutes. The RUC determined Package 6 Non-facility procedure with anesthesia was appropriate for this service with 2 additional minutes of scrub, dress, wait time to spray the topical anesthetic on the nostrils and then place and remove pledgets.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the respondents overestimated the work value of this service relative to the previous value for reporting this procedure, code 43200 (work RVU= 1.59). Therefore the RUC agreed with the specialty that the current work RVU of 1.59 is an appropriate value for code 43197. To justify this value, the RUC reviewed the key reference service CPT code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed* (work RVU= 2.78) and noted that the reference code has double the intra-service time compared to the surveyed code, 30 minutes and 15 minutes, respectively. Therefore, the RUC agreed that the reference code should be valued higher and a work value of 1.59 for code 43197 maintains proper relativity with this similar service. The RUC also compared CPT code 62284 *Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa)* (work RVU= 1.54) to the surveyed code and agreed that with identical intra-service time and analogous total times, these two codes should be valued similarly. **The RUC recommends and work RVU of 1.59 for CPT code 43197.**

43198 ***Esophagoscopy, flexible, transnasal; with biopsy, single or multiple***
The RUC reviewed the survey results from 75 otolaryngologists and gastroenterologists and agreed with the specialty society that the survey respondents, at the median level, accurately accounted for the time it takes to perform this service. The RUC recommends pre-service time of 25 minutes, intra-service time of 20 minutes and immediate post-service time of 10 minutes. The RUC determined Package 6 Non-facility procedure with

anesthesia was appropriate for this service with 2 additional minutes of scrub, dress, wait time to spray the topical anesthetic on the nostrils and then place and remove pledgets.

The RUC reviewed the survey respondents' estimated work RVU and agreed with the specialty that the respondents overestimated the work value of this service relative to the previous value for reporting this procedure, code 43202 (work RVU= 1.89). Therefore, the RUC agreed with the specialty that the current work RVU of 1.89 is an appropriate value for code 43198. To justify this value, the RUC reviewed the key reference service CPT code 31625 *Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that reference code has 10 more minutes of intra-service time compared to the surveyed code. Therefore, the RUC agreed that the reference code should be valued higher and a work value of 1.89 for code 43198 maintains proper relativity with this similar service. The RUC also compared CPT code 57455 *Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix* (work RVU= 1.99) to the surveyed code and agreed that with identical intra-service time the two codes should be valued similarly. Finally, the RUC compared code 43198 to code 43197 and noted that the additional work increment associated with 5 more intra-service minutes to perform the biopsy places 43198 in proper relativity to the family of services. **The RUC recommends a work RVU of 1.89 for CPT code 43198.**

Flexible Esophagoscopy Services- Transoral

The specialties societies presented compelling evidence for the remaining flexible esophagoscopy family of services. There were two compelling evidence arguments given: a change in physician work since the last valuation and incorrect assumptions made during the last valuation. Physician work for these procedures used to be performed using fiberoptic instruments and it is now standard to use high-definition video endoscopes and high definition video monitors. Furthermore, during the previous valuation of these codes, there were no regulations and/or requirements for a complete history and physical of the patient within 30 days of the procedure now there are numerous documentation requirements (e.g. pre-sedation assessment and documentation of a comprehensive examination updated on the day of procedure) to meet various local, state, payor and Medicare accreditation, quality standards, and/or patient safety requirements. Incorrect assumptions were also made during previous reviews of the codes. Since the adoption of pre-service time packages by the RUC in 2008 the physician work of moderate sedation is now captured in the pre-service work rather than the intra-service work. Additionally, the Harvard review and subsequent CMS review only included gastroenterologists, although otolaryngologists and general surgeons also perform these services. The RUC agreed with the compelling evidence that there is potential misvaluation for these services of codes.

Prior to reviewing the transoral flexible esophagoscopy family of services the specialty societies explained the survey methodology used to obtain physician time and RVU recommendations. In May 2012, the AGA, ASGE and SAGES requested that the Research Subcommittee consider a mini-survey methodology for this and the other codes in the 43200-43232 family, which was approved. The Research Subcommittee required a standard survey be conducted of the new base code for flexible transoral esophagoscopy, 43200, specifically including the elements of pre- and post-service physician work. For the remaining codes that were surveyed in the 43201-43232 family, the mini-survey instrument only asked the physician to address the intra-service work component for the procedure.

Accordingly, the RUC agreed with the same pre- and post- service times for all of the codes in 43201-43232 as for the revised base code for flexible trans-oral esophagoscopy, 43200.

The RUC observed that the specialty societies recommended two different pre-service time packages one for a straightforward patient and one for a more complex patient. However, neither of the specialties' recommendations are greater than the median survey times for each code. Therefore, while the pre-service packages change within the family, it is uniform and stays within the median response from the survey respondents. In addition, the specialty recommended that the median post-service time of 10 minutes inadequately accounts for the typical post-operative physician work. The RUC, however, noted that considering the high number of respondents, 121, the survey's median post-service time of 10 minutes should be standard throughout the series of codes.

43200 ***Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed***
The RUC reviewed the survey results of 121 gastroenterologists, otolaryngologists, and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 15 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B *Facility straightforward patient under sedation* was appropriate with two additional minutes of pre-service time over the package is necessary to properly position the patient.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that a work RVU of 1.59, the current value and less than the survey 25th percentile, is appropriate for 43200. To justify this value, the RUC reviewed MPC code 57452 *Colposcopy of the cervix including upper/adjacent vagina* (work RVU=1.50) and determined that while both the reference code and surveyed code have identical intra-service time, 43200 requires work because moderate sedation is inherent and should be valued higher than 57452. The RUC also reviewed 91035 *Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation* (work RVU=1.59) and agreed that since both codes have similar intra-service and total times these services should be valued identically. **The RUC recommends a work RVU of 1.59 for CPT code 43200.**

43201 ***Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance***
The RUC reviewed the survey results of 121 gastroenterologists gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 15 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B *Facility straightforward patient under sedation* was appropriate with two additional minutes to properly position the patient.

The RUC first discussed the difference in the current survey median intra-service time, 15 minutes, compared to the previous intra-service time of 25 minutes. The specialties explained that this time change is due to the creation of pre-service time packages that has shifted the reporting of moderate sedation work from the intra-service to the pre-service. However, the RUC noted, and the specialties agreed, that the typical patient has changed from a patient with a stricture to a patient with achalasia and that the current value may not be appropriate. The RUC and the specialties also agreed that the current work RVU of 2.09 was too high and would create a rank order anomaly in this family of

esophagoscopy codes. The RUC determined that although the times were the same as 43200, the intensity and complexity of work for 43201 would be greater and therefore the work RVU should be higher. To determine an accurate work value, the RUC reviewed MPC code 64483 *Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU=1.90) and code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU=1.90) and agreed that both reference codes and the surveyed code have identical intra-service time of 15 minutes, with similar total times. Therefore, the RUC determined, and the specialty agreed, that a work RVU of 1.90, a direct crosswalk to CPT code 64483 and 54150, correctly ranks 43201 within the family of services. **The RUC recommends a work RVU of 1.90 for CPT code 43201.**

43202 *Esophagoscopy, flexible, transoral; with biopsy, single or multiple*
The RUC reviewed the survey results of 120 gastroenterologists, otolaryngologists, and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 15 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B *Facility straightforward patient under sedation* was appropriate with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that the survey median work RVU and 25th percentile work RVU both overstated the work included in this service. The specialties argued and the RUC agreed that the work and time to perform this service has not changed and that 15 minutes of intra-time is appropriate. The RUC discussed the difference in the survey intra-service time compared to the current Harvard time and noted that it is due to the shift in reporting moderate sedation work in pre-service time rather than the intra-service time. Therefore, the current work RVU of 1.89 should be maintained for code 43202. To justify this value, the RUC reviewed MPC code 64483 *Injection, anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU=1.90) and code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU=1.90) and determined that since these codes have identical intra-service times, 15 minutes, and similar total time their work RVUs should be analogous. The RUC also reviewed code 49084 *Peritoneal lavage, including imaging guidance, when performed* (work RVU= 2.00, 23/20/15) and determined that code 43202 was more complex due to moderate sedation, but was slightly less total work because of the intra-time difference. Finally, the RUC agreed that the work of code 43202 and 43201, with identical time components, should be valued similarly. **The RUC recommends a work RVU of 1.89 for CPT code 43202.**

43204 *Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices*
The RUC reviewed the survey results of 95 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty that the current work RVU of 3.76, the survey median, overestimated the physician work involved in this service. The RUC determined that a work RVU of

2.89, the survey 25th percentile, is an accurate measure of the physician work to perform code 43204. To justify this value, the RUC reviewed MPC code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU=2.78) and determined that the intensity and total physician work of 43204 is greater compared to the reference code because of a more complex patient. The RUC also noted that the higher intra-time in 31622 was due to moderate sedation work being included in the intra-time instead of pre-time component. In addition, the RUC reviewed code 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU=2.86) and noted that both codes have identical intra-service times and similar total times. The RUC reviewed code 93503 *Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes* (work RVU=2.91, 12/15/10), which has less total time, but higher intensity than code 43204. Finally, the RUC agreed with the specialties that this service was among the highest intensity services of this family of esophagoscopy codes because the patients undergoing this service are actively bleeding at the time of examination and treatment and typically have decompensated liver disease, as described in the vignette. The specialties noted, and the RUC agreed, that the difference in the current survey intra-time and Harvard intra-time is due to a shift of reporting moderate sedation work from the intra-service to the pre-service component. **The RUC recommends a work RVU of 2.89 for CPT code 43204.**

43205 ***Esophagoscopy, flexible, transoral; with band ligation of esophageal varices***
The RUC reviewed the survey results of 108 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty that the current work RVU of 3.78, slightly above the survey median, overestimated the physician work involved in this service. The RUC determined that a work RVU of 3.00, the survey 25th percentile, is an accurate measure of the physician work to perform code 43205. To justify this value, the RUC reviewed MPC code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU=2.78) and determined that the intensity and total physician work of 43205 is greater compared to the reference code because of a more complex patient. The RUC also noted that the higher intra-time in 31622 was due to moderate sedation work being included in the intra-time instead of pre-time component. In addition, the RUC reviewed code 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU=2.86), which has identical intra-service time compared to code 43205, but includes less intense guidance work. The RUC reviewed code 93503 *Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes* (work RVU=2.91, 12/15/10), which has less total time, but higher intensity than code 43205. Finally, the RUC agreed with the specialties that this service was among the highest intensity services of this family of esophagoscopy codes because the patients undergoing this service are actively bleeding at the time of examination and treatment and typically have decompensated liver disease, as described in the vignette. The RUC determined that the difference in the current survey intra-time and previous RUC survey in 1993 is due to a shift of reporting

moderate sedation work from the intra-service to the pre-service component. The RUC also compared the intensity difference between 43205 and 43204 and noted that the physician work was more intense for code 43205 due to increased complexity of banding varices in an actively bleeding patient. **The RUC recommends a work RVU of 3.00 for CPT code 43205.**

43206 ***Esophagoscopy, flexible, transoral; with optical endomicroscopy***
The RUC reviewed the survey results of 109 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 30 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B *Facility straightforward patient under sedation* was appropriate with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialties that both the survey median and 25th percentile work RVUs overstated the work included in this service. To determine an appropriate value, the RUC reviewed CPT code 12006 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm* (work RVU=2.39) and determined that with identical intra-service time of 30 minutes, this service would require similar total physician work even though 43206 includes moderate sedation and 12006 includes local anesthesia. Therefore, the RUC determined, and the specialty agreed, that a work RVU of 2.39, a direct crosswalk to code 12006, correctly ranks this new code to the base code 43200. In addition, the RUC considered that 43206 includes a diagnostic esophagoscopy followed by further diagnostic work utilizing an optical endomicroscope. This service is similar to two diagnostic services and that by applying the multiple procedure rule, would be equal to 2.39 work RVUs (1.59 + 1.59/2). **The RUC recommends a work RVU of 2.39 for CPT code 43206.**

43215 ***Esophagoscopy, flexible, transoral; with removal of foreign body***
The RUC reviewed the survey results of 102 gastroenterologists, otolaryngologists, and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that patients undergoing sclerotherapy of esophageal varices are considered difficult because of the underlying co-morbidities from cirrhosis, cancer, encephalopathy, and/or coagulopathy that are typical. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the 25th percentile. Therefore, the RUC determined that a work RVU of 2.60, the current value and less than the survey 25th percentile, is appropriate for CPT code 43215. To justify this value, the RUC reviewed three codes: MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU=2.70); CPT code 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 CPT code 31295 *Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa* (work RVU=2.70). Each of these reference codes have identical intra-service time, 20 minutes, compared to the surveyed code and provide ample support that the current work RVU of 2.60 accurately values

code 43215 relative to services across the RBRVS. Finally, the RUC discussed the differences in Harvard time compared to the current survey time. The specialties argued and the RUC agreed that the work to perform this service has not changed and that 20 minutes of intra-time is appropriate. The specialties noted that the difference in the current survey intra-time and Harvard intra-time is due to a shift of reporting moderate sedation work from the intra-service to the pre-service component. In addition, it was noted that the Harvard study did not include a typical patient and that code descriptor can represent a variety of foreign bodies. **The RUC recommends a work RVU of 2.60 for CPT code 43215.**

43216 ***Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery***
The RUC reviewed the survey results of 99 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 22 minutes and post-service time of 10 minutes. The specialties argued and the RUC agreed that the work to perform this service has not changed and that 22 minutes of intra-time is appropriate. The specialties noted that the time data included in the RUC database is asterisked to "not use for validation of physician work." As described in the RUC rationale, the value for this code is based on independent work by CMS to value the increment and not on survey data. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the 25th percentile. Therefore, the RUC determined that a work RVU of 2.40, the current value and less than the survey 25th percentile, is appropriate for CPT code 43216. To justify this value, the RUC reviewed MPC code 52000 *Cystourethroscopy (separate procedure)* (work RVU=2.23) and noted that the reference code has 7 minutes less intra-service time compared to the surveyed code and should be valued less. The RUC also reviewed two additional codes that bracket the recommended work value for 43216: CPT code 45341 *Sigmoidoscopy, flexible; with endoscopic ultrasound examination* (work RVU=2.60, intra-service time= 30 minutes) and CPT code 57454 *Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage* (work RVU=2.33, intra-service time= 20 minutes). Finally, the RUC compared code 43216 to code 43215, *flexible foreign body removal*, and agreed that while 43216 has 2 more minutes of intra-service time, the physician work is less intense and should be valued slightly less. The current work RVU of 2.40 is also relative to CPT code 43202, *flexible biopsy*, (RUC recommended work RVU= 1.89) as 43216 has 7 additional intra-service minutes. **The RUC recommends a work RVU of 2.40 for CPT code 43216.**

43217 ***Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique***
The RUC reviewed the survey results of 90 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 30 minutes and post-service time of 10 minutes. The specialties argued and the RUC agreed that the work to perform this service has not changed and that 30 minutes of intra-time is appropriate. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the 25th percentile. Therefore, the RUC determined that a work RVU of 2.90, the current value and less than the survey 25th percentile, is appropriate for CPT code 43217. To justify this value, the RUC reviewed MPC code 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 given both services have identical intra-service time, 30 minutes, both codes should have similar work values. The RUC also reviewed two codes that bracket the recommended work RVUs: CPT code 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU=2.86, intra-service time= 20 minutes) is a less intense procedure and should be valued slightly less and CPT code 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU=3.30, intra-service time= 30 minutes) is a more intense procedure and should be valued higher than code 43217. Finally, the RUC noted that the recommended work value appropriately ranks code 43217 to 43216, *flexible lesion removal by hot biopsy*, as 43217 has 8 additional minutes of intra-service time. **The RUC recommends a work RVU of 2.90 for CPT code 43217.**

43211 ***Esophagoscopy, flexible, transoral; with endoscopic mucosal resection***
The RUC reviewed the survey results from 62 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 45 minutes and post-service time= 18 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this new code, with a survey 25th percentile work RVU of 4.91. Consistent with the RUC approved EGD recommendations in January 2013, the RUC agreed that, to remain consistent, code 43211 should be valued less than the equivalent EGD code 43254 (recommended work RVU= 5.25). To define the appropriate reduction, the RUC determined the established increment between the base EGD code, 43235 (recommended work RVU= 2.26), and the base esophagoscopy code, 43200 (recommended work RVU= 1.59). Therefore, the resulting incremental difference of 0.67 work RVUs was subtracted from 43254, for a recommended work RVU of 4.58. To validate a work RVU of 4.58, the RUC compared the surveyed code to CPT code 20902 *Bone graft, any donor area; major or large* (work RVU= 4.58) and agreed that since both codes have identical intra-service time, 45 minutes, and analogous physician work, both codes should be valued identically. In addition, the RUC reviewed 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 noted that while both codes have identical intra-service time, the reference code is a more intense procedure and has more total time than 43211. Therefore, the RUC agreed that the reference code should be valued higher. **The RUC recommends a work RVU of 4.58 for CPT code 43211.**

43212 ***Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)***
The RUC reviewed the survey results from 53 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 30 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this new code, with a survey 25th percentile work RVU of 4.36. Consistent with the RUC approved EGD recommendations in January 2013, the RUC agreed that, to remain consistent, code 43212 should be valued less than the equivalent EGD code 43266 (recommended work RVU= 4.40). To define the appropriate reduction, the RUC determined the established increment between the base EGD code, 43235 (recommended work RVU= 2.26), and the base esophagoscopy code, 43200 (recommended work RVU= 1.59). Therefore, the resulting incremental difference of 0.67 work RVUs was subtracted from 43266, for a recommended work RVU of 3.73. To validate a work RVU of 3.73, the RUC compared the surveyed code to CPT code 31296 *Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)* (work RVU= 3.29) and noted that while both codes have identical intra-service time, 30 minutes, 43212 should be valued higher due to greater intensity and complexity. The RUC also reviewed CPT code 20660 *Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)* (work RVU= 4.00) and noted that this reference code is more intense than 43212 and should be valued slightly higher. Finally, the RUC compared 43212 to 43214 and agreed that with almost identical physician time, the two services are correctly valued similarly. **The RUC recommends a work RVU of 3.73 for CPT code 43212.**

43220 ***Esophagoscopy, flexible, transoral; with balloon dilation (less than 30 mm diameter)***
The RUC reviewed the survey results of 109 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B *Facility straightforward patient under sedation* was appropriate with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the 25th percentile. Therefore, the RUC determined that a work RVU of 2.10, the current value and less than the survey 25th percentile, is appropriate for CPT code 43220. To justify this value, the RUC reviewed CPT code 57421 *Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix* (work RVU=2.20) and noted that both codes have identical intra-service time, 20 minutes, and therefore, should be valued similarly. The RUC also reviewed CPT code 69801 *Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcana*l (work RVU=2.06) and agreed that while reference code has 5 minutes less intra-service time compared to 43220, the surveyed code has much greater total time and should be valued slightly higher. CPT code 52000 *Cystourethroscopy (separate procedure)* (work RVU= 2.23) was also reviewed and the RUC agreed that with less total time compared to the surveyed code, 42 minutes and 57 minutes, respectively, the reference code is

appropriately valued less than 43220. Finally, the RUC compared code 43220 to other similar codes in the family with 20 minutes of intra-service time and agreed that a work RVU of 2.10 accurately values this service relative to the other services. **The RUC recommends a work RVU of 2.10 for CPT code 43220.**

43213 ***Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)***
The RUC reviewed the survey results from 45 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 45 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that since there is no equivalent esophagoscopy crosswalk to determine the incremental physician work, the survey's 25th percentile work RVU of 5.00 is appropriate. To validate this work value, the RUC compared the surveyed code to CPT code 20902 *Bone graft, any donor area; major or large* (work RVU= 4.58) and agreed that while both services have identical intra-service time, 45 minutes, the surveyed code is a more intense procedure and should be valued slightly higher. The RUC also reviewed 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 noted that this reference code has greater total time than the surveyed code, 116 minutes and 101 minutes, respectively. Therefore, 43213 is appropriately valued slightly less than 36251. **The RUC recommends a work RVU of 5.00 for CPT code 43213.**

43214 ***Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)***
The RUC reviewed the survey results from 42 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 30 minutes and post-service time= 16 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this new code, with a survey 25th percentile work RVU of 3.86. Consistent with the RUC approved EGD recommendations in January 2013, the RUC agreed that, to remain consistent, code 43214 should be valued less than the equivalent EGD code 43233 (recommended work RVU= 4.45). To define the appropriate reduction, the RUC determined the established increment between the base EGD code, 43235 (recommended work RVU= 2.26), and the base esophagoscopy code, 43200 (recommended work RVU= 1.59). Therefore, the resulting incremental difference of 0.67 work RVUs was subtracted from 43233, for a recommended work RVU of 3.78. To validate a work RVU of 3.78, the RUC compared the surveyed code to 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use*

of cystoscopy, including radiological supervision and interpretation (work RVU= 3.30) and noted that while both codes have identical intra-service time, 30 minutes, 43214 should be valued higher due to greater intensity and complexity. In addition, the RUC reviewed CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17) and agreed that the reference code is a slightly more intense service compared to the surveyed code and is appropriately valued higher. **The RUC recommends a work RVU of 3.78 for CPT code 43214.**

43226 ***Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire***
The RUC reviewed the survey results of 114 gastroenterologists, otolaryngologists, and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 25 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1B *Facility straightforward patient under sedation* was appropriate with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the 25th percentile. Therefore, the RUC determined that a work RVU of 2.34, the current value and less than the survey 25th percentile, is appropriate for CPT code 43226. To justify this value, the RUC reviewed CPT code 49083 *Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance* (work RVU= 2.00) and agreed that while both services have identical intra-service time, code 43226 is a more intense and complex procedure to perform and should be valued higher. In addition, the RUC reviewed CPT code 57454 *Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage* (work RVU=2.33) and agreed that since the surveyed code has more intra-service time it should be valued slightly higher than the reference code. CPT code 69801 *Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal* (work RVU= 2.06) was also reviewed and the RUC agreed that with less total time compared to the surveyed code, 43 minutes and 57 minutes, respectively, the reference code is appropriately valued less than 43226. Finally, code 43226 was compared to code 43220 *flexible with balloon dilation* (RUC recommended work RVU= 2.10) and the RUC agreed that 43226 should be valued higher due to 5 more minutes of intra-service time. **The RUC recommends a work RVU of 2.34 for CPT code 43226.**

43227 ***Esophagoscopy, flexible, transoral; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)***
The RUC reviewed the survey results of 87 gastroenterologists and gastrointestinal and endoscopic surgeons and recommend the following physician time components: pre-service time of 33 minutes, intra-service time of 30 minutes and post-service time of 10 minutes. The RUC also accepted pre-service package 2B *Facility difficult patient under sedation* with two additional minutes to properly position the patient.

The RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty that they overestimated the work value at the median level. Therefore, the RUC determined that the survey 25th percentile work RVU of 3.26, less than the current value, is appropriate for CPT code 43226. To justify this value, the RUC reviewed CPT code 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU=3.36) and noted that both services have identical intra-service time, 30 minutes,

and should be valued similarly. In addition, the RUC compared 43227 to CPT code 58555 *Hysteroscopy, diagnostic (separate procedure)* (work RVU=3.33) and agreed that while the reference code has 5 minutes less intra-service time, it has greater total time and should be valued slightly higher than code 43227. The RUC also reviewed MPC code 15002 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children* (work RVU=3.65, intra= 20 minutes) and noted that although the surveyed code has 10 minutes more intra-service time, the reference code has much greater total time, 102 minutes compared to 73 minutes, and is appropriately valued higher than 43227. Finally, the RUC agreed with the specialties that this service was among the highest intensity services of this family of esophagoscopy codes because the patients undergoing this service are actively bleeding at the time of examination and treatment, as described in the vignette. The specialties noted, and the RUC agreed, that the difference in the current survey intra-time and Harvard intra-time is due to a shift of reporting moderate sedation work from the intra-service to the pre-service component. **The RUC recommends a work RVU of 3.26 for CPT code 43227.**

43229 ***Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)***
The RUC reviewed the survey results from 51 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 40 minutes, intra-service time= 45 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this new code, with a survey 25th percentile work RVU of 4.68. Consistent with the RUC approved EGD recommendations in January 2013, the RUC agreed that, to remain consistent, code 43229 should be valued less than the equivalent EGD code 43270 (recommended work RVU= 4.39). To define the appropriate reduction, the RUC determined the established increment between the base EGD code, 43235 (recommended work RVU= 2.26), and the base esophagoscopy code, 43200 (recommended work RVU= 1.59). Therefore, the resulting incremental difference of 0.67 work RVUs was subtracted from 43270, for a recommended work RVU of 3.72. To validate a work RVU of 3.72, the RUC compared the surveyed code to CPT code 19105 *Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma* (work RVU= 3.69) and agreed that since both codes have 45 minutes of intra-service time and almost identical total time, the two services should be valued similarly. The RUC also reviewed 31626 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple* (work RVU= 4.16) and noted that the reference code is a more intense procedure and should be valued higher than 43229. Finally, the RUC compared 43229 to 43212 and 43214 and agreed that while 43229 has 15 minutes more intra-service time compared to these two codes, this surveyed code should be valued similarly as it is a less intense services comparably. **The RUC recommends a work RVU of 3.72 for CPT code 43229.**

43231 ***Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination***
The RUC reviewed the survey results from 45 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-

service time= 41 minutes, intra-service time= 30 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the survey respondents' physician work values estimates and agreed with the specialty societies that they were overvalued. The RUC noted that the median intra-service time of 30 minutes is less than the current time of 40 minutes. However, the previous survey valued this procedure with moderate sedation inherent in the intra-service time. With the subsequent establishment of pre-service time packages, moderate sedation is now considered pre-service time. Removing 10 minutes of intra-service time, accounting for the moderate sedation, from the previous survey, provides a reasonable comparison to the new survey, and suggests that the recommended intra-service time of 30 minutes is accurate. Given this information and the fact that the physician work has not changed since the previous valuation, the RUC agreed with the specialty societies that the current work RVU of 3.19 is appropriate for this procedure. To justify this work value, the RUC compared the surveyed code to CPT codes 36200 *Introduction of catheter, aorta* (work RVU= 3.02, intra time= 30 minutes) and 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU= 3.30, intra time= 30 minutes) and noted that both reference services have identical intra-service time compared to the surveyed code, with comparable physician work. Therefore, the recommended work RVU of 3.19 is accurately valued between these two services. **The RUC recommends a work RVU of 3.19 for CPT code 43231.**

43232 ***Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)***
The RUC reviewed the survey results from 38 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 45 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the survey respondents' physician work values estimates and agreed with the specialty societies that they were overvalued. To ensure that the recommendation remains consistent with the equivalent fine needle aspiration procedure in the EGD family, the RUC applied the incremental approach to value this service. As the base value, the RUC started with the RUC recommended EGD fine needle aspiration code (43238, RUC recommended work RVU= 4.50) and subtracted out the difference between the base EGD (43235, RUC recommended work RVU= 2.26) and esophagoscopy (43200, RUC recommended work RVU= 1.59) codes = 0.67 work RVUs. This ensures that the value contains only the esophagoscopy incremental work and not the increased work associated with EGD procedure. The RUC agreed that the resultant work value of 3.83 (4.50 - 0.67) was appropriate for 43232. To justify a work value of 3.83, the RUC first noted that the established increment of fine needle aspiration in the EGD family is 0.67 (43238, recommended work RVU= 4.50 – 43237, recommended work RVU= 3.85), validating the increment used in this methodology. Additionally, the RUC compared the surveyed code to CPT codes 32553 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple* (work RVU= 3.80, intra time= 45 minutes) and 11044

Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less (work RVU= 4.10, intra time= 45 minutes) and noted that both services have identical intra-service time and comparable physician work to the surveyed code. Therefore, the RUC agreed that the recommended value of 3.83 is appropriately placed between these two reference services. **The RUC recommends a work RVU of 3.83 for CPT code 43232.**

Practice Expense:
At the October 2012 RUC meeting the PE Subcommittee reviewed the direct practice expense inputs recommended by the specialties and made modifications to the clinical staff times, medical supplies, and equipment items and time. In addition, several items listed as new equipment were reclassified as supplies with existing codes and equipment minutes were converted from units to minutes. The RUC accepted the direct practice expense inputs for these codes as modified by the Practice Expense Subcommittee.

At the January 2013 RUC meeting the practice expense for these services was a direct crosswalk to the approved practice expense for the related esophagoscopy codes approved at the October 2012 RUC meeting. At the January 2013 RUC meeting the Practice Expense Subcommittee recommended and the RUC approved the following changes to the practice expense for esophagogastroduodenoscopy and the specialty requests that the changes be applied to the esophagoscopy codes that were previously approved at the October 2012 RUC meeting.

- Addition of 3 minutes to "Prepare room, equipment, supplies" (L037D) for code 43252 (Esophagogastroduodenoscopy; with optical endomicroscopy) for the technician to turn on the optical endomicroscope processor unit system added to its esophagoscopy counterpart, 43206 (Esophagoscopy, flexible, transoral; with optical endomicroscopy)
- At the last meeting the Practice Expense Subcommittee used equipment practice expense input EQ322 Radiofrequency generator (Angiodynamics), liver RFA as a proxy. The specialty will identify a more appropriate RF ablation system for 43270 (Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)) and provide an invoice for this equipment. It should also be added to its esophagoscopy counterpart 43229(Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)) which replaced 43228
- Addition of "Instrument pack basic ($500 - $1,499)" (EQ137) for 43248 (Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire) added to its esophagoscopy counterpart 43226 (Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire)
- Addition of "Pack, cleaning, surgical instruments" (SA043) for 43248 (Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire) for cleaning the dilators added to its counterpart 43226 (Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire)

In April 2013, the RUC recommends the direct practice expense for the two facility only codes, 43231 and 43232, as submitted by the specialty societies and approved 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.

Esophagoscopy Gastroscopy Duodenoscopy (EGD) (Tab 11)
Joel Brill, MD (AGA); Nickl, Bentley, MD (ASGE) and Donald Selzer, MD (SAGES)

Several Esophagogastroduodenoscopy (EGD) codes were identified through CMS and RUC screens as potentially misvalued, including: MPC list screen; high expenditures screen; and fastest growing screen. The specialties agreed to survey the entire family of codes (43235-43259). In review of this family of codes prior to survey, the specialties determined that the coding nomenclature required revisions and new codes were necessary to describe current practice. In October 2012, the CPT Editorial Panel approved revised guidelines along with revision, addition, and deletion of codes within the EGD code set. In the Panel Action memo from the October CPT Editorial Panel meeting CPT requested clarifications from the involved specialty societies regarding instructions affecting the EGD codes (43235-43259). A specific request was made for the societies to provide clarification regarding the reporting of reduced service modifiers and an EGD service. After discussions with CPT and RUC staff it was determined that the CPT Editorial Panel's request for clarification will require a material change to codes 43237 and 43238 requiring approval by the CPT Editorial Panel. Therefore, the RUC approved the specialty societies' request to refer these services back to CPT and requested that they be surveyed for presentation at the April 2013 RUC meeting. Additionally, 43246 and 43251 were re-surveyed for April 2013 as the survey median times presented at the January 2013 meeting were anomalous.

After survey of the procedures for April, the specialty societies noted that the EGD with EUS procedures (43237-8, 43240, 43242, 43259 and 43253) are not inherently performed with moderate sedation by the same physician. However, due to CMS' consistent position, at the April meeting and in multiple Medicare Physician Payment Rules, that the Agency is looking for larger bundling of services, not unbundling of services, the moderate sedation for these services will remain bundled. Therefore, the EGD with EUS family of services will remain on Appendix G in the CPT codebook.

Prior to valuing this series of EGD codes, the RUC discussed the difference in survey methodologies between this series and the previously RUC recommended series of esophagoscopy codes in October 2012. The esophagoscopy codes surveyed for the October 2012 RUC meeting were conducted under a mini-survey format in which only the base code 43200 was fully surveyed and the rest of the family was only surveyed for the work value and intra-service time. Given that only one survey existed for pre and post-service times, this resulted in standardized time components. Following the October 2012 meeting, the specialty societies requested and received approval from the Research Subcommittee to fully survey all elements of the codes moving forward. The RUC agreed with the specialty societies that in order to accurately value each procedure, the surveyed times should be used rather than arbitrarily deriving times from a previous survey.

To maintain relativity with this family of services and the esophagoscopy services, the RUC and specialty societies agreed on a standardized set of methodologies to arrive at appropriate work values. The RUC administered three primary methodologies to value these services:

1. If a corresponding esophagoscopy code exists, and the previously billed codes are in the same endoscopic family, the RUC applied the Endoscopy Rule incremental approach.
2. If a corresponding esophagoscopy code exists and the additional codes were part of a different family of endoscopic procedure, the RUC applied the appropriate multiple procedure reduction.
3. If a corresponding esophagoscopy code did NOT exist, either the current value or the survey 25th percentile was recommended, whichever was lower.

43235 ***Esophagogastroduodenoscopy, flexible, transoral; diagnostic, with collection of specimen(s) by brushing or washing, when performed***

The RUC reviewed the survey results from 315 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 27 minutes, intra-service time= 15 minutes and post-service time= 12 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the survey's estimated work RVU and agreed that respondents overestimated the work value, with a 25th percentile (work RVU= 2.59) above the current value. Furthermore, the RUC noted that because the survey's median intra-service time is 5 minutes less compared to the current time, the current work RVU of 2.39 was also overvalued. To determine an appropriate work RVU, the RUC reviewed analogous CPT code 31579 *Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy* (work RVU= 2.26) and agreed that with identical intra-service time, 15 minutes, and similar total time, the two services should have identical work values. Therefore, 43235 should be valued at 2.26 work RVUs. To validate this RVU, the RUC reviewed MPC codes 64479 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level* (work RVU= 2.29) and 52000 *Cystourethroscopy* (work RVU= 2.23) and agreed that the services, with identical intra-service times, should all be valued similarly. **The RUC recommends a work RVU of 2.26 for CPT code 43235.**

43236 ***Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance***

The RUC reviewed the survey results from 78 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 27 minutes, intra-service time= 20 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. In addition, since the median intra-service time was less than the current time, the current value of 2.92 was deemed too high as well. Consistent with the previously approved esophagoscopy recommendations in October 2012, the RUC noted that the identical increment between the esophagoscopy base

code, 43200 (recommended work RVU= 1.59), and the submucosal injection code, 43201 (recommended work RVU= 1.90), should be maintained in this family of EGD services. Therefore, the established increment of 0.31 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 2.57 for 43236. To validate a work RVU of 2.57, the RUC compared the surveyed code to CPT code 32556 *Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance* (work RVU= 2.50) and agreed that with identical intra-service time, 20 minutes, and similar total time, the two services should be valued similarly. Code 43236 was also compared to MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU= 2.70) and it was agreed that while both services have identical intra-service time, the reference code is slightly more intense and should therefore be valued higher. **The RUC recommends a work RVU of 2.57 for CPT code 43236.**

43237 ***Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus***
The RUC reviewed the survey results from 37 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 38 minutes, intra-service time= 35 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the current work value of 3.98 for this procedure is too high. The RUC noted that while the surveyed intra-service time is 10 minutes less than the current time, the previous survey valued this procedure with moderate sedation inherent in the intra-service time. With the subsequent establishment of pre-service time packages, moderate sedation is now considered pre-service time. Removing 10 minutes of intra-service time, accounting for the moderate sedation, from the previous survey, provides a reasonable comparison to the new survey, and suggests that the recommended intra-service time of 35 minutes is accurate. The RUC agreed with the specialty societies that the survey 25th percentile work RVU of 3.85accurately reflects the physician work involved in 43237. To validate this work value, the RUC compared the surveyed code to the key reference service 31625 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites* (work RVU= 3.36) and noted that 43237 should be valued higher due to greater intra-service time compared to the reference code, 35 minutes and 30 minutes, respectively. In addition, the RUC reviewed CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17) and agreed while 43237 has 5 additional minutes of intra-service time, the reference code is more intense and should be valued higher. **The RUC recommends a work RVU of 3.85 for CPT code 43237.**

43238 ***Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)***
The RUC reviewed the survey results from 33 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 38 minutes, intra-service time= 45 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the current work value of 5.02 for this procedure is too high. The RUC noted that while the surveyed intra-service time is less than the current time, the previous survey valued this procedure with moderate sedation inherent in the intra-service time. With the subsequent establishment of pre-service time packages, moderate sedation is now considered pre-service time. However, even removing intra-service time, accounting for the moderate sedation, from the previous survey, the survey intra-service time of 45 minutes is still lower. Therefore, the RUC agreed with the specialty societies that the survey 25th percentile work RVU of 4.50 accurately values the physician work of 43238. To justify this work value, the RUC compared the surveyed code to the 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, intra time= 60 minutes) and agreed that while 43238 has less intra-service time compared to the reference code, the survey respondents indicated the EGD code is a more intense procedure. Given this, the RUC agreed that the recommended value, 4.50, slightly less than the reference code, is appropriate. The RUC also reviewed CPT code 20902 *Bone graft, any donor area; major or large* (work RVU= 4.58) and agreed that since both codes have identical intra-service time, the codes should be valued similarly. **The RUC recommends a work RVU of 4.50 for CPT code 43238.**

43239 ***Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple***
The RUC reviewed the survey results from 310 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 27 minutes, intra-service time= 15 minutes and post-service time= 12 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, it was also agreed upon that the current work RVU of 2.87 was too high. Consistent with the previously approved esophagoscopy recommendations in October 2012, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the biopsy code, 43202 (recommended work RVU= 1.89), should be maintained in this family of EGD services. Therefore, the established increment of 0.30 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 2.56 for 43239. To validate a work RVU of 2.56, the RUC compared the surveyed code to MPC code 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU= 2.50) and CPT code 55700 *Biopsy, prostate; needle or punch, single or multiple, any approach* (work RVU= 2.58) and determined that with identical intra-service time, 15 minutes, the recommended work value is relative to other similar reference codes in the RBRVS. Finally, the RUC compared 43239 to 43236 and agreed that while the intra-service times are slightly different, the work values should be almost identical to maintain relativity within the family of EGD and esophagoscopy codes. **The RUC recommends a work RVU of 2.56 for CPT code 43239.**

43240 ***Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed)***
The RUC reviewed the survey results from 33 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 70 minutes and post-service time= 30 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

Prior to valuing this procedure, the specialty societies presented compelling evidence that the current work value of 6.85 for CPT code 43240 may be misvalued. First, there has been a change in technique and patient population since the last valuation. When this service was last valued by the RUC in 2000, the standard method for pancreatic pseudocyst marsupialization was surgical cyst-enterostomy. Endoscopic drainage was utilized primarily for the simpler cases. Management of pancreatic pseudocysts has evolved over the past decade: today endoscopic drainage is the standard first line therapy, with surgical drainage largely reserved for those who have failed endoscopic treatment or are not candidates. Finally, new treatment guidelines by the GI endoscopy authorities, based on recent natural history data, now recommend non-drainage treatment of simple unilocular pseudocysts in healthy asymptomatic patients. Thus, those patients who typically had endoscopic drainage in 2000 are now rarely drained at all, while the sicker patients with more complex and technically demanding pseudocysts previously treated surgically are currently being managed with endoscopic therapy. Secondly, flawed assumptions were used in the previous valuation. The RUC originally valued this procedure based off a crosswalk to an endoscopic code outside the EGD family CPT code 43262 *Endoscopic retrograde cholangio-pancreatography (ERCP); with sphincterotomy/papilotomy*, which was Harvard valued at the time. Furthermore, this comparison for 43240 was derived from survey data from only 6 respondents, for what was then a new procedure. Given these arguments, the RUC accepted that there is compelling evidence that this procedure is currently misvalued.

The RUC agreed with the specialty society that the survey 25th percentile work RVU of 7.25, slightly above the current work value of 6.85, is appropriate. To justify this value, the RUC compared the surveyed code to CPT code 20555 *Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)* (work RVU= 6.00) and agreed that while both services have identical intra-service time, 70 minutes, 43240 is a more intense procedure and should be valued higher than the reference code. The RUC also reviewed CPT code 31276 *Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus* (work RVU= 8.84) and agreed since the reference code has 5 minutes more intra-service time, the recommended work RVU is appropriately valued less than this reference code. Finally, the RUC reviewed the incremental approach to ensure the recommendation is relative to other codes in the family. The RUC noted that 43240 contains the work of an upper diagnostic endoscopy with fine needle aspiration (CPT code 43242, RUC recommended work RVU= 5.39) and the approved incremental value of 2.14 for placement of an endoscopic stent. Added together, the resultant work value of 7.53 is comparable to the recommended value. **The RUC recommends a work RVU of 7.25 for CPT code 43240.**

43241 ***Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube, or catheter***
The RUC reviewed the survey results from 39 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 33 minutes, intra-service time= 30 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents greatly overestimated the value of this code, with a 25th percentile value of 3.50. The RUC noted that since there is no equivalent esophagoscopy code to compare, the current work RVU of 2.59 is appropriate. The RUC compared the surveyed code to CPT code 52005 *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service* (work RVU= 2.37) and agreed that while both codes have identical intra-service time, 30 minutes, and nearly identical total time, 43241 is a more intense procedure and should be valued slightly higher. Additionally, the RUC reviewed CPT code 57156 *Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy* (work RVU= 2.69) and agreed that since both this code and the surveyed code have identical intra-service time and comparable physician work, the recommended value for 43241 is appropriate. **The RUC recommends a work RVU of 2.59 for CPT code 43241.**

43242 ***Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)***
The RUC reviewed the survey results from 36 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 50 minutes and post-service time= 23 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, it was also agreed that the current work RVU of 7.30 was too high. Consistent with recently RUC reviewed fine needle aspiration recommendations, the RUC noted that the identical increment between the fine needle aspiration code, 43238 (RUC recommended work RVU= 4.50), and the endoscopic ultrasound (limited to esophagus) code, 43237 (RUC recommended work RVU= 3.85), should be maintained in this family of EGD services. Therefore, the established increment of 0.65 work RVUs was added to the base EGD with endoscopic ultrasound code, 43259 (recommended work RVU= 4.74), for a recommended work RVU of 5.39 for 43242. To justify this value, the RUC compared the surveyed code to CPT codes 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, intra time= 45 minutes) and code 52282 *Cystourethroscopy, with insertion of permanent urethral stent* (work RVU= 6.39, intra time= 50 minutes) and

noted that both reference codes have almost identical physician time components as the surveyed code and comparable physician work. Therefore, the RUC agreed that the recommended work value of 5.39 for 43242 is accurately valued between these two reference codes. **The RUC recommends a work RVU of 5.39 for CPT code 43242.**

43243 ***Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal / gastric varices***
The RUC reviewed the survey results from 58 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 30 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC agreed with the specialty societies that the current work RVU of 4.56 was too high relative to the RUC recommendations in this family of services. Since no equivalent esophagoscopy code exists to compare, the survey's 25th percentile work RVU of 4.37 was deemed appropriate. To validate this recommended work value, the RUC compared the surveyed code to CPT code 32550 *Insertion of indwelling tunneled pleural catheter with* cuff (work RVU= 4.17) and agreed since the two services have identical intra-service time, 30 minutes, both should be valued analogously. In addition, CPT code 52234 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)* (work RVU= 4.62, intra time= 30 minutes) was compared to 43243 and the RUC agreed that the reference code should be valued slightly higher than the surveyed code due to greater intensity and complexity. **The RUC recommends a work RVU of 4.37 for CPT code 43243.**

43244 ***Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal / gastric varices***
The RUC reviewed the survey results from 69 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 30 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC agreed with the specialty societies that the current work RVU of 5.04 was too high relative to the RUC recommendations in this family of services. Since no equivalent esophagoscopy code exists to compare, the survey's 25th percentile work RVU of 4.50 was deemed appropriate. To validate this recommended work value, the RUC compared the surveyed code to CPT code 32550 *Insertion of indwelling tunneled pleural catheter with* cuff (work RVU= 4.17) and agreed that while the two services have identical intra-service time, 30 minutes, 43244 should be valued higher as it is a more intense service. In addition, the RUC reviewed CPT code 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU= 4.71) and noted that the two services, with identical intra-service time and analogous total time, should be valued similarly. Finally, the RUC compared 43244 to 43243 and agreed that while both codes have identical physician time, 43244 is a more intense procedure and is accurately valued

slightly higher than 43243. **The RUC recommends a work RVU of 4.50 for CPT code 43244.**

43245 ***Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric / duodenal stricture(s) (eg, balloon, bougie)***
The RUC reviewed the survey results from 56 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 33 minutes, intra-service time= 23 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code, with a 25th percentile value of 3.58. The RUC noted that since there is no equivalent esophagoscopy code to compare, the current work RVU of 3.18 is appropriate. The RUC compared the surveyed code to CPT code 58555 *Hysteroscopy, diagnostic* (work RVU= 3.33) and agreed that the reference code, with slightly greater intra-service time compared to the surveyed code, 25 minutes and 23 minutes, respectively, should be valued higher. Additionally, CPT code 43245 was compared to CPT code 52287 *Cystourethroscopy, with injection(s) for chemodenervation of the bladder* (work RVU= 3.20) and it was agreed that while the surveyed code has two additional minutes of intra-service time, both services should be valued similarly. **The RUC recommends a work RVU of 3.18 for CPT code 43245.**

43246 ***Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube***
The RUC reviewed the survey results from 57 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 30 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

Prior to valuing this service, the RUC noted that this service was previously surveyed for the January 2013 meeting. The RUC and specialty societies agreed that the survey median intra-service time of 23 minutes grossly underestimated the time it takes to perform this procedure. The RUC agreed with the specialty societies that the surveyed intra-service time of 30 minutes for this meeting is a much better representation of the physician work for this procedure for two reasons. First, during the last valuation of this service, in 2005, the RUC approved imputed intra-service time, 38 minutes, greater than the median time from the survey, 30 minutes. Second, since moderate sedation was included as intra-service time during the previous valuation, and is now included as pre-service time, reducing the current time by 10 minutes, to 28 minutes, provides a comparison that matches up well with the surveyed time of 30 minutes. Given this, the RUC agreed with the specialty societies that the physician work has not changed and the current work RVU of 4.32 is appropriate for 43246. To justify this value, the RUC compared the surveyed code to CPT codes 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17, intra time= 30 minutes) and 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU= 4.71, intra time= 30 minutes) and noted that

both reference codes have identical physician time components as the surveyed code and comparable physician work. Therefore, the RUC agreed that the recommended work value of 4.32 for 43246 is accurately valued between these two reference codes. **The RUC recommends a work RVU of 4.32 for CPT code 43246.**

43247 ***Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body***
The RUC reviewed the survey results from 68 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 23 minutes, intra-service time= 30 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, it was also agreed upon that the current work RVU of 3.38 was too high. Consistent with the previously approved esophagoscopy recommendations in October 2012, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the removal of foreign body code, 43215 (recommended work RVU= 2.60), should be maintained in this family of EGD services. Therefore, the established increment of 1.01 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 3.27 for 43247. To validate a work RVU of 3.27, the RUC compared the surveyed code to 36200 *Introduction of catheter, aorta* (work RVU= 3.02) and agreed that while both services have identical intra-service time, 30 minutes, the surveyed code should be valued higher due to greater intensity and complexity. Additionally, the RUC reviewed CPT code 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU= 3.30) and agreed that with identical times and analogous intensity, this reference code and 43247 should be valued similarly. **The RUC recommends and work RVU of 3.27 for CPT code 43247.**

43248 ***Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire***
The RUC reviewed the survey results from 50 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 27 minutes, intra-service time= 20 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, it was also agreed upon the current work RVU of 3.15 was too high. Consistent with the previously approved esophagoscopy recommendations in October 2012, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the insertion of guide wire with dilation code, 43226 (recommended work RVU= 2.34), should be maintained in this family of EGD services. Therefore, the established increment of 0.75 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 3.01 for 43248. To validate a work RVU of 3.01, the RUC compared the surveyed

code to 31295 *Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa* (work RVU= 2.70) and agreed that while the two services have identical intra-service time, 20 minutes, the surveyed code should be valued higher, as it is a more intense procedure. In addition, the RUC reviewed CPT code 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open* (work RVU= 3.29) and agreed that while this reference code has the same intra-service time as the surveyed code, the reference code has greater total time and should thus be valued higher. **The RUC recommends a work RVU of 3.01 for CPT code 43248.**

43249 ***Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)***
The RUC reviewed the survey results from 56 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 27 minutes, intra-service time= 20 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, it was also agreed upon the current work RVU of 2.90 was too high. Consistent with the previously approved esophagoscopy recommendations in October 2012, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the balloon dilation code, 43220 (recommended work RVU= 2.10), should be maintained in this family of EGD services. Therefore, the established increment of 0.51 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 2.77 for 43249. To validate a work RVU of 2.77, the RUC compared the surveyed code to 31295 *Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine* fossa (work RVU= 2.70) and agreed that with identical intra-service time, 20 minutes, and analogous intensity and complexity, the two services should be valued similarly. In addition, the RUC also reviewed CPT code 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open* (work RVU= 3.29) and agreed that while this reference code and the surveyed code have identical intra-service time, the reference code has greater total time, 83 minutes compared to 62 minutes, and should be valued higher. Finally, the RUC compared this service to 43248 and noted that while both services have identical physician time components, 43249 is appropriately valued lower than 43248, as it is a less intense procedure. **The RUC recommends a work RVU of 2.77 for CPT code 43249.**

43233 ***Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)***
The RUC reviewed the survey results from 35 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 38 minutes, intra-service time= 30 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work value from the survey for this new code and agreed with the specialty societies that the 25th percentile work RVU of 4.45 accurately

values this service. To validate this work value, the RUC compared the surveyed code to CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17) and noted that while both codes have identical intra-service time, 30 minutes, the surveyed code should be valued higher because it is a more intense and complex to perform. The RUC also reviewed 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 since the reference code has greater total time compared to 43233, 108 minutes and 88 minutes, respectively, it is appropriately valued higher. **The RUC recommends a work RVU of 4.45 for CPT code 43233.**

43250 ***Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery***
The RUC reviewed the survey results from 59 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 24 minutes, intra-service time= 20 minutes and post-service time= 14 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, it was also agreed upon the current work RVU of 3.20 was too high. Consistent with the previously approved esophagoscopy recommendations in October 2012, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the removal of tumor by biopsy forceps code, 43216 (recommended work RVU= 2.40), should be maintained in this family of EGD services. Therefore, the established increment of 0.81 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 3.07 for 43250. To validate a work RVU of 3.07, the RUC compared the surveyed code to 31295 *Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa* (work RVU= 2.70) and agreed that while the two service have identical intra-service time, 20 minutes, the surveyed code should be valued higher, as it is a more intense procedure. In addition, the RUC reviewed CPT code 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open* (work RVU= 3.29) and agreed that while this reference code has the same intra-service time as the surveyed code, the reference code has greater total time and should thus be valued higher. Finally, the RUC reviewed 43250 in comparison to 43248 and 43249 and agreed that all three codes have identical intra-service time and are appropriately valued similarly. **The RUC recommends a work RVU of 3.07 for CPT code 43250.**

43251 ***Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique***
The RUC reviewed the survey results from 39 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 33 minutes, intra-service time= 20 minutes and post-service time= 10 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

Prior to valuing this service, the RUC noted that this service was previously surveyed for the January 2013 meeting. The RUC and specialty societies agreed that the survey median intra-service time of 20 minutes grossly underestimated the time it takes to perform this procedure. A five minute time differential between the base code 43235, 15 minutes, and 43251, 20 minutes, does not accurately account for the additional work in removing a lesion by snare technique. The specialty society's resurveyed code 43251 and the RUC reviewed the survey results in April 2013. The RUC noted that the median intra-service time was 20 minutes. The RUC remains convinced that the time is anomalous, especially considering that the analogous code for esophageal snare polypectomy, 43217, has an incremental intra-service time above the base code 43200, both surveyed in 2012, of 15 minutes.

Following discussion of the survey time data, the RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. Consistent with the recently approved esophagoscopy removal of lesion by snare technique recommendations, the RUC noted that the identical increment between the removal of lesion by snare technique code, 43217 (RU C recommended work RVU= 2.90), and the base esophagoscopy code, 43200 (RUC recommended work RVU= 1.59), should be maintained in this family of EGD services. Therefore, the established increment of 1.31 work RVUs was added to the base diagnostic EGD code, 43235 (RUC recommended work RVU= 2.26), for a recommended work RVU of 3.57 for 43251. This recommendation is lower than the current value. To justify this value, the RUC compared the surveyed code to CPT 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)* (work RVU= 3.29) and noted that while both services have identical intra-service time, 20 minutes, 43251 is a more intense procedure and should be valued higher. Additionally, the RUC reviewed CPT code 16035 *Escharotomy; initial incision* (work RVU= 3.74, intra time= 20 minutes) and agreed that since the reference code has greater total time compared to 43251, 70 minutes and 63 minutes, respectively, it is appropriately valued slightly higher than the surveyed code. **The RUC recommends a work RVU of 3.57 for CPT code 43251.**

43252 ***Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy***
The RUC reviewed the survey results from 26 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 27 minutes, intra-service time= 30 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code. To ensure relativity within the family of services, the RUC compared this new service to the newly created esophagoscopy optical endomicroscopy code 43206. To ensure consistency, the RUC maintained the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the optical endomicroscopy code, 43206 (recommended work RVU= 2.39). Therefore, the established increment of 0.80 work RVUs was added to the base EGD diagnostic code, 43235 (recommended work RVU= 2.26), for a recommended work RVU of 3.07 for 43250. To validate a work RVU of 3.06, the RUC compared the surveyed code to 36200 *Introduction of catheter, aorta* (work RVU= 3.02) and agreed that since both codes have identical intra-service time, 30 minutes, and comparable physician work, the two services should be valued similarly. In addition,

the RUC reviewed CPT code 50386 *Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU= 3.30) and noted that while the two services have identical intra-service time, the reference code has greater total time compared to the surveyed code, 90 minutes and 77 minutes, respectively. Therefore, the 43252 is appropriately valued less than 50386. **The RUC recommends and work RVU of 3.06 for CPT code 43252.**

43253 ***Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)***
The RUC reviewed the survey results from 34 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 40 minutes and post-service time= 23 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code at the median level. Consistent with the recently approved EGD fine needle aspiration recommendations, the RUC noted that the identical increment between the fine needle aspiration code, 43238 (RUC recommended work RVU= 4.50), and the endoscopic ultrasound (limited to esophagus) code, 43237 (RUC recommended work RVU= 3.85), should be maintained in this family of EGD services. Therefore, the established increment of 0.65 work RVUs was added to the base EGD with endoscopic ultrasound code, 43259 (RUC recommended work RVU= 4.74), for a recommended work RVU of 5.39 for 43253, lower than the survey median work RVU (5.77). To justify a work RVU of 5.39, the RUC compared the surveyed code to CPT codes 52315 *Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated* (work RVU= 5.20, intra time= 45 minutes) and 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* (work RVU= 5.53, intra time= 40 minutes) and noted that both reference codes have similar intra-service and total time compared to the surveyed code. Therefore, the RUC agreed that a work value of 5.39 for 43253 accurately places this service between these two reference codes. **The RUC recommends a work RVU of 5.39 for CPT code 43253.**

43254 ***Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection***
The RUC reviewed the survey results from 43 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 38 minutes, intra-service time= 45 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work value from the survey and agreed with the specialty societies that the 25th percentile work RVU of 5.25 accurately values this service. To validate this work value, the RUC noted that this service contains three additional services from the base code: removal of lesion by snare, band ligation, and submucosal injection. The consistent increment approach was applied to sum the incremental differences between the equivalent esophagoscopy codes and the base code, 43200 (recommended work RVU= 1.59): 43217 (recommended work RVU= 2.90), increment difference= 1.31; 43205 (recommended work RVU= 3.00), incremental difference= 1.41; and 43201 (recommended work RVU= 1.90), incremental difference= 0.31). Adding the work RVU differences, 3.03, to the base EGD code 43235 (recommended work RVU= 2.26) arrives at a work RVU of 5.29, slightly higher than the recommended work value of 5.25. The RUC compared the surveyed code to CPT code 52315 *Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated* (work RVU= 5.20) and agreed that since these two codes have identical intra-service time, 45 minutes, and comparable physician work, they should be valued similarly. Finally, the RUC reviewed 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 noted that while both services have identical intra-service time, the reference code has greater total time compared to 43254, 116 minutes and 103 minutes, respectively. Therefore, the reference code is accurately valued higher than the surveyed code. **The RUC recommends a work RVU of 5.25 for CPT code 43254.**

43255 ***Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method***

The RUC reviewed the survey results from 82 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 30 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC agreed with the specialty societies that the current work RVU of 4.81 was too high relative to the RUC recommendations in this family of services. Since no equivalent esophagoscopy code exists to compare, the survey's 25th percentile work RVU of 4.20 was deemed appropriate. To validate this recommended work value, the RUC compared the surveyed code to CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17) and agreed that since both codes have identical intra-service time (30 minutes), and analogous total time, the two services should be valued similarly. Additionally, the RUC reviewed CPT code 37191 *Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed* (work RVU= 4.71) and noted that while the reference code has identical intra-service time compared to 43255, 37191 should be valued greater because it is a more intense and complex service. **The RUC recommends a work RVU of 4.20 for CPT code 43255.**

43266 ***Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)***
The RUC reviewed the survey results from 51 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 40 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work value from the survey for this new code and agreed with the specialty societies that the 25th percentile work RVU of 4.40 accurately values this service. To validate this work value, the RUC compared the surveyed code to CPT code 49418 *Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous* (work RVU= 4.21) and noted that since both codes have identical intra-service time, 40 minutes, and analogous physician work, the two services should be valued similarly. The RUC also reviewed CPT code 58558 *Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C* (work RVU= 4.74) and agreed that the reference code should be valued higher since it is a more intense procedure than 43266. Finally, the RUC compared 43266 to 43233 (recommended work RVU= 4.45) and agreed that while 43266 has 10 minutes more intra-service time, placement of an endoscopic stent is a more intense procedure than balloon dilation of the esophagus, therefore, both services should be valued similarly. **The RUC recommends a work RVU of 4.40 for CPT code 43266.**

43257 ***Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease***
The RUC reviewed the survey results from 25 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 45 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC agreed with the specialty societies that the current work RVU of 5.50 was too high relative to the RUC recommendations in this family of services. Since no equivalent esophagoscopy code exists to compare, the survey's 25th percentile work RVU of 4.25 was deemed appropriate. To validate this recommended work value, the RUC compared the surveyed code to CPT code 31648 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe* (work RVU= 4.20) and agreed that since both services have identical intra-service time, 45 minutes, and analogous intensity, they should both be valued similarly. The RUC also reviewed CPT code 20902 *Bone graft, any donor area; major or large* (work RVU= 4.58) and noted that while both services have identical intra-service time, the reference code has much greater total time compared to the surveyed code and should thus be valued higher. **The RUC recommends a work RVU of 4.25 for CPT code 43257.**

43270 ***Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)***
The RUC reviewed the survey results from 49 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 45 minutes and post-service time= 15 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work value from the survey for this new code and agreed with the specialty societies that the 25th percentile work RVU of 4.39 accurately values this service. To validate this work value, the RUC compared the surveyed code to CPT code 11044 *Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less* (work RVU= 4.10) and agreed that while both codes have identical intra-service time, 45 minutes, 43270 is a more intense and complex service and should be valued higher than the reference code. The RUC also reviewed CPT code 20902 *Bone graft, any donor area; major or large* (work RVU= 4.58) and noted that with greater total time compared to the surveyed code, 123 minutes and 101 minutes, respectively, the reference code is accurately valued higher than 43270. **The RUC recommends a work RVU of 4.39 for CPT code 43270.**

43259 ***Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)***
The RUC reviewed the survey results from 36 gastroenterologists and gastrointestinal and endoscopic surgeons and recommends the following physician time components: pre-service time= 41 minutes, intra-service time= 45 minutes and post-service time= 20 minutes. The RUC agreed that two additional minutes of pre-service time above the standard was warranted to position the patient, endoscopy equipment/monitor and anesthesia lines/equipment prior to induction of moderate sedation.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents overestimated the value of this code at the median level, a work RVU of 5.45. The RUC also noted that the surveyed intra-service time is lower than the current time of 69 minutes. However, since moderate sedation was included as intra-service time during the previous valuation, and is now included as pre-service time, reducing the current time by 10 minutes, to 59 minutes, provides a comparison between the surveys. Considering the surveyed time is still lower, the RUC agreed with the specialty societies that the current work RVU of 5.19 is too high and accepted the survey 25th percentile work RVU of 4.74. To justify this value, the RUC compared the surveyed code to CPT codes 20902 *Bone graft, any donor area; major or large* (work RVU= 4.58, intra time= 45 minutes) and 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, intra time= 45 minutes) and noted that both reference codes have identical intra-service time as the surveyed code. Therefore, the RUC agreed that the current work value of 4.74 for 43259 is accurately valued between these two reference codes. Finally, the specialty societies explained that 43259 needs to be valued greater

than 43237 *EGD with EUS limited to the esophagus* (RUC recommended work RVU= 3.85) because there is more to examine (stomach and either duodenum or surgically altered stomach) in the surveyed code. **The RUC recommends a work RVU of 4.74 for CPT code 43259.**

Practice Expense:
The practice expense for these services was a direct crosswalk to the approved practice expense for the related esophagoscopy codes approved at the October 2012 RUC meeting. At the January 2013 RUC meeting the Practice Expense Subcommittee recommended and the RUC approved the following changes to the practice expense for esophagogastroduodenoscopy and the specialty requests that the changes be applied to the esophagoscopy codes that were previously approved at the October 2012 RUC meeting.

- Addition of 3 minutes to "Prepare room, equipment, supplies" (L037D) for code 43252 (*Esophagogastroduodenoscopy; with optical endomicroscopy*) for the technician to turn on the optical endomicroscope processor unit system added to its esophagoscopy counterpart, 43206 (*Esophagoscopy, flexible, transoral; with optical endomicroscopy*)
- At the last meeting the Practice Expense Subcommittee used equipment practice expense input EQ322 *Radiofrequency generator (Angiodynamics), liver RFA* as a proxy. The specialty will identify a more appropriate RF ablation system for 43270 (*Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)*) and provide an invoice for this equipment. It should also be added to its esophagoscopy counterpart 4320X5(*Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)*) which replaced 43228
- Addition of "Instrument pack basic ($500 - $1,499)" (EQ137) for 43248 (*Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire*) added to its
  esophagoscopy counterpart 43226 (*Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire*)
  - Addition of "Pack, cleaning, surgical instruments" (SA043) for 43248 (*Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by dilation of passage of dilator(s) through esophagus over guide wire*) for cleaning the dilators added to its counterpart 43226 (*Esophagoscopy, flexible, transoral; with insertion of guide wire followed by dilation over guide wire*)

In April 2013, the RUC recommended the direct practice expense inputs for CPT codes 43237-8, 43240, 43242, 43259 and 43253 and submitted by the specialty societies and approved by the Practice Expense Subcommittee.

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

RUC Database Flag:

The RUC agreed that the low IWPUT for CPT code 43241 was anomalous in comparison to the entire family of EGD services. Additionally, the RUC agreed that CPT code 43251 has anomalous intra-service time. A 5 minute time differential between the base code 43235, 15 minutes, and 43251, 20 minutes, does not accurately account for the additional work in removing a lesion by snare technique. Therefore, a flag will be added to the database to indicate that these codes should not be used for valuation comparisons.

Endoscopic Retrograde Cholangiopancreatography (ERCP) (Tab 12)
Nicholas Nickl, MD (ASGE); Edward Bentley, MD (ASGE); Joel Brill, MD (AGA); Shivan Mehta, MD (AGA); Bruce Cameron, MD (ACG)

In September 2011, several ERCP codes were identified by CMS through the MPC List screen. In February 2013, the CPT Editorial Panel revised the entire ERCP section to include: 1) deletion of 5 codes; 2) establishment of 5 new codes; 3) new guidelines and coding instruction; and 4) revisions to ERCP, small intestine and stomal endoscopy codes. After survey of these procedures, the specialty societies noted that these ERCP procedures are not inherently performed with moderate sedation by the same physician. However, due to CMS' consistent position, at the April meeting and in multiple Medicare Physician Payment Rules, that the Agency is looking for larger bundling of services, not unbundling of services, the moderate sedation for these services will remain bundled. Therefore, the ERCP family of services will remain on Appendix G in the CPT codebook.

During the CPT 2014 cycle, the RUC reviewed all the esophagoscopy, EGD and ERCP families of codes. This provided a unique opportunity for the RUC and specialty societies to review relativity across the board for these endoscopy series of codes. As with any large review, the RUC placed the highest importance on relativity both within the immediate family and throughout the larger family of these endoscopic services. In January 2013, the RUC approved several new codes, which now bundle physician work components previously reported by separate codes into one code. These recommendations were valued using an incremental methodology. The RUC noted that this methodology was necessary for three reasons. First, given that an entire genre of services is being reviewed over two years, relativity amongst the family is critical. The potential for rank order anomalies is high considering the large amount of codes reviewed in succession. Second, CMS (then HCFA) used the incremental approach in their initial valuation of these services in 1992 and 1993. According to CMS commentary in the Federal Register for those years, the Agency established a hierarchy of work from the least to the most difficult endoscopic procedure. Following this, fixed increments were added to the base procedure. For example, "with biopsy" was valued at an increment of 0.32 RVUs and "removal of a foreign body" was valued at an increment of 1.07 RVUs. Therefore, the RUC determined that these new codes should be valued the same way endoscopic services were initially valued at the creation of the RBRVS. Finally, the RUC has established valuation of physician work through incremental intra-service work as an approved, viable alternate methodology. Apropos to this rationale, endoscopy is listed as an example of this methodology in the RUC's instructions for specialty societies developing work value recommendations.

43260 ***Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with collection of specimen(s) by brushing or washing when performed***
The RUC reviewed the survey results from 66 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time=

48 minutes and post-service time= 25 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it is too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC agreed with the specialty societies that the physician work has not changed since the last RUC valuation. Therefore, the RUC recommends the survey 25th percentile, the current value, of 5.95 work RVUs. To justify this value, the RUC compared the surveyed code to CPT codes 93458 *Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed* (work RVU= 5.85, intra time= 45 minutes) and 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* (work RVU= 6.00, intra time= 45 minutes) and noted that both reference codes have almost identical physician time components as the surveyed code. Therefore, the RUC agreed that the current work value of 5.95 for 43260 is accurately valued between these two reference codes. **The RUC recommends a work RVU of 5.95 for CPT code 43260.**

43261 ***Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple***

The RUC reviewed the survey results from 57 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 55 minutes and post-service time= 23 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it is too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents slightly overestimated the value of this code at the median level. Consistent with the previously RUC approved esophagoscopy and EGD RUC recommendations for CPT 2014, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59), and the biopsy code, 43202 (RUC recommended work RVU= 1.89), should be maintained in this biopsy ERCP code. Therefore, the established increment for the physician work related to the biopsy, 0.30 work RVUs, was added to the base ERCP diagnostic code, 43260 (recommended work RVU= 5.95), for a recommended work RVU of 6.25 for 43261. The RUC noted that while this recommended value is almost identical to the current value of 6.26, the Committee agreed to accept the incremental value to ensure consistency is maintained with the other families of endoscopic codes reviewed in the CPT 2014 cycle. To validate this value across the RBRVS, the RUC compared the surveyed code to CPT codes 58563 *Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)* (work RVU= 6.16, intra time= 60 minutes) and 36247 *Selective catheter placement, arterial system; initial third order or*

more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family (work RVU= 6.29, intra time= 60 minutes) and noted that both reference codes have almost identical physician time components as the surveyed code. Therefore, the RUC agreed that the recommended work value of 6.25 for 43261 is accurately valued between these two reference codes. **The RUC recommends a work RVU of 6.25 for CPT code 43261.**

43262 ***Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy***

The RUC reviewed the survey results from 58 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 60 minutes and post-service time= 30 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it's too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC agreed with the specialty societies that the current work value of 7.38 overstates the work involved in this procedure. To determine a more appropriate value, the RUC noted that there has previously not been an equivalent increment established for sphincterotomy in either the esophagoscopy or EGD family of services reviewed in the last two meetings. Therefore, the RUC accepted the specialty societies' recommendation of the survey 25th percentile work RVU of 6.60. To justify this value, the RUC compared 43262 to the key reference service 58560 *Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)* (work RVU= 6.99) and agreed that with identical intra-service times, 60 minutes, and analogous total time, the two services should be valued similarly. Additionally, the RUC reviewed CPT code 52343 *Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 6.55) and noted that since both services have identical intra-service time and analogous physician work, the two should be valued similarly. **The RUC recommends a work RVU of 6.60 for CPT code 43262.**

43263 ***Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi***

The RUC reviewed the survey results from 43 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 60 minutes and post-service time= 30 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it's too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC agreed with the specialty societies that the physician work involved in 43263 has not changed since the last RUC review in 2000 and should remained valued at 7.28 work RVUs. To justify this work value, the RUC compared the surveyed code to CPT codes 37212 *Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day* (work RVU= 7.06, intra time= 60 minutes) and 52240 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; LARGE bladder tumor(s)* (work

RVU= 7.50, intra time= 60 minutes) and noted that both reference codes have almost identical physician time components as the surveyed code. Therefore, the RUC agreed that the recommended work value of 7.28 for 43263 is accurately valued between these two reference codes. Finally, the RUC noted that this service has almost identical physician time compared to 43262 and 43264, but higher work RVUs than both. The specialties noted that 43263 is a more intense procedure than these two referenced services. Since the sphincter cannot be paralyzed, it is being threaded with the cannula while moving back and forth. **The RUC recommends a work RVU of 7.28 for CPT code 43263.**

43264 ***Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)***
The RUC reviewed the survey results from 54 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 60 minutes and post-service time= 28 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it's too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC agreed with the specialty societies that the current work value of 8.89 overstates the work involved in this procedure. To determine a more appropriate value, the RUC first noted that there is currently no equivalent established increment in either the esophagoscopy or EGD families of services for this procedure. Therefore, the RUC agreed that the 25th percentile work RVU of 6.73 accurately values the physician work involved in 43264. To justify this value, the RUC compared the surveyed code to CPT codes 37197 *Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed* (work RVU= 6.29, intra time= 60 minutes) and 52343 *Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 6.55, intra time= 60 minutes) and agreed that since both references codes have identical intra-service time and comparable total times to the surveyed, the recommended value of 6.73 for CPT code 43264 is relative to these similar services. **The RUC recommends a work RVU of 6.73 for CPT code 43264.**

43265 ***Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)***
The RUC reviewed the survey results from 52 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 78 minutes and post-service time= 28 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it's too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC agreed with the specialty societies that the current work value of 10.00 overstates the work involved in this procedure. To determine a more appropriate value, the RUC first noted that there is currently no equivalent established increment in either

the esophagoscopy or EGD families of services for this procedure. Therefore, the RUC agreed that the 25th percentile work RVU of 8.03 accurately values the physician work involved in 43265. To justify this value, the RUC compared the surveyed code to CPT code 37183 *Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated imaging guidance and documentation)* (work RVU= 7.99, intra time= 77.5 minutes) and agreed that while the two services nearly identical intra-service time, 43265 has greater total time compared to the reference code and is correctly valued higher. Additionally, CPT code 37224 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty* (work RVU= 9.00) was reviewed and the Committee noted that the reference code has two additional minutes of intra-service time and is slightly more intense than 43265 and should therefore be valued higher. **The RUC recommends a work RVU of 8.03 for CPT code 43265.**

43274 ***Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent***

The RUC reviewed the survey results from 50 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 68 minutes and post-service time= 23 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it's too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the median value of 10.00 work RVUs overestimates the physician work involved in this service. To determine an appropriate value, the RUC agreed to apply the incremental methodology to ensure this new, bundled service is correctly valued in comparison to the individual components codes previously valued in the equivalent endoscopic families.

The RUC noted that 43274 now bundles in the physician work to perform sphincterotomy and placement of an endoscopic stent. Therefore, the incremental methodology for this procedure consists of adding the following elements:

- The base ERCP code (43260, RUC recommended work RVU= 5.95)
- The established increment of a sphincterotomy = 0.65 (43262, RUC recommended work RVU= 6.60 – 43260, RUC recommended work RVU= 5.95) = 0.65
- The established increment of placement of an endoscopic stent = 2.14 (4320X4, RUC recommended work RVU= 3.73 – 43200, RUC recommended work RVU= 1.59) = 2.14

Taking the above work RVUs, as laid out, the RUC determined a work RVU of 8.74 (5.95 + 0.65 + 2.14) accurately values the work of this bundled service relative to the individual component endoscopic codes, previously valued by the RUC. To validate this work RVU, the RUC compared the surveyed code to CPT codes 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, intra time= 68 minutes) 58561 *Hysteroscopy, surgical; with removal of leiomyomata* (work RVU= 9.99, intra time= 75 minutes) and agreed that with similar intra-service time and comparable physician work, 43274 is accurately valued between these reference codes. **The RUC recommends a work RVU of 8.74 for CPT code 43274.**

43275 ***Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)***
The RUC reviewed the survey results from 49 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 50 minutes and post-service time= 20 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it's too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC reviewed the estimated work values and agreed with the specialty societies that the survey respondents slightly overestimated the value of this code at the median level. Consistent with the esophagoscopy and EGD RUC recommendations for CPT 2014, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59), and the foreign body removal code, 43215 (RUC recommended work RVU= 2.60), should be maintained in this foreign body removal ERCP code. Therefore, the established increment for the physician work related to the biopsy, 1.01 work RVUs, was added to the base ERCP diagnostic code, 43260 (recommended work RVU= 5.95), for a recommended work RVU of 6.96 for 43275. To validate this work value across the RBRVS, the RUC compared the surveyed code to CPT codes 93457 *Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization* (work RVU= 6.89, intra time= 50 minutes) and 36252 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral* (work RVU= 6.99, intra time= 53 minutes) and agreed that with similar intra-service time and comparable physician work, 43275 is accurately valued in between these reference codes. **The RUC recommends a work RVU of 6.96 for CPT code 43275.**

43276 ***Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged***

The RUC reviewed the survey results from 48 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 60 minutes and post-service time= 25 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it's too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the median value of 9.88 work RVUs overestimates the physician work involved in this service. To determine an appropriate value, the RUC agreed to apply the incremental methodology to ensure this new, bundled service is correctly valued in comparison to the individual components codes previously valued in the equivalent endoscopic families.

The RUC noted that 43276 now bundles in the physician work to perform removal of a foreign body and placement of a stent. Therefore, the incremental methodology for this procedure consists of adding the following elements:

- The base ERCP code (43260, RUC recommended work RVU= 5.95);
- The established increment of a removal of foreign body = 1.01 (43215, RUC recommended work RVU= 2.60 – 43200, RUC recommended work RVU= 1.59) = 1.01
- The established increment of placement of an endoscopic stent = 2.14 (4320X4, RUC recommended work RVU= 3.73 – 43200, RUC recommended work RVU= 1.59) = 2.14

Taking the above work RVUs, as laid out, the RUC determined a work RVU of 9.10 (5.95 + 1.01 + 2.14) accurately values the work of this bundled service relative to the individual component endoscopic codes, previously valued by the RUC. The specialty societies noted that the physician work of performing the sphincterotomy is not included because it is typically performed during the initial stent placement and during the subsequent removal or exchange. To validate this work RVU, the RUC compared the surveyed code to CPT codes 52346 *Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 8.58, intra time= 60 minutes) and 92920 *Percutaneous transluminal coronary angioplasty; single major coronary artery or branch* (work RVU= 10.10, intra time= 68 minutes) and agreed that with similar intra-service time and comparable physician work, 43276 is accurately valued in between these reference codes. Finally, the RUC discussed whether or not there is overlap in the work taking out and replacing the stent. The specialties explained that the work is truly sequential for both procedures and there is no overlap when done concomitantly. There is also no concern that the work of finding the ampulla is captured in both procedures, as the ampulla is found immediately. **The RUC recommends a work RVU of 9.10 for CPT code 43276.**

43277 ***Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct***

The RUC reviewed the survey results from 47 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 70 minutes and post-service time= 25 minutes. The RUC agreed with the specialty

societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it's too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the median value of 10.00 work RVUs overestimates the physician work involved in this service. To determine an appropriate value, the RUC agreed to apply the incremental methodology to ensure this new, bundled service is correctly valued in comparison to the individual components codes previously valued in the equivalent endoscopic families.

The RUC noted that 43277 now bundles in the physician work to perform balloon dilation and a sphincterotomy. Therefore, the incremental methodology for this procedure consists of adding the following elements:

- The base ERCP code (43260, RUC recommended work RVU= 5.95);
- The established increment of balloon dilation = 0.51 (43220, RUC recommended work RVU= 2.10 – 43200, RUC recommended work RVU= 1.59) = 0.51
- The established increment of a sphincterotomy = 0.65 (43262, RUC recommended work RVU= 6.60 – 43260, RUC recommended work RVU= 5.95) = 0.65

Taking the above work RVUs, as laid out, the RUC determined a work RVU of 7.11 (5.95 + 0.51 + 0.65) accurately values the work of this bundled service relative to the individual component endoscopic codes, previously valued by the RUC. To validate this work RVU, the RUC compared the surveyed code to CPT codes 20555 *Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)* (work RVU= 6.00, intra time= 70 minutes) and 31276 *Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus* (work RVU= 8.84, intra time= 75 minutes) and agreed that with similar intra-service time and comparable physician work, 43277 is accurately valued in between these reference codes. **The RUC recommends a work RVU of 7.11 for CPT code 43277.**

43278 ***Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed***

The RUC reviewed the survey results from 40 gastroenterologists and recommends the following physician time components: pre-service time= 48 minutes, intra-service time= 75 minutes and post-service time= 30 minutes. The RUC agreed with the specialty societies that an additional 9 minutes of pre-service positioning is warranted. Patients will receive sedation next to the gantry because it's too narrow. Patients are then rolled over onto the fluoroscopic table and placed into the semi-prone position. Additionally, time is needed to strap the patient down and move equipment into place after the patient is properly positioned.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the 25th percentile value of 8.38 work RVUs overestimates the physician work involved in this service. To determine an appropriate

value, the RUC agreed to apply the incremental methodology to ensure this new, bundled service is correctly valued in comparison to the individual components codes previously valued in the equivalent endoscopic families. Consistent with the esophagoscopy and EGD RUC recommendations for CPT 2014, the RUC noted that the identical increment between the esophagoscopy base code, 43200 (recommended work RVU= 1.59), and the ablation code, 4320X5 (recommended work RVU= 3.72), should be maintained in this foreign body removal ERCP code. Therefore, the established increment for the physician work related to the ablation, 2.13 work RVUs, was added to the base ERCP diagnostic code, 43260 (recommended work RVU= 5.95), for a recommended work RVU of 8.08 for 43278. To validate this work value across the RBRVS, the RUC compared the surveyed code to CPT codes 37183 *Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated imaging guidance and documentation)* (work RVU= 7.99, intra time= 77.5 minutes) and 31276 *Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus* (work RVU= 8.84, intra time= 75 minutes) and agreed that with similar intra-service time and comparable physician work, 43278 is accurately valued in between these reference codes. **The RUC recommends a work RVU of 8.08 for CPT code 43278.**

43273 ***Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s)***

The RUC reviewed the survey results from 47 gastroenterologists and recommends 30 minutes of intra-service time for this add-on code. The RUC agreed with the specialty societies that the physician work for this service has not changed. The RUC recommends the current work RVU of 2.24 for 43273, which is below the survey 25th percentile. To validate this work value, the RUC compared the surveyed code to add-on codes 43338 *Esophageal lengthening procedure* (eg, Collis gastroplasty or wedge gastroplasty) (work RVU= 2.21) and 49327 *Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple* (work RVU= 2.38) and noted that all three codes have identical intra-service time, 30 minutes, and comparable physician work. Therefore, the RUC agreed that the recommended work value, in between these two services, is appropriate for CPT code 43273. Finally, the RUC noted that when this code was last reviewed as a new code in 2009, the median intra-service time was 45 minutes. However, review of the recommendation at that time reveals that the survey produced a much higher work RVU for this procedure. Since pre and post time were inadvertently collected in the ZZZ global survey, the RUC reduced the work value to account for the removal of pre- and post-service minutes. The survey results were also complicated by the fact that 000-day global codes were included on the reference list and this was followed by the RUC using a 000-day reference code for a diagnostic esophagoscopy as comparison for the calculated value. Given the history of the previous valuation, the median intra-service time of 30 minutes is a more accurate depiction of this procedure compared to the previous survey. **The RUC recommends a work RVU of 2.24 for CPT code 43273.**

Practice Expense:

The RUC recommends the direct practice expense for these facility-based procedures as submitted by the specialty societies and approved by the Practice Expense Subcommittee.

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

Cystourethroscopy (Tab 13)
James Giblin, MD (AUA); Richard Gilbert, MD (AUA); William Gee, MD (AUA)

In September 2011, the Relativity Assessment Workgroup identified CPT codes 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)* and 52332 *Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)* as part of the Codes Reported Together 75% or More screen and recommended a bundled code solution. In February 2013, the CPT Editorial Panel established a bundled code, 52356 *Cystourethroscopy, with lithotripsy including insertion if indwelling ureteral stent (eg, Gibbons or double-J type)* to combine the services described by CPT codes 52353 and 52332.

52332 ***Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)***
The RUC reviewed the recommendations from April 2010 for CPT code 52332 and agreed to reaffirm the current value, as it maintains relativity for this family of services. In April 2010, the RUC reviewed the survey responses from 39 urologists for code 52332 and agreed with the specialty society that there is no compelling evidence that the work for this service has changed. For additional support, the RUC also compared this service to CPT codes 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU = 2.86 and 30 minutes pre-service time, 20 minutes intra-service time and 10 minutes immediate post-service time) and 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU = 2.70 and 25 minutes pre-service time, 20 minutes intra-service time and 15 minutes immediate post-service time) which require similar physician time, intensity and complexity. **The RUC recommends reaffirming the current work RVU of 2.82 for CPT code 52332.**

52353 ***Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)***
The RUC reviewed the recommendations from October 2011 for CPT code 52353 and agreed to reaffirm the current value, as it maintains relativity for this family of services. In October 2011, the RUC reviewed the survey results from 86 urologists for CPT code 52353 and agreed that the survey respondents accurately estimated the physician work. The RUC noted that for the 2012 Physician Fee Schedule, CMS reduced the RVU from 7.88 to 7.50 work RVUs. **The RUC recommends reaffirming the current work RVU of 7.50 for CPT code 52353.**

52356 ***Cystourethroscopy, with lithotripsy including insertion if indwelling ureteral stent (eg, Gibbons or double-J type)***
The RUC reviewed the survey results from 153 urologists and determined that a work RVU of 8.00, the survey 25th percentile appropriately accounts for the physician work to perform this service. The RUC noted that this service is not separately reported with fluoroscopy. There was consensus among the RUC that the following physician time components are appropriate: pre-time of 53 minutes, intra service time of 60 minutes and post service time of 20 minutes. The RUC also agreed that an additional 2 minutes is appropriate to place the patient in a dorsal lithotomy position. The committee reviewed

key reference code 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* (work RVU=6.75) and agreed that 52356 requires more physician time, 45 minutes and 60 minutes intra-service time, respectively, and was rated higher by the survey respondents on all intensity and complexity measures. Therefore, 52356 requires more physician work than 52352. The RUC also reviewed 52346 *Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU=8.58) and noted that although these two services require similar physician work, the intensity of 52346 is greater. **The RUC recommends a work RVU of 8.00, the survey 25th percentile for CPT code 52356.**

Practice Expense:
The RUC accepted the direct PE inputs with minor modifications as recommended by the PE 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.

Insertion of Anterior Segment Device (Tab 14)
Stephen Kamenetzky, MD (AAO); Greg Kwasny, MD (AAO)

In October 2012, the CPT Editorial Panel approved to convert category III code, 0192T *Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach* to a category I code, 66183 due to widespread use and adequate published peer reviewed articles supporting the safety and effectiveness of the procedure.

66183 ***Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach***
In January 2013, the RUC recommended postponement until the April 2013 RUC meeting to allow the specialty society sufficient time to ensure that the post-operative visits were appropriately estimated. At the April 2013 RUC meeting, it was confirmed that post-operative visits were accurately calculated and that 70% of the physician work is captured in the post-operative visits. The RUC noted that patients with glaucoma undergoing this procedure require intense care for the entire 090-day global period, above any other ophthalmological service. The patient is in danger of further visual loss due to the intraocular pressure which the physician must frequently monitor. In addition, this procedure creates a fistula which must remain open after healing is complete. Closure of the fistula can occur throughout the entire 090-day global period and requires constant management of the patient. The RUC had a robust discussion regarding number of post-operative office visits and agreed that 8 visits: (3) 99212 and (5) 99213, the survey mode, rather than 9 visits, the survey median: (3) 99212 and (6) 99213 with the reduction of one office visit is more appropriate. To validate the number of visits, the RUC compared 66183 to CPT code 66174 *Transluminal dilation of aqueous outflow canal; without retention of device or stent* (work RVU=12.85) which was reviewed at the April 2010 RUC meeting and include 6 post-operative visits, (2) 99212 and (4) 99213. The RUC agreed that 66183 is a more intense procedure than 66174 and requires additional monitoring.

The RUC reviewed the survey results from 56 ophthalmologists and determined that a work RVU of 13.20, the survey 25th percentile is appropriate. The RUC compared 66183

to key reference code 65756 *Keratoplasty (corneal transplant); endothelial* (work RVU=16.84) and agreed that since 65756 requires 15 minutes more intra-service time, it should be valued higher. The RUC also reviewed 65850 *Trabeculotomy ab externo* (work RVU=11.39) and determined that the 66183 requires less intra-service time, but is more intense and complex to perform. **The RUC recommends a work RVU of 13.20, the survey 25th percentile for CPT code 66183.**

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

New Technology
CPT code 66183 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.

Mechanical Chest Wall Oscillations-PE Only (Tab 15)
Alan Plummer, MD (ATS), Burt Lesnick, MD (ACCP)

In February 2013 the CPT Editorial Panel created new CPT code 94669 Mechanical chest wall oscillation to facilitate lung function per session. In April 2013, the RUC reviewed the practice expense for the new code as well as the other codes in the family of services, CPT codes 94667 Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation and 94668 Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent. This family of services does not include physician work. The PE Subcommittee reviewed the practice expense inputs and noted that the PE Summary of Recommendation states that, "typically, after 30 minutes the machine is powered off and the vest or chest wrap is removed from the patient's chest." Practice expense inputs were revised to align with the 30 minutes of therapist intra-service time typical for CPT code 94669. The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.

Ultrasonic Wound Assessment (Tab 16)
Seth Rubenstein, DPM (APMA) Stephen Levine, PT, DPT (APTA) Jay Gregory, MD, FACS (ASGS)

In February 2013, the CPT Editorial Panel converted Category III code 0183T to a Category I code to report ultrasound wound assessment for low frequency, non-contact, non thermal ultrasound.

The American Podiatric Medical Association (APMA), American Physical Therapy Association (APTA) and American Society of General Surgeons (ASGS) conducted a RUC survey and received an inadequate number of survey responses. The specialty societies noted a wide variation in the survey intra-service time and determined that this was most likely the result of surveying a code and vignette that does not describe a typical wound size, thereby allowing survey respondents to consider whatever their personal typical patient would be. The specialty societies requested and the RUC agreed that this service be carrier priced for CPT 2014. The specialty societies will submit a coding proposal to describe two codes that differentiate the wound size and clearly indicate that the size reported is the total for all wounds treated.

The RUC recommends that CPT code 97610 be carrier priced for CPT 2014 and refers this issue to the CPT Editorial Panel.

Please note that a presenter from ASGS violated the RUC confidentiality policy and withdrew participation after being notified of the breach. Doctor Levy noted that this presenter will not participate in the presentation/discussion of this code at this meeting or in the future.

XI. CMS Request – CMS High Expenditure Procedure Codes/Other Screens

Destruction of Premalignant Lesions (Tab 17)
Brett Coldiron, MD (AAD); Michael Bigby, MD (AAD); Bruce Deitchman, MD (AAD); Mark Kaufman, MD, (AAD); Mollie MacCormack, M.D (AAD)
Facilitation Committee #2

CPT code 17004 was identified through the CMS High Expenditure Procedural Codes screen. The RUC recommended to survey for physician work and review practice expense for this family of services at the January 2013 RUC meeting. In January 2013, the RUC reviewed the survey results for these services and agreed with the specialty society that there may have been confusion among the survey respondents. Specifically, for CPT code 17004, the surveyed time may not have accurately reflected the physician work to treat the typical number of lesions (15 or more). The RUC recommended that the specialty society consider adding a question to the survey instrument to determine the typical number of lesions for this code. The specialty society submitted a request to withdraw the issue and resurvey for the April 2013 RUC meeting which was approved.

17000, ***Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion***
The RUC reviewed survey results from 232 dermatologists and determined that a work RVU of 0.61, less than the survey 25th percentile appropriately accounts for the physician work to perform this service. The RUC noted that 17000 is reported with 17003, *Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)* 72% of the time. Therefore, multiple lesions are typically treated. The RUC questioned whether or not an office visit was typically reported within the global period for this procedure. The specialty society noted that the survey instrument was revised to confirm whether or not an office visit was performed specifically in the 010-day global period. The survey respondents indicated that 70% of the time, an office visit is indeed performed. The specialty societies determined, and the RUC agreed, that the current work RVU of 0.65 overstated physician work, especially since this procedure is typically reported with an Evaluation and Management (E/M) service on the same date. In addition, the day of procedure time was reduced in this survey to 7 minutes from 9 minutes in the 2005 RUC survey. The specialty society appropriately reduced the work RVU to 0.61 to account for this difference using magnitude estimation. The RUC compared this service to similar service, 88302 *Level II - Surgical pathology, gross and microscopic examination Appendix, incidental Fallopian tube, sterilization Fingers/toes, amputation, traumatic Foreskin, newborn Hernia sac, any location Hydrocele sac Nerve Skin, plastic repair Sympathetic ganglion Testis, castration Vaginal mucosa, incidental Vas deferens, sterilization* (work RVU=0.13 and 11 minutes intra-service time) and 73140 *Radiologic*

examination, finger(s), minimum of 2 views (work RVU=0.13 and 4 minutes intra-service time) and added the typical 99212 office visit (work RVU=0.48) that is included in the global period, which results in a work RVU of 0.61. For additional support, the RUC also reviewed service 95018 *Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests* (work RVU=0.14 and intra time=2 minutes,) and added a 99212 office visit (work RVU=0.48) resulting in a work RVU of 0.62. **Therefore, the RUC recommends a work RVU of 0.61 for CPT code 17000.**

17003, *Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)*
The RUC reviewed survey results from 232 dermatologists and determined that a work RVU of 0.04, less than the survey 25th percentile appropriately accounts for the physician work for this procedure. The RUC noted that 17000 is reported with 17003 72% of the time. In addition, this service is typically reported with an Evaluation and Management (E/M) service. The RUC noted that the current intra-service time for this service is 2 minutes. The survey respondents indicated a median intra-service time of 1 minute. Since there was a 50% reduction in time, the RUC recommended reducing the work. Therefore, a 50% reduction in work RVU from current value of 0.07 equals 0.04. To further support this value, the RUC reviewed CPT code 95017 *Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests* (work RVU=0.07 and total time =1.86 minutes) which equates to 0.038 RVU per 1 minute. **The RUC recommends a work RVU of 0.04 for CPT code 17003.**

17004, *Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions*
The RUC reviewed survey results from 232 dermatologists and determined that a work RVU of 1.37, a direct cross walk to CPT code 17270 *Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less* (work RVU=1.37) appropriately accounts for the physician work required to perform this service. Although, CPT code 17004 requires less pre service time compared to 17270, the RUC agreed this was acceptable since 17004 is typically reported with an Evaluation and Management (E/M) service. Additionally, the results of the survey from the specialty society suggested that the typical number of lesions treated is 20. Treating 20 lesions using the values for 17000 and 17003 would result in 0.61 + (0.04 x 19) = 1.37. The RUC also compared 17004 to key reference code 17282 *Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm* (work RVU=2.09) and agreed that the treatment of malignant lesions is a more intense service requiring more physician work and therefore, should be valued higher. **The RUC recommends a work RVU of 1.37 for CPT code 17004.**

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 confirmed that the use of a camera is typical in this procedure and reaffirmed the practice expense inputs reviewed at the January RUC meeting.

Mohs Surgery (Tab 18)
Brett Coldiron, MD (AAD); John Zitelli, MD (ACR); Glenn Goldman, MD (ACMS); Bruce Deitchman, MD (AAD)

CPT codes 17311 and 17312 were identified through the CMS High Expenditure Procedural Codes screen. In January 2012, the RUC recommended the specialty society survey physician work and review practice expense for this family of services at the April 2013 RUC meeting.

The RUC reviewed the Mohs surgery CPT codes 17311-17315 survey results and noted that the survey 25th percentile work RVUs were all above the current work RVU. The specialty society indicated and the RUC agreed that there was not compelling evidence to increase these services at this time. Therefore, the RUC recommends maintaining the current work RVU for each code in this family of services.

The specialty society indicated that the typical Mohs surgeon will see 2-4 patients a day, one patient coming in after another and staggering care. The time included in these services does not count the time a patient may be waiting for the physician or waiting for the histologic tissue processing.

17311 ***Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks***
The RUC reviewed the survey results from 249 dermatologists (mohs surgeons) and determined that the current work RVU of 6.20 appropriately accounts for the physician work required to perform this service. The RUC noted that the survey intra-service time is the same as the current time. The RUC recommends maintaining the current physician time with a reallocation of the pre-time to 14 minutes pre-evaluation, 1 minute positioning and 5 minutes scrub/dress/wait pre-service time to align more to the pre-time packages. The RUC noted that in preparation of the reference service list, the specialty society was allowed to place 010 and 090-day global period codes adjusted with the post-operative visits removed in order to provide reference services with relative work RVUs for the survey respondents. Otherwise the 000-day and ZZZ global period codes would not provide adequate comparisons and would skew the survey results.

The RUC compared 17311 to key reference code 15260 *Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less* (global adjusted work RVU = 6.79 and 100 minutes intra-service time) and similar service 11646 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm* (global adjusted work RVU= 5.29 and 65 minutes intra-service time) and determined that maintaining the current work RVU of 6.20 for 17311 maintains the appropriate relativity among other services. CPT code 15260 requires slightly less intra-service, 100 minutes versus 115 minutes, respectively, but is

more intense and complex to perform. **The RUC recommends a work RVU of 6.20 for CPT code 17311.**

17312 ***Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 249 dermatologists (mohs surgeons) and determined that the current work RVU of 3.30 appropriately accounts for the physician work required to perform this service. The RUC noted that the survey intra-service time is the same as the current time. The RUC recommends maintaining the current physician time with reallocation of the pre-time to 2 minutes pre-evaluation, 1 minute positioning and 5 minutes scrub/dress/wait pre-service time. The RUC confirmed the additional 8 minutes of pre-time is appropriate for this add-on service because the patient must go back and undress again, be re-gowned, prepped, draped, re-anesthetized and given the pathology results. Subsequently, there is additional direct practice expense time where the clinical staff must account for additional cleaning.

The RUC compared 17312 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 determined that the key reference code requires 10 more minutes of physician work and is therefore appropriately valued higher. **The RUC recommends a work RVU 3.30 for CPT code 17312.**

17313 ***Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks***
The RUC reviewed the survey results from 249 dermatologists (mohs surgeons) and determined that the current work RVU of 5.56 appropriately accounts for the physician work required to perform this service. The RUC noted that the survey intra-service time is the same as the current time. The RUC recommends maintaining the current physician time with a reallocation of the pre-time to 14 minutes pre-evaluation, 1 minute positioning and 5 minutes scrub/dress/wait pre-service time to align closer to the pre-time package

The RUC compared 17313 to key reference code 15260 *Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less* (global adjusted work RVU = 6.79 and 100 minutes intra-service time) and similar service 11646 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm* (global adjusted work RVU= 5.29 and 65 minutes intra-service time) and determined that maintaining the current work RVU of 5.56 for 17313 maintains the appropriate relativity among other services. CPT code 15260 requires the same intra-service time of 100 minutes as the surveyed code, but is more intense and complex to perform. Additionally, the RUC noted that this mohs surgery service is appropriately less, relative to code 17311, mohs surgery to the face, which is a

more intense service and requires slightly more time. **The RUC recommends a work RVU of 5.56 for CPT code 17313.**

17314 ***Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 249 dermatologists (mohs surgeons) and determined that the current work RVU of 3.06 appropriately accounts for the physician work required to perform this service. The RUC noted that the survey intra-service time is the same as the current time. The RUC recommends maintaining the current physician time with reallocation of the pre-time to 2 minutes pre-evaluation, 1 minute positioning and 5 minutes scrub/dress/wait pre-service time. The RUC confirmed the additional 8 minutes of pre-time is appropriate for this add-on service because the patient must go back and undress again, be re-gowned, prepped, draped, re-anesthetized and given the pathology results. Subsequently, there is additional direct practice expense time where the clinical staff must account for additional cleaning.

The RUC compared 17314 to 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 determined that the key reference code requires 10 more minutes of physician work, and is therefore appropriately valued higher. The RUC also noted that this mohs surgery service is appropriately less, relative to code 17312, mohs surgery to the face, which is a more intense service and requires slightly more time. **The RUC recommends a work RVU 3.06 for CPT code 17314.**

17315 ***Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 249 dermatologists (mohs surgeons) and determined that the current work RVU of 0.87 appropriately accounts for the physician work required to perform this service. The RUC noted that the survey intra-service time is the same as the current time. The RUC confirmed the intra-service time of 30 minutes is appropriate as the patient typically has a large lesion, requiring not only a pathology block, but also a surgical component. This service is rare, as 1 in 100 mohs surgery cases require it to be performed.

The RUC compared 17315 to key reference code 13102 *Repair, complex, trunk; each additional 5 cm or less (List separately in addition to code for primary procedure)* (work RVU = 1.24) and determined that these services require the same time, but 13102 is more intense and complex. Therefore, maintaining the current work RVU of 0.87 for 17315 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 0.87 for CPT code 17315.**

Practice Expense

The RUC noted that there was an error in the prior direct practice expense inputs and therefore compelling evidence existed to increase the clinical staff time by 15 minutes in codes 17311-17314 and 2 minutes in code 17215 for the Histotechnologist (L037B) to clean (line 49). Additionally supply input *slide, microscope* (SL122) has been replaced with a new type of slide, *Slide, charged,* that currently is not listed as a 2013 CMS direct PE input. An invoice is included in this submission. The RUC recommends the direct practice expense inputs with modifications as approved by the Practice Expense Subcommittee.

Nasal/Sinus Endoscopy (Tab 19)
Wayne Koch, MD (AAO-HNS); Jane Dillon, MD (AAO-HNS)

CPT code 31237*Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)* was identified through the CMS High Expenditure Procedural Codes screen. The RUC recommended survey of physician work and review of practice expense for this family of services at the April 2013 RUC meeting.

31237 ***Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)***
The RUC reviewed the survey results from 153 otolaryngologists and agreed with the specialty on the following physician time components: 23 minutes of pre-service time, 20 minutes of intra-service time and 5 minutes of immediate post-service time.

The RUC reviewed the survey data and agreed that current work RVU of 2.98 no longer accurately reflects the physician work involved in this service. Specifically, the RUC noted the decrease in intra-service time from the previous survey performed in 1993. Given this, the RUC agreed with the specialty society that the 25th percentile survey value of 2.60 accurately accounts for the work to perform 31237. To justify this value, the RUC reviewed MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU= 2.70) and noted that both services have identical intra-service time, 20 minutes; however, the reference code has 12 additional minutes of total time and is therefore properly valued slightly higher than the surveyed code. In addition, the RUC compared code 31237 to CPT code 57454 *Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage* (work RVU= 2.33) and agreed that while both procedures have identical intra-service time, the surveyed code should be valued higher due to greater total time and increased intensity compared to 57454. **The RUC recommends a work RVU of 2.60 for CPT code 31237.**

31238 ***Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage***
The RUC reviewed the survey results from 132 otolaryngologists and agreed with the specialty on the following physician time components: 18 minutes of pre-service time, 25 minutes of intra-service time and 10 minutes of immediate post-service time. These recommended pre- and post-service times reflect a reduction of 5 minutes in each category to account for any potential overlap of physician work between the endoscopy service and an Evaluation and Management service that is typically performed on the same date of service.

The RUC reviewed the survey data and agreed that the current work RVU of 3.26 no longer accurately reflects the physician work involved in this service. As with the survey data for 31237, the median intra-service time is lower than the last RUC survey performed in 1993. Given this, the RUC agreed with the specialty society that the 25th

percentile survey value of 2.74 accurately accounts for the work of 31238. To justify this value, the RUC reviewed the key reference code 31296 *Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)* (work RVU= 3.29) and noted that the reference code has 5 additional minutes of intra-service time and greater total time compared to the surveyed code. Therefore, the reference code is accurately valued higher than 31238. In addition, the RUC reviewed codes 57460 *Colposcopy of the cervix including upper/adjacent vagina; with loop electrode biopsy(s) of the cervix* (work RVU= 2.83) and 52204 *Cystourethroscopy, with biopsy(s)* (work RVU= 2.59) and agreed that since both codes have identical intra-service time, 25 minutes, compared to the surveyed code, 31238 is appropriately valued between these services. **The RUC recommends a work RVU of 2.74 for CPT code 31238.**

31239 ***Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy***
The RUC reviewed the survey results from 105 otolaryngologists and ophthalmologists and agreed with the specialties on the following physician time components: 46 minutes of pre-service time, 60 minutes of intra-service time and 20 minutes of immediate post-service time. The RUC also agreed with the following post-operative visits for this 010 day global code: one 99213 and one-half day discharge management service, 99238. The RUC noted that while the survey respondents did not indicate a discharge management service was typical, there was consensus that the physician work of detailing to the patient the post-operative care instructions and prescriptions, preparing the operative report and scheduling the follow-up visit is necessary physician work and should be captured in a discharge management code.

The RUC reviewed the survey data and agreed that the current work RVU of 9.33 no longer accurately reflects the physician work involved in this service. The RUC again noted that the surveyed median intra-service time is lower than the last RUC survey performed in 1994, 60 minutes versus 90 minutes. To determine an appropriate value, the RUC compared the surveyed code to CPT code 22523 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic* (work RVU= 9.04) and agreed that both codes have almost identical intra-service time, 58 minutes compared to 60 minutes, and similar total time. Therefore, the RUC agreed to directly crosswalk the physician work of 22523 to the surveyed code, 31239. To justify a work RVU of 9.04, the RUC compared the surveyed code to MPC code 22520 *Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic* (work RVU= 9.22) and agreed that since the reference code has slightly greater total time and is a more intense procedure, it is appropriately valued slightly higher than 31239. Finally, the RUC validated the crosswalk by noting that the recommended post-operative visits contain one less 99213 and the addition of a half-day discharge code compared to the current time for this code. By subtracting out the work of a 99213 (0.97) and adding in the work of a half-day discharge (0.64) to the current work RVU (9.33) the resulting value (9.00) is almost identical to the recommended value of 9.04. **The RUC recommends a work RVU of 9.04 for CPT code 31239.**

31240 ***Nasal/sinus endoscopy, surgical; with concha bullosa resection***
The RUC reviewed the survey results from 125 otolaryngologists and agreed with the specialty on the following physician time components: 38 minutes of pre-service time, 20 minutes of intra-service time and 15 minutes of immediate post-service time.

The RUC reviewed the survey respondent's estimated physician work values and agreed that the current work value of 2.61, almost identical to the 25th percentile value (2.64), remains appropriate for this code. The RUC noted that the median intra-service time is reduced from the last survey performed in 1993, 20 minutes versus 30 minutes. However, it appears that in 1993 the RUC recommended a much higher value (4.00) for this procedure, but CMS (then HCFA) rejected this recommendation by lowering the value for the services in this family by 33 percent. This arbitrary reduction was justified by the Agency, noting that the intensities would have been too high based on the RUC recommendations at the time. Given how these services were previously considered by the RUC, the RUC agreed that the current value, properly valued relative to the other codes in this family of services, is appropriate. Further justification was gained by comparing the surveyed code to key reference code 31295 *Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa* (work RVU= 2.70). The RUC noted that since both codes have identical intra-service time and analogous total time, the two codes should be valued similarly. Finally, CPT code 36555 *Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age* (work RVU= 2.68) was compared to code 31240 and since both codes have identical intra-service time, they should be valued simiarly. **The RUC recommends a work RVU of 2.61 for CPT code 31240.**

Practice Expense:
The PE Subcommittee determined that the equipment time needed to be recalculated to comply with the CMS definition of appropriate allocation of equipment time. This resulted in removing 15 minutes of equipment time for each of the three scopes included in this procedure. The RUC noted that the specialty did not agree with this decision, stating that staff observes the patient for recurrent bleeding and if bleeding occurs the scopes need to be available in the room and therefore cannot be used by other patients. However, the RUC agreed that the 15 minutes of patient monitoring should be removed from all the equipment time to comply with CMS standards. The Chair noted that a PE Subcommittee workgroup is going to be established to review monitoring time issues. The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.

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

Implantation and Removal of Patient Activated Cardiac Event Recorder (Tab 20)
Richard Wright, MD (ACC); Amit Shanker, MD (ACC); Mark Schoenfeld, MD (HRS); David Slotwiner, MD (HRS)

In the Final Rule for the 2013 Medicare Fee Schedule, a request was made to review CPT codes 33282 Implantation of patient-activated cardiac event recorder and 33284 Removal of an implantable, patient-activated cardiac event recorder in the non-facility setting. CMS was asked to establish appropriate non-facility PE RVUs for these services. CMS acknowledged that the Agency received very few Medicare claims for these services in the non-facility setting; nonetheless, the Agency believed it was appropriate to consider the relative resources involved in furnishing these services in the non-facility setting. CMS reiterated that the valuation of a service under the PFS in a particular setting does not address whether those services and the setting in which they are furnished are medically reasonable and necessary for a patient's medical needs and condition. CMS

proposed to review CPT codes 33282 and 33284 and requested recommendations from the RUC and other public commenters on the appropriate physician work RVUs (as measured by time and intensity), and facility and non-facility direct PE inputs for these services. The RUC reviewed the survey data and confirmed that these procedures are typically performed in a hospital under moderate sedation.

33282 ***Implantation of patient-activated cardiac event recorder***
The RUC reviewed the survey results from 36 electrophysiologists and agreed that a work RVU of 3.50, the survey 25th percentile is appropriate for this procedure. The RUC noted that this value is a reduction from the current work RVU of 4.80. The RUC reviewed key reference code 33212 *Insertion of pacemaker pulse generator only; with existing single lead* (work RVU=5.26) and determined that 33212 requires 20 minutes more intra-service time and is a more complex procedure requiring more physician work, therefore it should be valued higher. The RUC also compared 33282 to CPT codes 20102 *Exploration of penetrating wound (separate procedure); abdomen/flank/back* (work RVU=3.98) and 64633 *Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint* (work RVU=3.84) and agreed that both reference codes require more physician time and work to perform compared to the surveyed code. **The RUC recommends a work RVU of 3.50 for CPT code 33282.**

33284 ***Removal of an implantable, patient-activated cardiac event recorder***
The RUC reviewed the survey results from 36 electrophysiologists and agreed that a work RVU of 3.00, the survey 25th percentile is appropriate for this procedure. The RUC noted that this value is lower than the current work RVU of 3.14. To support this value, the RUC reviewed key reference code 33233 *Removal of permanent pacemaker pulse generator only* (work RVU=3.39) and determined that since this is a more complex procedure requiring more physician work, it should be valued higher. The RUC also compared 33284 to CPT code 46945 *Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group* (work RVU=2.21) and agreed that 33284 required more physician work and complexity. **The RUC recommends a work RVU of 3.00 for CPT code 33284.**

Practice Expense
The RUC accepted the direct PE inputs with minor modifications as recommended by the PE 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.

Renal Allotransplantation (Tab 21)
Michael Abecassis, MD (ASTS); Thomas Cooper, MD (AUA)
Facilitation Committee #2

CPT code 50360 *Renal allotransplantation, implantation of graft; without recipient nephrectomy* was identified through the Harvard-Valued Annual Allowed Charges ≥ $10 million screen. The RUC recommended survey of physician work and review of practice expense for this service.

The specialty societies presented compelling evidence to justify a change in the physician work value. The physician work and time components of CPT code 50360 were valued in the Harvard studies. Since that time, there has been a change in patient population and donor grafts. The number of transplants performed annually in patients aged 50 years or older has steadily increased, and the number performed annually in patients aged 65 years or older tripled between 1998 and 2011. In addition, diabetes and hypertension as the primary cause of renal failure has increased in kidney transplant recipients. The effects of these diseases, along with increased time on dialysis at the time of transplant, have resulted in higher prevalence of peripheral vascular disease, coronary artery disease and cerebrovascular disease at the time of transplant, often requiring vascular procedures prior to transplantation. These co-morbidities and prior interventions translate into more complex and intense work in the pre, intra and post- operative transplant period.

Increases in the number of candidates on the waiting list and relatively flat organ donation rates have resulted in steady decreases in transplant rates for adult wait-listed candidates. In 1998, the deceased donor transplant rate was 20.6 transplants per 100 wait-list years, compared with 11.4 transplants per 100 wait-list years in 2011. As a result of the flat organ donation rates and increasing number of candidates on the waiting list, the percentage of deceased donors who had co-morbidities that would affect the graft has increased; the major components of the kidney donor risk index (KDRI) has increased over time. In combination with an older, sicker, and more complex typical recipient, a more marginal graft results in higher complexity and intensity of work both intra-operatively and post-operatively, including but not limited to delayed graft function, requiring post-transplant dialysis, higher risk of infection, higher need for post-transplant assessment of the graft, including biopsy, and generally increased post-transplant morbidity.

As mentioned above, CPT code 50360 was reviewed as part of the Harvard study. The Harvard reports indicate that the pre-, intra-, and post-operative time estimates were collected from five general surgeons. However, transplant surgeons were not part of the Harvard study. In 1992, CPT code 50360 underwent CMS Refinement Panel review and the work RVU was increased from 26.43 to 27.71. However, there is no discussion of this change in the Federal Register.

In 1997, a CMS contractor was tasked with transforming the post-operative time from the Harvard study into hospital and office visits. This was undertaken so that changes in the work RVUs for Evaluation and Management (E/M) codes after the first Five-Year-Review could be incorporated into codes with a global period of 10 or 90 days. The Harvard post-op time data was transformed into hospital and office visits. This transformation increased the total Harvard time from 839 to 1,526 minutes and resulted in a negative IWPUT. Most noticeable is the change in hospital visit time from 308 minutes in the Harvard study to 978 minutes using E/M visits. The RUC agreed with the specialty society that the methodology to impute frequency and level of post-op E/M visits was flawed. Therefore, the RUC agreed with the specialty society that there is compelling evidence that the current value for this procedure is potentially misvalued. This marks the first time this procedure has been surveyed for both time and physician work by surgeons familiar with the procedure.

The RUC reviewed survey data from 109 transplant specialists and agreed that the survey 25th percentile slightly overestimated the physician work and complexity. The RUC noted

that the number of post-operative visits has decreased, but as mentioned, these were imputed rather than based on survey data. The RUC reviewed key reference code 47780 *Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract* (work RVU=42.32, intra-service time=240 minutes) and noted that 50360 required 30 minutes less intra service time, less hospital visits, but more office visits. The RUC agreed that CPT code 50360 should be valued lower. In addition, the RUC reviewed MPC codes 33512 *Coronary artery bypass, vein only; 3 coronary venous grafts* (work RVU=43.98, intra service time=213 minutes) and 33426 *Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring* (work RVU=43.28, intra-service time= 205 minutes) and noted that although 50360 requires similar intra-service work, 33512 and 33426 require more total physician work and time, and therefore, should be valued slightly higher.

In addition, the RUC determined that an additional 50 minutes of pre service evaluation time is appropriate due to the extensive time required to evaluate the patient and coordinate with other health care providers after the patient's admission to the hospital and prior to surgery. Specifically, after the patient is admitted to the hospital, the surgeon performs a history and physical examination, reviews the patient's medical record and current laboratory data to ensure suitability for transplant. This work exceeds the standard pre-service work associated with most major surgical operations for the typical recipient, as the surgeon will not have had the opportunity to assess the patient for months, possibly years, prior to the transplant. Therefore, for recipients with complicated past medical histories and the typical co-morbidities, consultation with the referring and transplant center nephrologist and anesthesiologist is completed to rule out any prohibitive medical conditions and to determine if urgent dialysis is required prior to surgery. If the latter is required, coordination with the dialysis service is initiated to schedule the operating room making sure that the graft is not exposed to unacceptable cold ischemic times. Similarly, if any further evaluation is required, this will also need to be completed in the context of optimal cold ischemic times. The additional pre-service evaluation time is consistent with other RUC reviewed transplant procedures, but less than 32851 *Lung transplant, single; without cardiopulmonary bypass* and 33945 *Heart transplant, with or without recipient cardiectomy* **The RUC recommends a work RVU of 40.90 for CPT code 50360.**

Practice Expense:

The RUC accepted the direct PE inputs as submitted by the specialty society.

Percutaneous Implantation of Neurostimulator - PE Only (Tab 22)
Alexander Mason, MD (AANS, CNS); Eduardo Fraifield, MD (AAPM); Christopher Merifield, MD (ISIS)

In the Final Rule for 2013, CPT code 63650 *Percutaneous implantation of neurostimulator electrode array, epidural* was identified by stakeholders as a procedure performed in the non-facility setting. CMS requested non-facility practice expense (PE) inputs. The RUC determined that review of physician work is not necessary at this time, as this service was last surveyed in February 2008 and re-reviewed in October 2010. The RUC recommended that the service be referred to the PE Subcommittee for review at the April 2013 RUC meeting. The specialty clarified that 63650 is frequently furnished in the physician office and that 2 arrays are required. The PE Subcommittee noted that this code was previously a 090-day global and still retains its pre-service time for a standard 090-day global. The current standard is 0 minutes for a 010-day global in the facility setting.

However, if the specialty can justify time, 15 minutes of pre-service time for minimal use of clinical staff or 30 minutes for extensive use of clinical staff may be appropriate. The specialty society confirmed that there is extensive use of clinical staff and the pre-service time was modified from 090-day global standard of 60 minutes to 30 minutes in the facility. The PE Subcommittee reviewed the non-facility clinical staff time input Obtain vital signs and reduced it to 3 minutes for 1-3 vital signs and reduced Setup scope (nonfacility setting only) to 0 minutes because there is no scope utilized for this service. The PE Subcommittee also adjusted equipment minutes. **The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.**

Aqueous Shunt (Tab 23)
Stephen A. Kamenetzky, MD (AAO)

CPT code 66180 was identified through the Harvard-Valued Annual Allowed Charges ≥ $10 million screen. In January 2013, the RUC recommended survey of physician work and review of practice expense for this family of services. The direct practice expense inputs were reviewed at the January 2013 meeting. However, the review of physician work was postponed for review at the April 2013 RUC meeting in order to assure the surveyed post-operative visits were calculated correctly.

In April 2013, the American Academy of Ophthalmology noted that based on data from the last meeting the specialty society was informed that 66180 is typically reported (73%) with *67255 Scleral reinforcement (separate procedure); with graft* and it appears that these services should be surveyed as a bundled code. The specialty society requested that 66180 and 66185 be referred to CPT to create codes to describe with and without patch. The specialty society also noted that they will survey 67255 with this family of services. **The RUC agreed and recommends that these services be referred to the CPT Editorial Panel for revision**.

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs for 66180 and 66185 in January 2013. The RUC recommends reaffirming the practice expense inputs as reviewed and approved by the RUC at the January 2013 RUC meeting.

Repair of Eyelid (Tab 24)
Stephen A. Kamenetzky, MD (AAO); Tamara Fountain, M.D, (ASOPRS)
Facilitation Committee #3

CPT code 67917 *Repair of ectropion; extensive (eg, tarsal strip operations)* was identified through the Harvard-Valued Annual Allowed Charges ≥ $10 million screen. In October 2012, the RUC recommended survey of physician work and review of practice expense for this family of services at the April 2013 RUC meeting.

The RUC noted that for all the codes the current values were below the 25th percentile of the survey. The RUC evaluated potential cross-walk codes for each code and considered whether they supported the current value, a lower value or a higher value. For many of the codes, the RUC determined that the current value undervalued the service, but there was not compelling evidence to justify an increase above current values. After a robust discussion of the codes, the RUC determined that the current values or lower values were appropriate and identified cross-walk codes to justify current values. Deliberations of the

RUC were made more difficult by a scarcity of RUC-surveyed cross-walk codes with the same global period and similar intra times and total times.

67914 ***Repair of ectropion; suture***
The RUC reviewed the survey results from 33 ophthalmologists for CPT code 67914 and determined that the current work RVU of 3.75 appropriately accounts for the physician work required to perform this service. The survey 25th percentile work RVU was above the current work RVU, but the specialty societies indicated and the RUC agreed that there was not compelling evidence to increase the value. This 090-day global service includes 25 minutes pre-service, 20 minutes intra-service, 10 minutes immediate post-service, a half day discharge day management and 3 office visits. The RUC compared 67914 to 26160 *Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger* (090-day global, work RVU = 3.57, 20 minutes intra-service time, a half day discharge day management and 3 office visits) and 21073 *Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)* (090-day global, work RVU = 3.35, 20 minutes intra-service time, and 4 office visits) and determined that a work RVU of 3.75 for 67914 is appropriate relative to these similar services. **The RUC recommends a work RVU of 3.75 for CPT code 67914.**

67915 ***Repair of ectropion; thermocauterization***
The RUC reviewed CPT code 67915 and determined that the survey respondents overestimated the work required to perform these services. Therefore, the RUC recommends a crosswalk to CPT code 28470 *Closed treatment of metatarsal fracture; without manipulation, each* (090-global, work RVU = 2.03, 15 minutes of intra-service time and 3 office visits). CPT code 67915 is a 090-day global service that includes 23 minutes pre-service, 10 minutes intra-service, 5 minutes immediate post-service and 2 office visits. CPT code 67915 requires 5 minutes less intra-service time than 28470, but is more intense involving a procedure on the eye compared to the foot. For additional support, the RUC referenced similar service 46945 *Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group* (090-global, work RVU = 2.21, 15 minutes intra-service time and 2 office visits). **The RUC recommends a work RVU of 2.03 for CPT codes 67915.**

67916 ***Repair of ectropion; excision tarsal wedge***
The RUC reviewed CPT code 67916 and determined that the current work RVU of 5.48 appropriately accounts for the physician work required to perform this service. The survey 25th percentile work RVU was above the current work RVU, but the specialty societies indicated and the RUC agreed that there was not compelling evidence to increase the work value at this time. CPT code 67916 is a 090-day global service that includes 25 minutes pre-service, 25 minutes intra-service, 10 minutes immediate post-service, a half day discharge day management and 3 office visits. The RUC compared 67916 to 28525 *Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each* (090-day global, work RVU = 5.62, 30 minutes intra-service time, a half day discharge day management and 4 office visits) and determined that 28525 requires 5 more minutes of intra-service time and slightly more physician work than the surveyed service. Thus, using magnitude estimation the RUC recommends maintaining the current work RVU. **The RUC recommends a work RVU of 5.48 for CPT code 67916.**

67917 ***Repair of ectropion; extensive (eg, tarsal strip operations)***

The RUC reviewed the survey results from 34 ophthalmologists for CPT code 67917 and compared it to 67924 *Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)* (recommended work RVU = 5.93). CPT code 67917 is a 090-day global service that includes 25 minutes pre-service, 33 minutes intra-service, 10 minutes immediate post-service, a half day discharge day management and 3 office visits. The RUC noted that 67917 requires 33 minutes intra-service time compared to 40 minutes intra-service time for 67924, however it is more intense to perform extensive repair to the ectropion. The specialty societies indicated and the RUC agreed that the current work RVU of 6.19 for 67917 represents too much of a difference between the repair of the entropion service and should be the same as 67924. The RUC also compared 67917 to similar services 58600 *Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral* (090-day global, work RVU 5.91, 35 minutes intra-service time, 1 discharge day management and 1 office visit) and 23071 *Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater* (090-day global, work RVU=5.91, 45 minutes intra-service time, a half day discharge day management and 2 office visits) and determined a work RVU of 5.93 is appropriate compared to these similar services. **The RUC recommends a work RVU of 5.93 for CPT code 67917.**

67921 ***Repair of entropion; suture***
The RUC reviewed the survey results from 34 ophthalmologists for CPT code 67921 and determined that the current work RVU of 3.47 appropriately accounts for the work required to perform this service. CPT code 67921 is a 090-day global service that includes 25 minutes pre-service, 15 minutes intra-service, 5 minutes immediate post-service, a half day discharge day management and 3 office visits. For additional support to maintain the current value, the RUC referenced similar services 21073 *Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)* (090-day global, work RVU=3.45, 20 minutes intra-service time and 4 office visits) and 26160 *Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger* (090-day global, work RVU = 3.57, 20 minutes intra-service time, a half day discharge day management and 3 office visits). **The RUC recommends a work RVU of 3.47 for CPT code 67921.**

67922 ***Repair of entropion; thermocauterization***
The RUC reviewed CPT code 67922 and determined that the survey respondents overestimated the work required to perform these services. Therefore, the RUC recommends a crosswalk to CPT code 28470 *Closed treatment of metatarsal fracture; without manipulation, each* (090-global, work RVU = 2.03, 15 minutes of intra-service time and 3 office visits). CPT code 67922 is a 090-day global service that includes 23 minutes pre-service, 10 minutes intra-service, 10 minutes immediate post-service and 2 office visits. CPT code 67922 requires 5 minutes less intra-service time than 28470, but is more intense involving a procedure on the eye compared to the foot. For additional support, the RUC referenced similar service 46945 *Hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group* (090-global, work RVU = 2.21, 15 minutes intra-service time and 2 office visits). **The RUC recommends a work RVU of 2.03 for CPT codes 67922.**

67923 ***Repair of entropion; excision tarsal wedge***
The RUC reviewed CPT code 67923 and determined it requires the same physician work as 67916 *Repair of ectropion; excision tarsal wedge* (recommending a work RVU of 5.48). CPT code 67923 is a 090-day global service that includes 25 minutes pre-service, 25 minutes intra-service, 10 minutes immediate post-service, a half day discharge day

management and 3 office visits. The RUC compared 67923 to 28525 *Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each* (090-day global, work RVU = 5.62, 30 minutes intra-service time, a half day discharge day management and 4 office visits) and determined that 28525 requires 5 more minutes of intra-service time and slightly more physician work than the surveyed service, therefore using magnitude estimation a work RVU of 5.48 appropriately places CPT code 67923 relative to other similar services. The RUC recommends reducing the work RVU to 5.48 for CPT code 67923, the same as 67916. **The RUC recommends a work RVU of 5.48 for CPT code 67923.**

67924 ***Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)***
The RUC reviewed 67924 and determined that the current work RVU of 5.93 appropriately accounts for the physician work required to perform this service. CPT code 67924 is a 090-day global service that includes 25 minutes pre-service, 40 minutes intra-service, 10 minutes immediate post-service, a half day discharge day management and 3 office visits. The RUC supported maintaining the current work RVU comparing 67924 to similar services 58600 *Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral* (090-day global, work RVU 5.91, 35 minutes intra-service time, 1 discharge day management and 1 office visit) and 23071 *Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater* (090-day global, work RVU=5.91, 45 minutes intra-service time, a half day discharge day management and 2 office visits). **The RUC recommends a work RVU of 5.93 for CPT code 67924.**

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 accepted the direct PE inputs with modifications as recommended by the PE Subcommittee.

MRI-Neck and Lumbar Spine (Tab 25)
Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); Joshua Hirsch, MD (ACR); Gregory Nicola, MD (ASNR)
Facilitation Committee #3

CPT codes 72141 and 72148 were identified through the CMS High Expenditure Procedural Codes screen. The RUC recommended a survey of physician work and review of practice expense for this family of services at the April 2013 RUC meeting. The specialties added additional codes to survey as part of this family of services. The RUC agreed that the work and intensity of spine codes are similar across lumbar, thoracic and cervical regions. The RUC also discussed that the MRI brain CPT codes were recently reviewed at the January 2013 RUC meeting. The MRI spine codes have similar work and intensity and should maintain rank order with the MRI brain codes.

72141 ***Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material***
The RUC reviewed the survey results from 52 radiologists and neuroradiologists and recommends the following physician time components: pre-service time of 5 minutes, intra-service time of 20 minutes and post-service time of 5 minutes. The RUC noted that

all services in the family that do not require contrast material have the same amount of pre, intra and post service time and the same level of intensity, and therefore, should be valued the same. The RUC reviewed the survey 25th percentile work RVU of 1.60 and determined that the respondents overestimated the physician work required to perform this service. The RUC determined that a work value of 1.48, which is the lowest current RVU out of the three without contrast material codes in the family (CPT code 72148), is the appropriate value for all codes without contrast materials across the lumbar, thoracic and cervical regions. It also maintains relativity with similar CPT code 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material* (RUC recommended work RVU=1.48, 5 minutes pre-time, 18 minutes intra-time, 5 minutes post-time), which the RUC reviewed in January 2013 and recommended the current value.

The RUC also compared the surveyed code to CPT code 70336 *Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)* (work RVU=1.48, 20 minutes intra-time) and noted that the codes have the same intra-service time and should be valued the same. For additional support the RUC compared the surveyed code to CPT 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 physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family* (work RVU=1.42, 4 minutes pre-time, 20 minutes intra-time, 5 minutes post-time) and 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family* (work RVU=1.50, 5 minutes pre-time, 25 minutes intra-time, 10 minutes post-time. The RUC noted that 99203 and the surveyed code have identical intra-service time and similar pre- and post-service time, justifying the similar work value. The RUC also noted that 99214 has slightly more intra-service time but is less intense to perform, justifying the similar work value. **The RUC recommends a work RVU of 1.48 for CPT code 72141.**

72142 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)*

The RUC reviewed the survey results from 52 radiologists and neuroradiologists and recommend the following physician time components: pre-service time of 5 minutes, intra-service time of 23 minutes and post-service time of 5 minutes. The RUC noted that all services in the family that require contrast materials have the same amount of pre, intra and post service time and the same level of intensity, and therefore, should be valued the same. The RUC reviewed the survey median work RVU of 2.00 and determined that the respondents overestimated the physician work required to perform this service. The RUC determined that a work value of 1.78, which is the lowest current RVU out of the three with contrast material(s) codes in the family (CPT code 72149), is the appropriate value for all codes with contrast material(s) across the lumbar, thoracic and cervical regions. Additionally, the value is between the survey 25th and median for

this service. It also maintains relativity with similar CPT code 70552 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)* (RUC recommended work RVU=1.78, 5 minutes pre-time, 20 minutes intra-time and 7 minutes post-time), which the RUC reviewed in January 2013 and recommended the current value. The RUC also compared the surveyed code to CPT code 70498 *Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU=1.75, 7 minutes pre-time, 20 minutes intra-time and 10 minutes post-time) and noted that both services are with contrast material(s) and agreed that 72142 should be valued slightly higher because it has slightly more intra-service time. **The RUC recommends a work RVU of 1.78 for CPT code 72142.**

72146 ***Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material***

The RUC reviewed the survey results from 46 radiologists and neuroradiologists and recommend the following physician time components: pre-service time of 5 minutes, intra-service time of 20 minutes and post-service time of 5 minutes. The RUC noted that all services in the family that do not require contrast material have the same amount of pre, intra and post service time and the same level of intensity and should be valued the same. The RUC reviewed the survey 25th percentile work RVU of 1.61 and determined that the respondents overestimated the physician work required to perform this service. The RUC determined that a work value of 1.48, which is the lowest current RVU out of the three without contrast material codes in the family (CPT code 72148), is the appropriate value for all codes without contrast materials across the lumbar, thoracic and cervical regions. It also maintains relativity with similar CPT code 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material* (RUC recommended work RVU=1.48, 5 minutes pre-time, 18 minutes intra-time, 5 minutes post-time), which the RUC reviewed in January 2013 and recommended the current value.

The RUC also compared the surveyed code to CPT code 70336 *Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)* (work RVU=1.48, 20 minutes intra-time) and noted that the codes have the same intra-service time and should be valued the same. For additional support the RUC compared the surveyed code to CPT 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 physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family* (work RVU=1.42, 4 minutes pre-time, 20 minutes intra-time, 5 minutes post-time) and 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family* (work RVU=1.50, 5 minutes pre-time, 25 minutes intra-time, 10 minutes post-time. The RUC noted that 99203 and the surveyed code have identical intra-service time and similar pre- and post-service time, justifying the similar

work value. The RUC also noted that 99214 has slightly more intra-service time but is less intense to perform, justifying the similar work value. **The RUC recommends a work RVU of 1.48 for CPT code 72146.**

72147 ***Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)***
The RUC reviewed the survey results from 46 radiologists and neuroradiologists and recommend the following physician time components: pre-service time of 5 minutes, intra-service time of 23 minutes and post-service time of 5 minutes. The RUC noted that all services in the family that require contrast materials have the same amount of pre, intra and post service time and the same level of intensity, and therefore, should be valued the same. The RUC reviewed the survey median work RVU of 2.00 and determined that the respondents overestimated the physician work required to perform this service. The RUC determined that a work value of 1.78, which is the lowest current RVU out of the three with contrast material(s) codes in the family (CPT code 72149), is the appropriate value for all codes with contrast material(s) across the lumbar, thoracic and cervical regions. Additionally, the value is between the survey 25th and median for this service. It also maintains relativity with similar CPT code 70552 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)* (RUC recommended work RVU=1.78, 5 minutes pre-time, 20 minutes intra-time and 7 minutes post-time), which the RUC reviewed in January 2013 and recommended the current value. The RUC also compared the surveyed code to CPT code 70498 *Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU=1.75, 7 minutes pre-time, 20 minutes intra-time and 10 minutes post-time) and noted that both services are with contrast material(s) and agreed that 72147 should be valued slightly higher because it has slightly more intra-service time. **The RUC recommends a work RVU of 1.78 for CPT code 72147.**

72148 ***Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material***
The RUC reviewed the survey results from 49 radiologists and neuroradiologists and recommend the following physician time components: pre-service time of 5 minutes, intra-service time of 20 minutes and post-service time of 5 minutes. The RUC noted that all services in the family that do not require contrast material have the same amount of pre, intra and post service time and the same level of intensity, and therefore, should be valued the same. The RUC reviewed the survey 25th percentile work RVU of 1.60 and determined that the respondents overestimated the physician work required to perform this service. Therefore, the current value of 1.48 is appropriate for this service. Additionally, the RUC determined that a work value of 1.48, which is lowest current RVU out of the three without contrast material codes in the family, is the appropriate value for all codes without contrast materials across the lumbar, thoracic and cervical regions. It also maintains relativity with similar CPT code 70551 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material* (RUC recommended work RVU=1.48, 5 minutes pre-time, 18 minutes intra-time, 5 minutes post-time), which the RUC reviewed in January 2013 and recommended the current value.

The RUC also compared the surveyed code to CPT code 70336 *Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)* (work RVU=1.48, 20 minutes intra-time) and noted that the codes have the same intra-service time and should be valued the same.

For additional support the RUC compared the surveyed code to CPT 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.*
Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family (work RVU=1.42, 4 minutes pre-time, 20 minutes intra-time, 5 minutes post-time) and 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family* (work RVU=1.50, 5 minutes pre-time, 25 minutes intra-time, 10 minutes post-time). The RUC noted that 99203 and the surveyed code have identical intra-service time and similar pre- and post-service time, justifying the similar work value. The RUC also noted that 99214 has slightly more intra-service time but is less intense to perform, justifying the similar work value. **The RUC recommends a work RVU of 1.48 for CPT code 72148.**

72149 ***Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)***
The RUC reviewed the survey results from 49 radiologists and neuroradiologists and recommend the following physician time components: pre-service time of 5 minutes, intra-service time of 23 minutes and post-service time of 5 minutes. The RUC noted that all services in the family that require contrast materials have the same amount of pre, intra and post service time and the same level of intensity, and therefore, should be valued the same. The RUC reviewed the survey 25th percentile work RVU of 1.75 and agreed with the specialty societies that the current value of 1.78 is appropriate for this service. Additionally, the RUC determined that a work value of 1.78, which is the lowest current RVU out of the three with contrast material(s) codes in the family, is the appropriate value for all codes with contrast material(s) across the lumbar, thoracic and cervical regions. It also maintains relativity with similar CPT code 70552 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)* (RUC recommended work RVU=1.78, 5 minutes pre-time, 20 minutes intra-time and 7 minutes post-time), which the RUC reviewed in January 2013 and recommended the current value. The RUC also compared the surveyed code to CPT code 70498 *Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU=1.75, 7 minutes pre-time, 20 minutes intra-time and 10 minutes post-time) and noted that both services are with contrast material(s) and agreed that 72149 should be valued slightly higher because it has slightly more intra-service time. **The RUC recommends a work RVU of 1.78 for CPT code 72149.**

72156 ***Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical***
The RUC reviewed the survey results from 52 radiologists and neuroradiologists and recommend the following physician time components: pre-service time of 5 minutes, intra-service time of 25 minutes and post-service time of 5 minutes. The specialty noted and the RUC agreed that all services in the family that are performed without contrast material, followed by with contrast material(s) have the same amount of pre, intra and

post service time and the same level of intensity and should be valued the same. The RUC reviewed the survey median work RVU of 2.29 and determined it appropriately accounts for the work required to perform this service. The RUC determined that a work value of 2.29, which is the median survey value for this procedure and the lowest survey median RVU out of the three without and with contrast material(s) codes in the family, is the appropriate value for all codes without and with contrast material(s) across the lumbar, thoracic and cervical regions. Additionally, it is lower than the current value. It also maintains relativity with similar CPT code 70553 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences* (RUC recommended work RVU=2.36, 5 minutes pre-time, 25 minutes intra-time and 7 minutes post-time), which the RUC reviewed in January 2013 and recommended the current value. The RUC noted that the lower work value for 72156 is justified because an MRI of the spine without and with contrast requires slightly less time and intensity than the brain MRI codes without and with contrast. The RUC also compared the surveyed code to CPT code 72197 *Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences* (work RVU=2.26, 10 minutes pre-time, 25 minutes intra-time and 10 minutes post-time) and noted that both codes are without and with contrast. The RUC agreed that while 72197 and the surveyed code have identical intra-service time, the spine is a more complex region of the body and should be valued slightly higher. Additionally, the RUC compared the surveyed code to key reference service 74261 *Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material* (work RVU=2.40, 5 minutes pre-time, 40 minutes intra-time and 5 minutes post-time) and noted that the lower intensity image processing for CT colonography requires more time, but the higher intensity and complexity for a spine MRI supports the only slightly lower work value of 2.29. **The RUC recommends a work RVU of 2.29 for CPT code 72156.**

72157 ***Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic***
The RUC reviewed the survey results from 46 radiologists and neuroradiologists and recommend the following physician time components: pre-service time of 5 minutes, intra-service time of 25 minutes and post-service time of 5 minutes. The specialty noted and the RUC agreed that all services in the family that are performed without contrast material, followed by with contrast material(s) have the same amount of pre, intra and post service time and the same level of intensity and should be valued the same. The specialty societies indicated and the RUC agreed that a work RVU of 2.29, between the survey 25th percentile and median, is appropriate for this service. The RUC determined that a work value of 2.29, the survey median work RVU for 72156, which is the lowest survey median RVU out of the three without and with contrast material(s) codes in the family, is the appropriate value for all codes without and with contrast material(s) across the lumbar, thoracic and cervical regions. Additionally, it is lower than the current value. It also maintains relativity with similar CPT code 70553 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences* (RUC recommended work RVU=2.36, 5 minutes pre-time, 25 minutes intra-time and 7 minutes post-time), which the RUC reviewed in January 2013 and recommended the current value. The RUC noted that the lower work value for 72157 is justified because an MRI of the spine without and with contrast requires slightly less time and intensity than the brain MRI codes without and with contrast. The RUC also compared the surveyed code to CPT code 72197 *Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast*

material(s) and further sequences (work RVU=2.26, 10 minutes pre-time, 25 minutes intra-time and 10 minutes post-time) and noted that both codes are without and with contrast. The RUC agreed that while 72197 and the surveyed code have identical intra-service time, the spine is a more complex region of the body and should be valued slightly higher. Additionally, the RUC compared the surveyed code to key reference service 74261 *Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material* (work RVU=2.40, 5 minutes pre-time, 40 minutes intra-time and 5 minutes post-time) and noted that the lower intensity image processing for CT colonography requires more time, but the higher intensity and complexity for a spine MRI supports the only slightly lower work value of 2.29. **The RUC recommends a work RVU of 2.29 for CPT code 72157.**

72158 ***Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar***
The RUC reviewed the survey results from 49 radiologists and neuroradiologists and recommend the following physician time components: pre-service time of 5 minutes, intra-service time of 25 minutes and post-service time of 5 minutes. The specialty noted and the RUC agreed that all services in the family that are performed without contrast material, followed by with contrast material(s) have the same amount of pre, intra and post service time and the same level of intensity and should be valued the same. The specialty societies indicated and the RUC agreed that a work RVU of 2.29, between the survey 25th percentile and median, is appropriate for this service. The RUC determined that a work value of 2.29, the survey median work RVU for 72156, which is the lowest survey median RVU out of the three without and with contrast material(s) codes in the family, is the appropriate value for all codes without and with contrast material(s) across the lumbar, thoracic and cervical regions. Additionally, it is lower than the current value. It also maintains relativity with similar CPT code 70553 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences* (RUC recommended work RVU=2.36, 5 minutes pre-time, 25 minutes intra-time and 7 minutes post-time), which the RUC reviewed in January 2013 and recommended the current value. The RUC noted that the lower work value for 72158 is justified because an MRI of the spine without and with contrast requires slightly less time and intensity than the brain MRI codes without and with contrast. The RUC also compared the surveyed code to CPT code 72197 *Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences* (work RVU=2.26, 10 minutes pre-time, 25 minutes intra-time and 10 minutes post-time) and noted that both codes are without and with contrast. The RUC agreed that while 72197 and the surveyed code have identical intra-service time, the spine is a more complex region of the body and should be valued slightly higher. Additionally, the RUC compared the surveyed code to key reference service 74261 *Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material* (work RVU=2.40, 5 minutes pre-time, 40 minutes intra-time and 5 minutes post-time) and noted that the lower intensity image processing for CT colonography requires more time, but the higher intensity and complexity for a spine MRI supports the only slightly lower work value of 2.29. **The RUC recommends a work RVU of 2.29 for CPT code 72158.**

CT-Angiography-Abdomen and Pelvis (Tab 26)
Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); Sean Tutton, MD (SIR); Robert Vogelzang, MD (SIR); Michael Hall, MD (SIR); Jerry Niedzwiecki, MD (SIR);

In the Final Rule for 2013, CMS re-stated they believe that when codes are bundled, the new codes should be reviewed along with their component codes to ensure consistency in RVUs and inputs. The survey of CPT code 74174 *Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing* pre-dates this CMS recommendation. CMS believes there is an anomalous relationship between the physician times assigned to codes in this family. CPT code 74174 describes computed tomographic angiography (CTA) of both the abdomen and pelvis together. This CPT code includes 5 minutes of pre-service time, 30 minutes of intraservice time, and 5 minutes of post-service time, which is consistent with several other similar bundled CPT codes. CPT code 74175 describes CTA of the abdomen only, and includes 10 minutes of pre-service time, 30 minutes of intra-service time, and 10 minutes of post-service time. Similarly, CPT code 72191 describes CTA of the pelvis only, and includes 9 minutes of pre-service time, 30 minutes of intra-service time, and 10 minutes of post-service time. CMS does not believe that CTA of just the abdomen or just the pelvis should include more pre- and post-service time than the combined code. Also, while CMS believes furnishing the bundled code does not involve much more time than furnishing the stand-alone codes, they find it unlikely that the bundled service requires exactly the same intra-service time as the component services. CMS requested recommendations from the RUC and other pubic commenters on the appropriate work and time values for these services. In January of 2012, the Relativity Assessment Workgroup reviewed the specialty societies' proposal to equalize the pre and post times across the family at 5 minutes and retain the existing work RVUs. This recommendation was placed on the April 2013 RUC agenda to re-review the rationale and recommend changes to the times based on the existence of new pre-service packages.

The RUC noted that the specialty societies proposed two distinct actions on these three codes. First, the pre-service and post-service times for the component codes, 72191 *CTA pelvis with and without contrast* and 74175 *CTA abdomen with and without contrast,* should not be higher than the bundled code 74174 *CTA abdomen and pelvis with and without contrast*. The RUC agreed and recommends 5 minutes of pre-service time and 5 minutes of post-service time for both 72191 and 74175, so that they are identical to the pre- and post-service components of 74174. Secondly, the specialties noted that while the intra-service times are all identical, 30 minutes, the relativity among the work RVUs for these three codes is appropriate. Thus, a new survey of the family is not necessary. The RUC disagreed stating that while the relativity of the work values for these three codes may be appropriate, the intra-service time appears anomalous. CPT code 74174 requires review of two anatomical sites and should thus take some additional intra-service time for the physician to interpret and report the findings compared to the single-site components codes.

The RUC recommends the current values as interim, with modified pre- and post-service times for the following codes: 72191 (work RVU= 1.81, pre time= 5 minutes, intra time= 30 minutes, post time= 5 minutes); 74175 (work RVU= 1.90, pre time= 5 minutes, intra time= 30 minutes, post time= 5 minutes); and 74174 (work RVU= 2.20, pre time= 5 minutes, intra time= 30 minutes, post time= 5 minutes). In addition, the RUC recommends all three codes be re-surveyed for physician work and time at the October 2013 RUC meeting.

<u>Fluoroscopic Guidance (Tab 27)</u>

Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); Sean Tutton, MD (SIR); Robert Vogelzang, MD (SIR); Michael Hall, MD (SIR); Jerry Niedzwiecki, MD (SIR); Marc Lieb, MD (ASA); Richard Rosenquist, MD (ASA)

CPT code 77003 was identified through the CMS High Expenditure Procedural Codes screen and the MPC List screen. The RUC submitted work and practice recommendations for the 2013 Medicare Physician Payment Schedule. In the Final Rule for 2013, CMS indicated that the Agency will maintain the current work RVU of 0.60 for CPT code 77003 as interim. CMS indicated that it was necessary to review code 77003 alongside codes 77001 and 77002 in 2013 for the 2014 Medicare Physician Payment Schedule. CMS requested public comments on the appropriate work values and practice expense inputs for these services. The RUC recommended surveying for work and developing PE inputs for 77001 and 77002 for review at the April 2013 RUC meeting. CPT code 77003 was recently reviewed in January 2012 and was not resurveyed with the family.

77001*Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)*

The RUC reviewed the survey results from 74 radiologists and anesthesiologists and agreed with the specialty societies that the respondents overestimated the physician time involved in this service and that the following current physician time components should be maintained: pre-service time of 0 minutes, intra-service time of 9 minutes and post-service time of 4 minutes. The RUC reviewed the survey and determined that the current value of 0.38 is appropriate for this service. To validate this work value, the RUC compared the surveyed code to key reference service 36148 *Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)* (work RVU=1.00, 15 minutes intra-service). While both 77001 and 36148 involve catheter directed procedures, 36148 includes both the vascular access and imaging guidance whereas, 77001 represents the guidance only, which requires less intensity to perform. Less work and the lower intensity account for the lower value for 77001. Additionally, MPC code 95874 *Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)* (work RVU=0.37, 20 minutes intra-service) was reviewed and the RUC agreed that with slightly less total time and higher intensity 77001 should be valued slightly higher. **The RUC recommends a work RVU of 0.38 for CPT code 77001**.

77002 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)*

The RUC reviewed the survey results from 73 radiologists, anesthesiologists and physical medicine and rehabilitation physicians and recommended the following physician time components: pre-service time of 7 minutes, intra-service time of 15 minutes and post-service time of 5 minutes. The RUC determined that the current value of 0.54 is appropriate for this service. To validate this work value, the RUC compared the surveyed code to key reference service 76937 *Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent*

recording and reporting (List separately in addition to code for primary procedure) (work RVU=0.30, 0 minutes pre-service, 10 minutes intra-service and 4 minutes post-service) and agreed that with higher intra-service time and intensity, 77002 should be valued higher than the reference code. Additionally, recently valued MPC codes 93224 *External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional* (work RVU=0.52, 2 minutes pre-service, 15 minutes intra-service and 7 minutes post-service) and 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU=0.56, 4 minutes pre-service, 10 minutes intra-service and 4 minutes post-service) were reviewed and the RUC agreed that 77002 has slightly more total time than 93224 and should be valued slightly higher and 77002 has more time, but is less intense to perform than 76536 and should be valued slightly higher. **The RUC recommends a work RVU of 0.54 for CPT code 77002**.

77003 ***Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)***
The RUC reviewed the RUC recommendations from January 2012 for CPT code 77003 and agreed to reaffirm the established values, as they are appropriate relative to the family of services reviewed at the April 2013 RUC meeting. In January 2012, the RUC reviewed the survey responses from 122 anesthesiologists, interventional radiologists, radiologists, spine surgeons and pain medicine physicians and determined that the physician work for CPT code 77003 should be maintained at 0.60 work RVUs, lower than the survey's 25th percentile. The RUC reaffirms the following recommended physician time components: pre-service time of 7 minutes, intra-service time of 15 minutes and post-service time of 5 minutes. **The RUC recommends reaffirming a work RVU of 0.60 for CPT code 77003.**

Practice Expense
The RUC recommends practice expense for CPT codes 77001 and 77002 with minor modifications as approved by the PE Subcommittee. The RUC reaffirms recently reviewed practice expense for CPT code 77003 as previously approved by the PE Subcommittee.

IMRT-PE Only (Tab 28)
Najeeb Mohideen, MD, (ASTRO); Micheal Kuettel, MD, PhD, (ASTRO); Dwight Heron, MD, (ASTRO); and Gerald White, MS (ASTRO)

CPT codes 77301 and 77338 were identified through the Services with Stand-Alone PE Procedure Time screen. In October 2012, the RUC recommended that the PE Subcommittee review the direct PE inputs for these services at the April 2013 meeting. CMS requested a practice expense survey for clinical staff time only, which was conducted for the family. The specialty societies convened a consensus panel that included a number of experts familiar with these services to evaluate the survey results and existing direct practice expense inputs for these procedures.

77301 ***Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications***
The PE Subcommittee reviewed the survey results from 22 radiation oncologists and noted that the survey times are higher than the current clinical staff times. The specialty society did not present compelling evidence to increase any of the existing PE times. The

PE subcommittee agreed that the existing times were appropriate. The specialty clarified that the patient is only in the office from the beginning of the service period through *acquire and process CT scan* (line 38) and that two, not three, staff present during the *contouring* phase of the procedure (lines 39-41). The specialty also clarified that CMS clinical labor type, *Medical Dosimetrist/Medical Physicist (L107A)* was not included as an option on the survey, because it is not a known staff type in a typical clinic that performs this service and respondents would not recognize it. The service can be performed by a senior dosimetrist or a junior physicist and is typically performed by a senior dosimetrist. As a result, the survey respondents chose dosimetrist as the staff type. The specialty recommends and the PE Subcommittee agrees that the *Medical Dosimetrist/Medical Physicist (L107A)* is representative of the senior dosimetrist staff level and should be maintained as one of the two staff, along with the *Medical Physicist (L152A),* performing contouring for this service. **The RUC reviewed and approved the direct practice expense inputs as submitted by the specialty and recommended by the Practice Expense Subcommittee.**

77338 ***Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan***
The PE Subcommittee reviewed the survey results from 22 radiation oncologists and noted that the survey times are higher than the current clinical staff times. The specialty society did not present compelling evidence to increase any of the existing PE times. The PE subcommittee agreed that the existing times were appropriate. **The RUC reviewed and approved the direct practice expense inputs as submitted by the specialty and recommended by the Practice Expense Subcommittee.**

Radiation Treatment Delivery PE Only (Tab 29)
Najeeb Mohideen, MD, (ASTRO); Micheal Kuettel, MD, PhD, (ASTRO); Dwight Heron, MD, (ASTRO); and Gerald White, MS (ASTRO)

CPT codes 77372 and 77402-77417 were identified through the Services with Stand-Alone PE Procedure Time screen. In October 2012, the RUC recommended that the PE Subcommittee review the PE direct inputs for these services at the April 2013 meeting. The specialty society is requesting referral to the CPT Editorial Panel for CPT codes 77402-77417.

77372 ***Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based***
The PE Subcommittee reviewed the survey results from 18 radiation oncologists and noted that the survey times are higher than the current clinical staff times. Survey respondents indicated significantly higher clinical staff times for the pre-service, service (pre-service) and post-service periods than are currently included. The specialty recommended and the RUC agreed that these times should be maintained at current RUC standards. Since there is no compelling evidence to change the clinical staff time of this procedure, times consistent or below the current inputs are appropriate. The PE Subcommittee noted that the intra-service portion of the service period validates the range of the current PE inputs. Survey respondents did include a dosimetrist in addition to the typical staff of *Radiation Therapist (L050C)* and *Medical Physicist (L152A),* to *Prepare system for treatment* (line 37); however, the PE Subcommittee agreed that although this additional staff may be used in clinics, it should not be included in the intra-service time. Equipment time for the *SRS system, Lincac* (ER082) was recalculated to include Prepare Machine (line 23). This time is needed prior to the patient entering the

office to set up the machine for the service. **The RUC reviewed and approved the direct practice expense inputs with a minor modification as recommended by the Practice Expense Subcommittee.**

The specialty society is requesting referral to the CPT Editorial Panel for CPT codes 77402-77417 because questions regarding the appropriateness of the existing radiation treatment delivery codes to describe current practice have been raised in multiple venues.

- In Table 8 of the 2013 Medicare Physician Final Rule, CMS asked for review of multiple treatment delivery codes.
- The AMA/RUC has raised questions regarding the time associated with IMRT delivery.
- Others have raised the question of the appropriate coding for newer techniques.
- Image guidance that may be used with radiation treatment delivery has also grown. It is sometimes performed with conventional treatments and almost always is used with IMRT, suggesting a bundling solution.

As clinical practice has evolved, several issues have arisen which require CPT clarification. The specialty intends to address a number of interrelated issues and revise the entire treatment delivery family. The RUC recommends CPT codes 77402-77417 be referred to the CPT Editorial Panel for review at the May CPT meeting.

Hyperthermia-PE Only (Tab 30)
Najeeb Mohideen, MD, (ASTRO); Micheal Kuettel, MD, PhD, (ASTRO); Dwight Heron, MD, (ASTRO); and Gerald White, MS (ASTRO)

CPT code 77600 *Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)* was identified through the Services with Stand-Alone PE Procedure Time screen. In October 2012, the RUC recommended that the PE Subcommittee review the direct PE inputs for these services at the April 2013 meeting.

The PE Subcommittee reviewed the survey results from 5 radiation oncologist practices and noted that the survey times are higher than the current clinical staff times. The number of responses is low because very few radiation oncologists perform this service resulting in a small pool of potential survey respondents. Survey respondents indicated time in the pre-service period where currently there is none. Respondents also indicated significantly higher time in the service period (pre-service and post-service) and post-service period than is currently included. The specialty recommended and the PE Subcommittee agreed that these times should be maintained at current RUC standards, since there is no compelling evidence to change the clinical staff time of this procedure. The PE Subcommittee noted that the *Treatment* (line 40) time in the intra-service portion of the service period validates the time of the current PE input. **The RUC reviewed and approved the direct practice expense inputs with a minor modification as recommended by the Practice Expense Subcommittee.**

Continuing Medical Physics Consultation-PE Only (Tab 31)
Najeeb Mohideen, MD, (ASTRO); Micheal Kuettel, MD, PhD, (ASTRO); Dwight Heron, MD, (ASTRO); and Gerald White, MS (ASTRO)

CPT Codes 77336 *Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment*

documentation in support of the radiation oncologist, reported per week of therapy was identified in the Final Rule for 2013 as a potentially misvalued service. CMS requested that the RUC review the direct practice expense (PE) inputs only, for this family of services.

The PE for 77336 has changed since this service was last reviewed in September 2002. The specialty society provided compelling evidence regarding a change in technology, staff type, staff time and equipment. Since this service was last reviewed, treatments have become increasingly complex with the use of modulated fields, gated delivery, and intricate non-coplanar patient setup geometries. Multileaf collimators (MLC's) have replaced simple alloy blocks and dynamic jaw movement has replaced simple physical wedges. Stereotactic treatment delivery and on-board imaging has allowed the use of smaller fields, making accurate patient positioning and accurate and precise delivery even more critical. The treatment units that deliver the radiation beams have become more complex as well, incorporating imaging hardware, computerized control and even robotic positioning. Equipment and treatment complexity now requires a higher level of oversight to assure that treatments are delivered safely. Further, it is now necessary that the medical physicist and not the dosimetrist provide this service and ongoing patient support. One can no longer verify a correct setup by simple inspection of gantry angle and choice of beam modifier. It is the physicist who has the required training and expertise in all aspects of the radiation therapy treatment process from patient imaging to planning to treatment delivery. The PE Subcommittee reviewed and approved this compelling evidence and the RUC agreed.

The PE Subcommittee recommends the addition of a new piece of equipment *beam characterization measurement equipment kit* to replace previous equipment items. This equipment is used by the physicist to verify the delivery of the radiation beams of the treatment unit and imaging system, which has not been performed as part of a code that the patient would receive prior to this service. Invoices for this equipment are included.

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

<u>High Dose Rate Brachytherapy-PE Only (Tab 32)</u>
Najeeb Mohideen, MD, (ASTRO); Micheal Kuettel, MD, PhD, (ASTRO); Dwight Heron, MD, (ASTRO); and Gerald White, MS (ASTRO); Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); Mark Alson, MD (ACR); Jan Jeske, MD (ACR)

CPT codes 77785-77787 were identified in CMS' final rule through the Services with Stand-Alone PE Procedure Time Screen. In October 2012, the RUC recommended that the PE Subcommittee review the PE direct inputs for these services at the April 2013 meeting. As CMS requested for this screen, a practice expense survey for clinical staff time only was conducted for the family. The specialty societies convened a consensus panel that included a number of experts familiar with these services to evaluate the survey results and existing direct practice expense inputs for these procedures.

77785 ***Remote afterloading high dose rate radionuclide brachytherapy; 1 channel***
The RUC reviewed the survey results from 37 radiation oncologists and noted that the survey times were either higher than the current clinical staff times or exceeded PE Subcommittee standards. The RUC agreed with the expert panel that the respondents overestimated the clinical staff time involved in many elements of the service. The

specialty recommends and the RUC agrees that an *emergency service container safety kit* should be added to this service as it is missing from the direct PE equipment inputs. An invoice is included with this submission. In addition, the RUC recommends that for brachytherapy procedures additional activities beyond the PE Subcommittee standards should be included in the equipment time calculations. These procedures require extensive room/procedure preparation and use a live radiation source. There are federal guidelines for handling the source, documentation, etc. Many of the activities that are performed before/after the procedure need to be done in the room because of contamination potentials (i.e. room survey, transfer tube cleaning, etc.). The RUC recommends the following activities to be included in equipment time calculations:

- Prepare room (Line 30)
- Set up remote monitoring (Line 31)
- Position patient (Line 32)
- Intra time (Lines 36-49 accounting for concurrent activities)
- Monitor patient (Line 51)
- Clean room (Line 52)
- Clean transfer tubes (Line 53)

77786 ***Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels***
The RUC reviewed the survey results from 39 radiation oncologists and noted that the survey times were either higher than the current clinical staff times or exceeded PE Subcommittee standards. The RUC agreed with the expert panel that the respondents overestimated the clinical staff time involved in many elements of the service. The specialty recommends and the RUC agrees that an *emergency service container safety kit* should be added to this service as it is missing from the direct PE equipment inputs. An invoice is included with this submission. In addition, the RUC recommends that for brachytherapy procedures additional activities beyond the PE Subcommittee standards should be included in the equipment time calculations. These procedures require extensive room/procedure preparation and use a live radiation source. There are federal guidelines for handling the source, documentation, etc. Many of the activities that are performed before/after the procedure need to be done in the room because of contamination potentials (i.e. room survey, transfer tube cleaning, etc.). The RUC recommends the following activities to be included in equipment time calculations:

- Prepare room (Line 30)
- Set up remote monitoring (Line 31)
- Position patient (Line 32)
- Intra time (Lines 36-49 accounting for concurrent activities)
- Monitor patient (Line 51)
- Clean room (Line 52)
- Clean transfer tubes (Line 53)

77787 ***Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels***

The RUC reviewed the survey results from 34 radiation oncologists and noted that the survey times were either higher than the current clinical staff times or exceeded PE Subcommittee standards. The RUC agreed with the expert panel that the respondents overestimated the clinical staff time involved in many elements of the service. The specialty recommends and the RUC agrees that an *emergency service container safety kit*

should be added to this service as it is missing from the direct PE equipment inputs. An invoice is included with this submission. In addition, the RUC recommends that for brachytherapy procedures additional activities beyond the PE Subcommittee standards should be included in the equipment time calculations. These procedures require extensive room/procedure preparation and use a live radiation source. There are federal guidelines for handling the source, documentation, etc. Many of the activities that are performed before/after the procedure need to be done in the room because of contamination potentials (i.e. room survey, transfer tube cleaning, etc.). The RUC recommends the following activities to be included in equipment time calculations:

- Prepare room (Line 30)
- Set up remote monitoring (Line 31)
- Position patient (Line 32)
- Intra time (Lines 36-49 accounting for concurrent activities)
- Monitor patient (Line 51)
- Clean room (Line 52)
- Clean transfer tubes (Line 53)

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

Cytopatholgy (Tab 33)
Jonathan Myles, MD; (CAP); Michael McEachin MD (CAP): Marina Mosunjac, MD (ASC); Emily Volk, M.D (CAP); Christine Booth, MD (CAP)

CPT code 88112 was identified through the CMS High Expenditure Procedural Codes screen. The RUC recommended survey of physician work and review of practice expense for this service at the April 2013 RUC meeting.

88112 ***Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal***
In April 2003, The RUC reviewed the survey results for new service CPT code 88112. At that time the code was surveyed for pre-and post-service time in addition to intra-service time and the total time was 43 minutes including with a work value of 1.18. At that time the RUC determined that the new service required more physician time and a higher level of intensity than CPT codes 88104 *Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation* (work RVU=0.56) and 88108 *Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)* (work RVU= 0.44). In the subsequent years the service has changed considerably, pre- and post-service times are no longer included in the physician work as they previously would have been. Also the vignette has changed and urinary specimen is now typical for this service.

The RUC reviewed the survey results from 194 pathologists and recommends 15 minutes of intra-service physician time for this service.
The RUC reviewed the survey and determined that the 25th percentile work RVU of 0.56 is appropriate for this service. To validate this work value the RUC compared the surveyed code to key reference service 88104 *Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation* (work RVU=0.56, 24 minute intra-service) and noted that 88112 is more intense and is often used on more

complicated specimens due to the use of concentration technique which allows the instrument to remove cellular "junk" and the physician to review a greater magnitude of cells in close detail. Although code 88104 requires more physician time to perform, the higher intensity of 88112 justifies the identical work value. The RUC also compared the 88112 to CPT code 88108 *Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)* (work RVU=0.44, 19 minutes intra-service) which is also a concentration technique, but an older technique. The RUC original recommendation for CPT code 88108 was a work RVU of 0.56 and it was subsequently reduced to 0.44 by CMS. The RUC continues to support the recommendation of 0.56 for CPT code 88108, and determined that 88112 should have a work value of 0.56 as well. The RUC notes that this recommendation reflects a significant reduction from the current value of 1.18. **The RUC recommends a work RVU of 0.56 for CPT code 88112.**

Practice Expense
Equipment time elements for each equipment item on the RUC practice expense recommendations made prior to CPT 2011 were determined by CMS. At its April 2010 meeting, the RUC changed policy and specialties now provide the actual number of minutes that the equipment item is used for each service. The specialty discovered an error in the current CMS equipment direct practice expense inputs file for 88112. All equipment items for this service are shown as being used for one minute. This is clearly a data input error as it is impossible to perform this service using all of the equipment items for only one minute. The RUC recommends that equipment direct PE inputs be corrected to reflect the times recommended by the PE Subcommittee in the attached spreadsheet.

The specialty society has submitted comments to CMS stating that they do not agree that courier transportation costs, specimen disposal costs, copath system, software, and laboratory information system maintenance contracts are indirect PE expenses. This is an ongoing issue between CMS and the specialty, and the RUC is maintaining the items on the spreadsheet simply to acknowledge the unresolved issue and will not comment on the inclusion or exclusion of these PE inputs or the pricing proposed by the specialty at this time. **The RUC reviewed and approved the direct 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.

<u>In Situ Hybridization (Tab 34)</u>
Jonathan Myles, MD; (CAP); Michael McEachin MD (CAP); Emily Volk, M.D (CAP); Christine Booth, MD (CAP)

For the NPRM for 2012, CMS received comments that unlike the new FISH codes for urinary tract specimens (88120 and 88121), the existing codes (88365-88368) still allow for multiple units of each code as these codes are reported per probe. CMS stated that they reviewed the current work and practice expense (PE) costs associated with 88120 and 88121 and agree at this time that they are accurate. However, the first 6 months of 2011 claims data were shared with the RUC and CMS requests that additional review of these data be considered to determine if further action is warranted. CMS requested that the RUC review both the direct PE inputs and the work values for codes 88365, 88367 and 88368. The RUC determined that these services should be tabled until January 2012 in order to review 2011diagnosis claims data from CMS. In January 2012, the RUC

reviewed 2011 diagnosis claims data, and the American College of Pathologists indicated that they will develop a CPT Assistant article to direct physicians to use the new FISH codes for urinary tract infections (CPT codes 88120 and 88120). The RUC indicated that the specialty should specify the number of probes utilized for these services in the CPT Assistant article. The RUC recommended that it re-review codes 88365, 88367 and 88368 in 1 year after 2012 utilization is available (January 2013). The RUC agreed with the specialty society to maintain current values, but also recommended reviewing 3 more years of data for CPT codes 88120 and 88121 to determine if utilization has shifted from 88365, 88367 and 88368 to these codes. The RUC recommended resurveying the work and develop PE inputs for 88365, 88367 and 88368 for review at the April 2013 RUC meeting.

In April 2013, the College of American Pathologists (CAP) noted that while preparing to survey these services they discovered that the vignette for 88365 required revision. Additionally, the code descriptors for 88365, 88367 and 88368 required revision to describe the typical practice of these services, such as specifying each separately identifiable antibody, cytologic preparation or hematologic smear as was revised in the recent immunohistochemistry services. **The RUC recommends that CPT codes 88365, 88367 and 88368 be referred to the CPT Editorial Panel for revision.**

Psychotherapy for Crisis and Interactive Complexity (Tab 35)
Jeremy Musher, MD (APA); Sherry Barron-Seabrook, MD (SVS); James Georgoulakis, PhD (APA); Doris Tomer, LCSW (NASW)

Specific psychotherapy codes were identified through the CMS High Expenditure Procedural codes screen. However, the specialties were already in the process of revising this entire section as indicated from the Fourth Five-Year Review. In April 2012, 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 would 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 would conduct RUC surveys for these services for review of work and direct PE inputs at the April 2013 RUC meeting. In the Final Rule for 2013 CMS assigned interim values to the new psychotherapy codes and indicated that they will re-review all assumptions when they review all recommended values for this family of CPT codes. CMS requested review of the psychotherapy for crisis and interactive complexity codes prior to a review of the work and practice expense of all the new psychology codes. **The RUC reaffirms its April 2012 recommendations for the new psychotherapy codes. The RUC requests that CMS review all the psychotherapy services (all recommendations attached) for consideration in 2014.**

The psychotherapy for crisis codes are timed codes for patients whose presenting problems are typically life threatening and require immediate attention so the crisis is diffused and the safety of the patient and/or others is restored. CPT code 90785 *Interactive complexity* may not be reported with the psychotherapy for crisis codes.

90839 ***Psychotherapy for crisis; first 60 minutes***
The RUC reviewed the survey data from 60 adult and child psychiatrists, psychologists and social workers for CPT code 90839 and determined that the median survey work RVU of 3.13 appropriately accounts for the work required to perform this service. The RUC determined that the survey median of 10 minutes pre-service, 60 minutes intra-

service and 20 minutes immediate post-service time is appropriate to perform this service. The RUC compared the surveyed code to specialty society survey key reference code 99215 *Evaluation and Management Office Visit* (work RVU = 2.11 and 35 minutes intra-service time) and determined that 90839 requires significantly more time to complete (25 minutes more intra-time), and therefore appropriately requires more physician work to perform. For additional support, the RUC also compared the surveyed service to similar services 99205 *Evaluation and Management office visit, new patient* (work RVU = 3.17 and 45 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). The RUC also noted that RUC recommended services 90791 *Psychiatric diagnostic evaluation* (RUC recommended work RVU = 3.00) and 90792 *Psychiatric diagnostic evaluation with medical services* (RUC recommended work RVU = 3.25) require similar work and the same physician times (10 minutes pre-service, 60 minutes intra-service and 20 minutes immediate post- service time). The RUC determined that the recommended physician work and time place this service in the proper rank order relative to codes in the psychotherapy family and other services on the physician payment schedule. **The RUC recommends a work RVU of 3.13 for CPT code 90839.**

90840 ***Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)***

The RUC reviewed the survey data from 60 adult and child psychiatrists, psychologists and social workers for CPT code 90840 and determined that the survey 25th percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC determined that 30 minutes intra-service time is appropriate to perform this service. The RUC compared the surveyed code to key reference code 99355 *Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes* (work RVU = 1.77) and determined that 90840 requires similar physician work to perform. For additional support, the RUC also compared the surveyed service to similar service 99215 *Evaluation and Management office visit, established patient* (work RVU = 1.50 and 40 minutes total time) and RUC recommended services 90832 *Psychotherapy, 30 minutes with patient and/or family member* (RUC recommended work RVU = 1.50) and 90833 *Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)* (RUC recommended work RVU = 1.50) and determined that the recommended physician work and time place this service in the proper rank order relative to other services. Finally, the RUC noted that the recommendation for this add-on procedure is accurately valued slightly less than half of the base procedure, 90839, given that 90840 requires half the intra-service time as the base code and does not include any pre-service or immediate post-service work. **The RUC recommends a work RVU of 1.50 for CPT code 90840.**

90785 ***Interactive complexity (List separately in addition to the code for primary procedure)***

CPT code 90785 was created to capture additional work that occurs during diagnostic psychiatric evaluation, psychotherapy, psychotherapy performed with an Evaluation and Management service and group psychotherapy sessions. CPT 90785 may only be reported once with one of the nine codes for the aforementioned services. If 90785 is conducted with group therapy it would be reported with only the individual patients that require this additional complexity, not necessarily all patients in the group. This service

may not be reported with the psychotherapy for crisis codes or in conjunction with an E/M service when no psychotherapy service is reported.

CPT code 90785 replaces a series of procedures under the old framework describing play services or services that required an interpreter or translator. The new interactive complexity service refers to specific communication factors that complicate the delivery of a psychiatric/psychotherapy procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young or underdeveloped patients. The interactive complexity code is intended to only capture the increased intensity of work performed and capture post-service time. The RUC noted that this interactive complexity code was created because the CPT Editorial Panel recognized this as a frequent scenario seen in this specialty, and constant use of a -22 *Increased procedural services* modifier would create an administrative burden. CPT code 90785 replaces a series of add-on codes such as 90802 *Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication* (deleted service), which included interactive complexity, that was not used routinely, but more commonly with children.

The RUC reviewed the survey data from 116 adult and child psychiatrists, psychologists and social workers for CPT code 90785 and determined that the survey 25th percentile work RVU of 0.33 appropriately accounts for the physician work to perform this service. The RUC noted that the survey median immediate post-service time of 16 minutes to perform this interactive complexity service was overestimated, therefore the RUC recommends the survey 25th percentile of 11 minutes, all reflected in the post-service period. The RUC compared 90785 to the similar services MPC and ZZZ code 95874 *Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)* (work RVU = 0.37 and total time of 20 minutes); 36400 *Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; femoral or jugular vein* (work RVU = 0.38 and total time of 20 minutes); and 36405 *Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; scalp vein* (work RVU= 0.31 and total time of 18 minutes) and determined that the recommended physician work and time places this service in the proper rank order relative to other services. **The RUC recommends a work RVU of 0.33 for CPT code 90785.**

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

Evoked Potentials and Reflex Tests (Tab 36)
Marianna Spanaki, MD, PhD (AAN); Marc Nuwer, MD, PhD (ACNS); Joseph Zuhosky, MD (AAPMR)

In February 2010, CPT code pairs 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*/95926 *Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs* and 95928 *Central motor evoked potential study*

(transcranial motor stimulation); upper limbs/95929 *Central motor evoked potential study (transcranial motor stimulation); lower limbs* were identified by the Codes Reported Together 75% or More screen. At the request of the RUC, the specialty societies submitted a coding proposal which was approved by the CPT Editorial Panel to create two bundled codes which will allow providers to report short latency somatosensory evoked potential studies of the upper and lower limbs and central motor evoked potential study of the upper and lower limbs. At the February 2011 RUC meeting, the RUC reviewed the survey results for new codes 95938 *Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs* and 95939 *Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs*. The specialty had obtained strong, valid survey results for code 95938, but not for 95939, as only 31% of the respondents indicated the vignette was typical. The RUC and specialty societies agreed that a new survey should be conducted and the survey results presented at the April 2011 RUC meeting with an inpatient vignette scenario. The RUC reviewed these services and submitted recommendations for CPT 2012.

In the Final Rule for 2013, CMS accepted the RUC recommended values on an interim basis, but determined that there are valuation and time inaccuracies, both across the evoked potential study codes and relative to the new bundled codes. For example, for CPT codes 95925 and 95926, CMS does not believe that the correct intra-service time for CPT code 95938 can be the sum of the intra-service times of CPT codes 95925 and 95926, as CMS is confident that there are efficiencies that result from performing these services together. Given these anomalous relationships, CMS requested public comments on the appropriate work and time values for codes 95925, 95926, 95928, 95929, 95938 and 95939.

The RUC agreed with the specialty society that these codes represent two distinct families. The RUC reaffirmed that there was an error in the time file for 95938 and the correct times are 10 minutes pre, 20 minutes intra and 10 minutes post. After correcting this error, the time for codes 95925, 95926 and 95938 are rational. For the second family, the RUC noted that code 95939 was surveyed in April 2011 and recommended that the specialty societies resurvey codes 95928 and 95929 and develop PE inputs for April 2013.

95928 ***Central motor evoked potential study (transcranial motor stimulation); upper limbs***

The RUC reviewed the survey data for CPT code 95928 and determined that the survey 25th percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC agreed that 15 minutes pre-service, 40 minutes intra-service and 10 minutes immediate post-service time accurately accounts for the physician time required to perform this service alone. The RUC reiterated that due to the addition of 95939 *Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs* (work RVU = 2.25 and 15 minutes pre-service, 30 minutes intra-service and 15 minutes immediate post-service time) in CPT 2012, codes 95928 and 95929 are expected now to be performed predominately in the outpatient setting. CPT code 95939 would typically be performed in the inpatient setting where the overall number of muscle sites tested is lower, accounting for the lower intra-service time and a much greater level of intensity than 95928 or 95929. The existing codes, 95928 and 95929 would continue to shift toward being typically performed in non-facility settings, requiring a greater number of muscle sites tested per limb, requiring more intra-service time and physician work.

The specialty societies indicated and the RUC agreed that 95939 is a different service, it is an electrical motor evoked potential study, in which the physician delivers 600 volts to the brain. CPT 95939 is more like electroconvulsive shock therapy, but with a much shorter duration so the entire body jerks and all four limbs are moving. Additionally, it is under general anesthesia so the physician can measure the motor pathways directly. CPT code 95939 is more straightforward than 95928 and 95929, but it is also dangerous, so the intensity is greater. Once 95939 was broken out, it described a different service and therefore was appropriately valued differently. The RUC noted that the utilization for 95928 has decreased by 10,000, down to an estimated 1,797 for 2012, as the correct service will now be reported with 95939. The creation of CPT code 95939 represented a 25% savings in work RVUs and substantial overall savings to the Medicare system in 2012.

The RUC compared 95928 to key reference service 95861 *Needle electromyography; 2 extremities with or without related paraspinal areas* (work RVU = 1.54 and 30 minutes intra-service time) and noted that 95928 requires slightly less work, less time and is less intense than 95861. Therefore, the 25th percentile work RVU, which is the current work RVU of 1.50 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 1.50 for CPT code 95928.**

95929 ***Central motor evoked potential study (transcranial motor stimulation); lower limbs***

The RUC reviewed the survey data for CPT code 95929 and determined that the survey 25th percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC agreed that 15 minutes pre-service, 40 minutes intra-service and 10 minutes immediate post-service time accurately account for the physician time required to perform this service alone. The RUC reiterated that due to the addition of 95939 *Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs* (work RVU = 2.25 and 15 minutes pre-service, 30 minutes intra-service and 15 minutes immediate post-service time) in CPT 2012, codes 95928 and 95929 are expected now to be performed predominately in the outpatient setting. CPT code 95939 would typically be performed in the inpatient setting where the overall number of muscle sites tested is lower, accounting for the lower intra-service time and a much greater level of intensity than 95928 and 95929. The existing codes, 95928 and 95929 would continue to shift toward being typically performed in non-facility settings, requiring a greater number of muscle sites tested per limb, requiring more intra-service time and physician work. The specialty societies indicated and the RUC agreed that 95939 is a different service, it is an electrical motor evoked potential study, in which the physician delivers 600 volts to the brain. CPT 95939 is more like electroconvulsive shock therapy but with a much shorter duration so the entire body jerks and all four limbs are moving. Additionally, it is under general anesthesia so the physician can measure the motor pathways directly. CPT code 95939 is more straightforward than 95928 and 95929, but it is also dangerous, so the intensity is greater. Once 95939 was broken out, it described a different service and was therefore valued differently. The RUC noted that the utilization for 95929 has decreased by approximately 18,000, down to an estimated 1,440 for 2012, as the correct service will now be reported with 95939. The creation of CPT code 95939 represented a 25% savings in work RVUs and substantial overall savings to the Medicare system in 2012.

The RUC compared 95929 to key reference service 95861 *Needle electromyography; 2 extremities with or without related paraspinal areas* (work RVU = 1.54 and 30 minutes

intra-service time) and noted that 95929 requires slightly less work, less time and is less intense than 95861. Therefore, the 25th percentile work RVU, which is the current work RVU of 1.50 appropriately places this service relative to other similar services. **The RUC recommends a work RVU of 1.50 for CPT code 95929.**

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings and was redistributed back to the Medicare conversion factor in 2012.

Practice Expense:
The RUC accepted the direct PE inputs with minor modifications as recommended by the PE Subcommittee.

Negative Pressure Wound Therapy (Tab 37)
In the Final Rule for 2013, CMS created two HCPCS codes to provide a payment mechanism for negative pressure wound therapy services furnished to beneficiaries through means unrelated to the durable medical equipment benefit: G0456 *Negative pressure wound therapy,(eg vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters* and G0457 *Negative pressure wound therapy,(eg vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 sq cm*. The two new codes will be contractor priced on an interim basis for CY 2013. CMS requested comments on the appropriate value for this service.

In January 2013, the RUC noted that industry individuals developed a Coding Change Proposal (CCP) to describe the NPWT disposable device, however subsequently withdrew the proposal. The RUC recommended that codes G0456 and G0457 be placed on the LOI to allow specialties that may have an interest a chance to survey and develop new PE inputs**. No specialty indicated an interested in developing recommendations for the service.**

In April 2013, industry individuals have again submitted a CCP to create two category I codes to describe these services with the use of a disposable device. Depending on Panel Action, at the May CPT meeting, this issue may be on the LOI for the October 2013 RUC meeting.

XII. Practice Expense Subcommittee (Tab 38)

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

The Practice Expense (PE) Subcommittee's Migration of Radiologic Images from Film to Digital Workgroup has finalized their recommendation to the RUC. For the 604 imaging CPT codes being transitioned to digital equipment, the supplies and equipment identified as being film inputs will be removed in favor of a digital PACS workstation. That

workstation will be accrued in minutes corresponding to the intra-service time for codes moving forward. The Workgroup has come up with a very detailed list, everything from the digital workstation up to the plugs in the wall and the central server based PACS system. CMS will be making a determination where the individual workstation allocable to that study and that patient ends and where the overhead generically available for multiple patients and multiple codes begins. **The PE Subcommittee makes the following recommendations to the RUC:**

Recommendations

- **For existing codes:**
    - **Remove recommended supplies and equipment as noted on spreadsheet from 604 imaging CPT codes (see *Film to Digital Codes-Supplies-Equipment-Final* attached).**
    - **Replace supplies and equipment for 604 imaging CPT codes with recommended PACS equipment. Invoices will be provided by specialties (see *Digital Imaging Equipment Overview* attached).**
    - **No modification to clinical labor activities at this time.**
- **For new codes and codes undergoing review:**
    - **Clinical labor activities for imaging codes will be replaced with more detailed activities. These detailed activities specified below are specific to CPT code 70450, *Computed tomography, head or brain; without contrast material*. Using these as a guide, specialty societies will need to determine the allocated clinical labor equipment and time recommendations based on previous inputs and current clinical practice. These recommendations will be reviewed at the Practice Expense Subcommittee on a code by code basis.**
    - **For Pre-service activity: *Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information and confirm contrast protocol with interpreting MD* performed by a CT technologist, or similar list:**
        - **Pre-service activity: *Availability of Prior Images Confirmed* performed by a CT technologist.**
        - **Pre-service activity: *Patient clinical information and questionnaire reviewed by technologist, order from physician confirmed and exam protocoled by radiologist,* performed by a CT technologist.**
    - **For Post-service activity: *Process films, hang films and review study with interpreting MD prior to patient discharge* performed by a CT technologist, or similar list:**
        - **Post-service activity: *Technologist QC's images in PACS, checking for all images, reformats, and dose page.***
        - **Post-service activity: *Review examination with interpreting MD.***
        - **Post-service activity: *Exam documents scanned into PACS. Exam completed in RIS system to generate billing process and to populate images into Radiologist work queue.***

The PE Subcommittee's Contrast Imaging Workgroup has developed a standard set of supplies for CT and MR that will be presumed to be standard any time there is contrast given. The PE Subcommittee noted that CMS equipment code ER079, *Power Injector for CT Contrast* is needed for CPT codes with contrast imaging, however it is not included in the standard because it is already included in CT and MR rooms.

The PE Subcommittee has discussed the issue of moderate sedation monitoring time at both this meeting and the prior meeting in January. There has been some debate about how long patients in the office setting are monitored following moderate sedation. At the last meeting we agreed that the standard should be no more than 2 hours of monitoring following moderate sedation in the office setting. At the April RUC meeting, there was an appeal that under certain circumstances more time is needed and a number of specialties recommended 60 minutes of RN monitoring, representing 4 hours of post-service patient monitoring. The Chair will establish a Workgroup to review the data for CPT codes with moderate sedation and other (e.g. vascular access) monitoring time and recommend adjustments if necessary.

At a previous meeting the Pathologists were requested to do a survey to collect data on the number of blocks assumed in the determination of practice expense recommendations for CPT codes 88302-88309. In response the College of American Pathologists (CAP) and other stakeholders, conducted a national study of the number of blocks typically produced for CPT codes 88302-88309. This independent evidence confirms the conservative estimation made by the CAP, and approved by the RUC, in January 2012 of the appropriate typical number of blocks associated with each of these services and which the RUC previously recommended, based on the data presented and on the RUC's clinical knowledge. **Based on this additional evidence, the PE Subcommittee confirms the number of blocks approved by the RUC at January 2012 RUC Meeting and recommends submission of practice expense inputs to CMS.**

The RUC approved the Practice Expense Subcommittee Report.

XIII. Administrative Subcommittee (Tab 39)

Doctor Michael Bishop, Chair, provided a summary of the Administrative Subcommittee report:

The Administrative Subcommittee reviewed the internal medicine rotating seat and "any other" rotating seat nominations (Tab 44). The Subcommittee noted that each seat had one nominee; therefore "an election will be unnecessary in the case that there is an unchallenged seat and the seat will be awarded to the candidate by voice vote."

The Administrative Subcommittee reviewed the anti-lobbying policy drafted by the AMA Office of General Counsel, which was mirrored from the CPT anti-lobbying policy. The discussion focused on whether this drafted policy is too general. After discussion with the AMA General Counsel, the Administrative Subcommittee voted to keep the policy general. There was one member of the Subcommittee who opposed the drafted policy, due to concern that the process outlined in the policy to review violations was not articulated, not against developing an anti-lobbying policy itself. **The Administrative Subcommittee recommends the following anti-lobbying policy:**

Lobbying Policy
Lobbying of members of the AMA/Specialty Society RVS Update Committee ("RUC"), members of the HCPAC Review Board, RUC/HCPAC Advisors or the staff or leadership of medical and healthcare professional societies (including consultants engaged by such societies), either directly or via third parties, is prohibited. *(Note: References to "RUC"*

herein, where appropriate, apply equally to the HCPAC Review Board as though expressly stated.)

"Lobbying" means **unsolicited** communications of any kind made at any time (including, except as permitted below, during meetings) for the purpose of attempting to improperly influence voting by members of the RUC on valuation of CPT® codes or any other item that comes before the RUC, one of its workgroups or one of its subcommittees. **Any communication that can reasonably be interpreted as inducement, coercion, intimidation or harassment is strictly prohibited. Violation of the prohibition on lobbying may result in sanctions, such as being suspended or barred from further participation in the RUC process.**

Information that accompanies a recommendation, presentation or commentary to the RUC or a workgroup or a subcommittee during meetings of those groups, and responses to inquiries from a RUC member, RUC/HCPAC Advisor or a RUC staff member, do not constitute "lobbying."

In order for the members of the RUC and HCPAC Review Board and for RUC/HCPAC Advisors to function effectively, their review of medical specialty societies' recommendations for valuation of CPT® codes made to the RUC or to one of its workgroups or subcommittees ("RVU Submission") must be based on the information contained in the RVU Submission and the RUC members independent judgment. RUC staff is responsible for organizing and submitting information to the RUC/HCPAC Advisors, workgroups and committees, and the RUC for consideration. Information relating to a RVU Submission must be initially submitted to RUC staff no later than twenty-one (21) days prior to the start of the meeting at which the recommendation will be considered. Information submitted outside of this process or beyond the deadline will not be considered unless approved and disseminated by RUC staff.

In some cases, the Chair of the RUC may convene a "facilitation committee" which is an informal group that meets during a RUC meeting to allow selected RUC members, with input from RUC/HCPAC Advisors and other invited participants, to confer and attempt to reach consensus on a recommendation for presentation at the RUC meeting. The expression of views during meetings of facilitation committees is not considered lobbying.

Complaints about lobbying should be reported promptly in writing to the Director, Physician Payment Policy and Systems.

Point of Clarification

A RUC member clarified that the language: "… must be based on the information contained in the RVU Submission and the RUC members' independent judgment" does not exclude RUC members from consulting with colleagues or literature. It is only intended to inhibit lobbying efforts.

The RUC approved the Administrative Subcommittee Report.

XIV. HCPAC Review Board (Tab 40)

Anthony Hamm, DC, provided the Health Care Professionals Advisory Committee Review Board report:

Dr. Hamm indicated that the HCPAC reviewed and provided recommendations for one revised code regarding Pharmacologic Management.

Pharmacologic Management with Psychotherapy
James Georgoulakis, PhD, (APA)

Specific psychotherapy codes were identified through the CMS High Expenditure Procedural codes screen. However, the specialties were already in the process of revising this entire section as indicated from the Fourth Five-Year Review. In April 2012, the specialty societies indicated and the RUC and HCPAC agreed that codes 90785, 90839, 90840 and 90863 be carrier priced to allow for education and experience with a significantly different coding structure. This would allow providers to gain experience with the codes prior to conducting a HCPAC survey. After a year of experience with the new coding structure the specialties would conduct surveys for these services for review of work and direct PE inputs at the April 2013 HCPAC meeting. In the Final Rule for 2013 CMS assigned interim values to the new psychotherapy codes and indicated that they will re-review all assumptions when they review all recommended values for this family of CPT codes.

90863 ***Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)***
The HCPAC reviewed the survey results from 32 psychologists who practice in the two states that allow clinical psychologists to perform pharmacologic management under state scope of practice laws, for CPT code 90863. The HCPAC noted that the respondents chose 99213 *Evaluation and Management Office Visit* (work RVU = 0.97 and 15 minutes intra-service time) as the key reference service. The HCPAC noted that when the RUC reviewed the Psychotherapy performed with an Evaluation and Management service (E/M), codes 90833, 90836 and 90838, the RUC assumed the typical E/M reported would be a 99212. The HCPAC determined that the survey median work RVU of 0.98 was not appropriate as this service is an add-on code for Psychotherapy codes 90832, 90834 and 90837 and would result in too high of a work RVU compared to the RUC recommended Psychotherapy with E/M codes. The HCPAC determined that the survey respondents 25th percentile intra-service time of 15 minutes and a cross-walk to the work of 99212 (work RVU=0.48 and 16 minutes total time) was more appropriate. Additionally, a work RVU of 0.48 would appropriately align this service relative to the Psychotherapy with E/M services. **The HCPAC recommends a work RVU of 0.48 for CPT code 90863.**

Practice Expense:
The HCPAC reviewed the direct practice expense inputs and recommends 5 minutes of clinical staff for the *Medical/Technical Assistant* (L026A) to obtain vital signs (blood pressure, respiratory rate, heart rate, height, weight and temperature) and 15 minutes of equipment time for *One Couch and Two Chairs* (EFO42).

The RUC filed the HCPAC Review Board Report.

XV. Research Subcommittee (Tab 41)

Doctor Scott Collins, Chair, provided a summary of the Research Subcommittee report:

The RUC reviewed and accepted the February conference call report.

In October 2012, the CPT Editorial Panel created CPT codes 994XX1 and 994XX2 to replace CPT Category III codes, 0260T and 0261T, which describe services for hypothermia in a critically ill neonate per day. In January 2013, the RUC reviewed these codes and determined that the survey data could not be considered reliable due to the low performance rate. Furthermore, there was concern that these services overlapped with the critical care services. For these reasons, the RUC agreed that these codes should be carrier priced. After review by the RUC, the AAP confirmed that they are planning on submitting a coding change proposal to the CPT Editorial Panel in October 2013 to create one new "procedure-focused" code for the initiation of total body or selective head cooling and will request the deletion of the two current neonatal hypothermia codes.

The AAP submitted a request to use a targeted survey sample to survey the new code for the January 2014 RUC meeting. Specifically, the AAP will survey those who indicated that they perform the service. **The Research Subcommittee recommends the use of a targeted survey sample for the new neonatal hypothermia code**.

At the October 2012 RUC meeting, the Research Subcommittee was charged with exploring the use and availability of extant databases among specialty societies and how databases that meet the RUC's criteria and can be incorporated into future recommendations. Currently, the Society of Thoracic Surgeons' National Database has been approved as an extant database and The American Speech-Language and Hearing Association's National Outcome Measurement System (NOMS) database has been approved as a secondary source to complement the survey data. The Research Subcommittee solicited specialty societies to determine how many other databases are currently available or in development that may or may not meet the RUC criteria and plans to submit for approval.

On March 13, 2013, an email to all specialty society staff with an attached survey was sent. A total of 38 specialty societies responded and confirmed that their societies do not currently have database that meets all RUC criteria or have plans to develop a database to be used for RUC purposes. The American Academy of Orthopaedic Surgeons (AAOS) indicated that they are part of the governance of a registry called the American Joint Replacement Registry (AJRR). The AJRR has the ability to meet the criteria listed above. However, the registry is still scaling up and likely doesn't have enough information to provide meaningful alternative data. There are no plans to further develop this registry to submit for RUC approval. The American College of Chest Physicians is developing a database that may meet the criteria and will submit for approval. However, a specific time frame has not yet been determined. The Research Subcommittee will take no further action at this time.

The Research Subcommittee discussed reference service lists (RSL) and the problems with developing code specific RSLs. There is going to be some analysis of the past several years and what has been done in approving RSLs in an attempt to review the current policy, which is elaborated in our structure and function documents, and make a determination if that policy needs to be modified or if there is a way that the process can

be improved. The work will be ongoing and an update will be provided at the next meeting.

During the February 2013 conference call, the Research Subcommittee agreed to review and modify the RUC survey process presentation. **The Research Subcommittee recommends the edits as outlined in the final report and if approved by the RUC will post a revised version to the RUC participant website.**

The Research Subcommittee approved some new introductory language for the survey cover memo. This change was driven by the American Academy of Ophthalmology (AAO) after the specialty society discovered that there may have been some coaching going on. We thank the AAO for taking immediate action by marking those surveys and presenting the data differentially. **The Research Subcommittee developed language that can be found in the final report and recommends that specialty societies incorporate the language into their survey cover memo**

The RUC approved the Research Subcommittee Report.

XVI. Relativity Assessment Workgroup (Tab 42)

Doctor Marc Raphaelson, Chair, provided the Relativity Assessment Workgroup report:

The Relativity Assessment Workgroup (RAW) looked at four screens for potentially misvalued codes and potential future screens.

Site-of Service Anomalies
In the past a number of services that had been performed in the inpatient setting have moved to the outpatient setting. AMA staff re-ran the site-of-service anomaly screen and no additional site-of-service anomalies were identified and no action is recommended.

High Volume Growth
AMA staff assembled a list of services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2006 to 2011. The query resulted in the identification of 59 services. **The Workgroup requests that specialty societies submit an action plan for the October 2013 meeting for services identified by this screen that have not been reviewed in the last 3 years or are not in the process of review.**

CMS/Other
In the last few years the Workgroup established the threshold for CMS/Other source codes with Medicare utilization of 500,000 or more, which resulted in 19 codes. The AMA staff lowered the threshold to CMS/Other source codes with 2011 Medicare utilization of 250,000 or more. These are relatively high volume codes that have never been reviewed by the RUC. The result was 42 services, 13 of which have already been identified and will be addressed in CPT 2014 and 10 of which are currently G codes. The Workgroup discussed whether or not the RUC should value the G-codes involved. The majority of members of the RAW indicated that these codes have not gone through the CPT process, but they are being used and have been valued by CMS without the RUC having the opportunity to make a recommendation regarding their value. **The Workgroup requests that the specialty societies submit an action plan for the**

October 2013 meeting for services not reviewed in the last 3 years or are not in the process of review.

Services Surveyed by One Specialty – Now Performed by a Different Specialty
AMA staff re-examined the dominant specialties for services surveyed by one specialty and now performed by a different specialty based on 2011 Medicare utilization, which resulted in the identification of two services. **The Workgroup requests that the specialty societies submit an action plan at the October 2013 meeting for the two services (CPT codes 96103 and 96372).**

Additional Screens
Many of the screens have arisen at the request of the CMS and the Workgroup discussed how it can develop additional proactive screens that can be used to identify potentially misvalued services. The Workgroup recommends that AMA staff gather data and conduct the following analysis to determine possible future screens:

1. *Pre-time* – identify services RUC reviewed prior to the implementation of the pre-service packages, identify these older services that have a pre-time greater than pre-time package 4 Facility – Difficult Patient/Difficult procedure. This is intended to screen for procedures that may include incorrectly high pre-service time, for further review.
2. *Post-Operative Visits* – identify 010 and 090-day global services that have a large number of post-operative services. Conduct a frequency analysis of the number of post-operative visits and post-operative time to determine outlier codes. This is intended to allow the Workgroup to identify services that may include excessive postoperative visits, for further review.
3. *Conscious Sedation* – request that CMS provide data for each procedure in Appendix G (CPT Codes that include Moderate (Conscious) Sedation), to determine the frequency for conscious or other sedation performed by another provider the same day. This is intended to allow the Workgroup to identify services for which moderate sedation may not be typical and the resource inputs assumed by the RUC may be incorrect.
4. *Conscious Sedation Appendix G List* – Identify each procedure in Appendix G for which the work of conscious sedation is included in the intra-service work rather than the pre-service work. This is intended to identify services for which the physician time allocation, and perhaps work, may be misvalued.
5. The RAW recognizes that RUC has addressed significant anomalies in work values as nearly 1500 services have now been reviewed under the potentially misvalued services project. The RAW recommends that further analysis be prepared to review the impact of this work in addressing the relativity of work values across families of services in the RBRVS. This analysis will be beneficial in evaluating future work plans to address work value relativity.

The RUC approved the Relativity Assessment Workgroup Report.

XVII. Post Time Workgroup (Tab 43)

Doctor Brenda Lewis, Workgroup Member, provided the Post Time Workgroup report:

The Post-Time Workgroup has met via conference call before this meeting as well as at the meeting. We have had several discussions about developing post-time packages and have come up with a recommendation. The recommendation is still in progress; however, we have defined the activities required and set minimum times required for those activities. The survey would then guide us, but if the specialty recommends times that

exceed the minimums, they would need to explain the need for that time. For all facility based procedure, the Workgroup identified the following post-service activities and discussed time as follows:

Dressing: 2 minutes
Operative note: 5 minutes
Recovering/Stabilization of patient:
Local: 1 minute
IV Sedation: 5 minutes
General Anesthesia: 10 minutes
Communication with patient/family: 5 minutes
Written post-op note:
Simple procedure: 2 minutes
Complex procedure: 5 minutes

Based on these estimates discussed, post time for facility based procedures ranged between 15 and 27 minutes, current survey data medians reflect 15-30 minutes. Therefore, there is no evidence that the survey data is overstated. The Workgroup will continue to discuss and refine post time and prepare recommendations for the October 2013 RUC meeting.

In the 2013 Final Rule CMS requested that the RUC consider assigning services that require only local anesthesia without sedation to the ‘‘no sedation/anesthesia care’’ pre-service time package, or that the AMA RUC create one or more new pre-service time packages to reflect the pre-service time typically involved in furnishing local anesthesia without sedation.

The Workgroup members reviewed pre-service time packages and determined that procedures that require only local anesthesia should be assigned to packages 1A and 2A when performed in the facility. The Workgroup noted that package 5 currently does not have time allocated for local anesthesia. However, it was noted that package 6 does include 5 minutes for the administration of local anesthesia. The Workgroup will review the pre-service time packages for office procedures (package 5 and 6) to determine appropriate designation for local anesthesia or to develop a new package.

The RUC approved the Post Time Workgroup Report.

XVIII. BETOS Workgroup (Tab 44)

Doctor Chad Rubin, Chair, provided the BETOS Workgroup report:

The Workgroup has had two conference calls and one face-to-face meeting to discuss the BETOS classifications. The Workgroup’s charge from the RUC is to review, revise and maintain BETOS. We are pursuing all of those simultaneously. This is a work in progress, but we do have two recommendations for the RUC:

To ensure the BETOS system is properly maintained, **the BETOS Workgroup recommends that the RUC add a question to the Summary of Recommendation (SOR) form requesting a suggested BETOS category for all new CPT codes.** These recommendations will be forwarded to CMS with the RUC submission each May.

The Workgroup received many comments from specialty societies that the current Ambulatory classification is severely flawed. First, there is no identifiable definition of what CMS considers Ambulatory for classification purposes. Second, simply reviewing site-of-service information shows wide variability within the classification. For example, 21% of the services classified as Ambulatory were primarily performed in the Inpatient setting in 2011. **Therefore, the BETOS Workgroup recommends that the Ambulatory sub-classification be removed from BETOS and the services currently classified as such be reclassified.** Several specialty societies have offered revised classifications for many of the current Ambulatory procedures. However, AMA staff will work over the summer with specialties to obtain comments on codes without a suggested reclassification and also work out issues where separate societies have offered different classifications for the same code.

The RUC approved the BETOS Workgroup Report.

XIX. Other Issues

- There was a referral to the Research Subcommittee to review the process of crosswalking codes. The precedent had been that only codes that were approved and published by CMS could be used as a crosswalk to codes under consideration at the RUC. Recently codes under consideration are being crosswalked to other codes under consideration. If this is a new precedent it should be formally established.
- The Practice Expense Subcommittee has a higher volume of work than can be accommodated in a one day meeting and needs to consider options such as meeting on Wednesday or doing some of the work ahead of time on a conference call.
- A RUC member commented that the RUC is very detail oriented and that is its function. However, the member noted that there is a great amount of talent around the table and thinking about some of the larger issues of fairness and equity around payment and delivery options would be a very useful thing.
- A RUC member commented that when asked about the role that the RUC plays in national healthcare, the member estimated that over the last couple decades RUC members have spent 36,000 volunteer days devoted to this process. This represents a tremendous contribution from physicians.
- Doctor Phurrough, from CMS emphasized the importance of specialty societies submitting good invoices to assist with the pricing of equipment items. In addition, he suggested that the RUC address the issue of large families of codes being split into groups to be reviewed throughout the same CPT cycle. It creates a problem because the recommended values, which have not yet been approved and published by CMS, for the codes reviewed first, are not available for the specialty to include as a reference service in the surveys.
- Doctor Levy noted the discussion regarding global periods during the CMS presentation earlier in the meeting. She will establish a workgroup to review the issues of global periods in general. This workgroup should initially consider if the RUC should pursue global period changes and/or a review of services reported within a global bundle. This effort would first require dialogue with CMS. The workgroup will meet via conference call or at the next RUC meeting.
- The Society of Thoracic Surgeons (STS) has requested that the Research Subcommittee review and approve an intensity survey methodology. In order for the Research Subcommittee to review, STS will provide methodology they have used to develop: RSLs, instructions, survey instruments and final recommendations.

Doctor Levy adjourned the meeting at 5:00 pm on Saturday, April 27, 2013.

AMA/Specialty Society RVS Update Committee **Tab 38**
Practice Expense Subcommittee
April 25, 2013

Members Present: Scott Manaker, MD, PhD, FCCP (Chair), Guy Orangio, MD (Vice Chair), Albert Bothe (CPT Resource), James Blankenship, MD, Joel Brill, MD, Sandra Cadena, PhD, ARNP, CNE, Neal Cohen, MD, William Gee, MD, David Han, MD, Timothy Laing, MD, Alan Lazaroff, MD, Geraldine B. McGinty, MD, Margaret Neal, MD, Eileen M. Moynihan, MD, Tye Ouzounian, MD, Chad Rubin, MD, John Seibel, MD, Robert Stomel, DO, Thomas J. Weida, MD

I. Migration of Radiologic Images from Film to Digital Workgroup (PACS)

The Migration from Film to Digital Imaging Workgroup met on February 25, 2013 and March 20, 2013 via conference call to discuss the transition from film to digital imaging. 604 imaging CPT codes were previously identified as being transitioned to digital equipment. The supplies and equipment to be removed were also previously identified. In February and March the Workgroup identified the recommended PACS equipment to replace film components that will be removed from the codes and clinical labor activities that will be implemented as codes are reviewed moving forward. The Workgroup completed its work and submitted its recommendations to the PE Subcommittee for review. **The PE Subcommittee makes the following recommendations to the RUC:**

Recommendations

- **For existing codes:**
  - **Remove recommended supplies and equipment as noted on spreadsheet from 604 imaging CPT codes (see *Film to Digital Codes-Supplies-Equipment-Final* attached).**
  - **Replace supplies and equipment for 604 imaging CPT codes with recommended PACS equipment. Invoices will be provided by specialties (see *Digital Imaging Equipment Overview* attached).**
  - **No modification to clinical labor activities at this time.**
- **For new codes and codes undergoing review:**
  - **Clinical labor activities for imaging codes will be replaced with more detailed activities. These detailed activities specified below are specific to CPT code 70450, *Computed tomography, head or brain; without contrast material*. Using these as a guide, specialty societies will need to determine the allocated clinical labor equipment and time recommendations based on previous inputs and current clinical practice. These recommendations will be reviewed at the Practice Expense Subcommittee on a code by code basis.**
  - **For Pre-service activity: *Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information and confirm contrast protocol with interpreting MD* performed by a CT technologist, or similar list:**
    - **Pre-service activity: *Availability of Prior Images Confirmed* performed by a CT technologist.**

- **Pre-service activity:** ***Patient clinical information and questionnaire reviewed by technologist, order from physician confirmed and exam protocoled by radiologist,*** **performed by a CT technologist.**

- **For Post-service activity:** ***Process films, hang films and review study with interpreting MD prior to patient discharge*** **performed by a CT technologist, or similar list:**
  - **Post-service activity:** ***Technologist QC's images in PACS, checking for all images, reformats, and dose page.***
  - **Post-service activity:** ***Review examination with interpreting MD.***
  - **Post-service activity:** ***Exam documents scanned into PACS. Exam completed in RIS system to generate billing process and to populate images into Radiologist work queue.***

II. Moderate Sedation Monitoring Time

At the January 2013 Practice Expense (PE) Subcommittee Meeting the issue of RN time for monitoring a patient that has received moderate sedation was brought to the attention of the Subcommittee. Currently the standard is 15 minutes for every hour of post-service patient monitoring. There is currently no stated limit on the number of hours that a specialty can recommend for post-service patient monitoring. At the April RUC meeting, a number of specialties recommended 60 minutes of RN monitoring, representing 4 hours of post-service patient monitoring. The PE Subcommittee determined that 2 hours of monitoring was sufficient for most procedures utilizing moderate sedation. **The PE Subcommittee is recommending that the RUC add a limit of 30 minutes of RN monitoring, representing 2 hours of post-service patient monitoring.**

In addition at the April 2013 RUC meeting the PE Subcommittee noted that many codes may currently have more monitoring time than this new standard. **The Chair will establish a Workgroup to review the data for CPT codes with moderate sedation and other (e.g. vascular access) monitoring time and recommend adjustments if necessary.**

III. Contrast Imaging Workgroup Update

As requested the American College of Radiology (ACR) has provided supply packages for MRI and CT for the PE Subcommittee's review. The PE Subcommittee recommends that the supply packages be distributed for specialty society comment following the RUC meeting and then finalized to be used as the standard for supply pack for imaging codes with contrast. The PE Subcommittee noted that CMS equipment code ER079, *Power Injector for CT Contrast* is needed for CPT codes with contrast imaging, however it is not included in the standard because it is already included in CT and MR rooms.

IV. Pathology AP Block Study Results

In the Final Rule CMS asked for comment and data on the number of blocks assumed in the determination of practice expense recommendations for CPT codes 88302-88309. In response the College of American Pathologists (CAP) and other stakeholders, conducted a national study of the number of blocks typically produced for CPT codes 88302-88309. In February 2013, the RUC's Research Subcommittee approved CAP's methodology utilized to confirm the number of blocks. CAP submitted the results of this study to the PE Subcommittee for review.

Laboratories of various sizes and locations around the country were asked to review the number of blocks typically used for the CPT codes 88302-88309 using the RUC approved vignettes. A total of 90 different laboratories responded to our request for patient specific data resulting in a review of 1,214 surgical pathology cases. Some laboratories may not process all types of surgical pathology specimens and thus submitted data for only the applicable code(s).

The results of the multispecialty study are summarized below.

CPT CODE	# LABS Reporting	Cases Reviewed	Median from Study	CMS/RUC Assumptions – January 2012
88302	33	140	1	1
88304	83	380	3	2
88305	83	416	4	2
88307	35	161	13	12
88309	31	135	21	18

This independent evidence confirms the conservative estimation made by the CAP, and approved by the RUC, in January 2012 of the appropriate typical number of blocks associated with each of these services and which the RUC previously recommended, based on the data presented and on the RUC's clinical knowledge. **Based on this additional evidence, the PE Subcommittee confirms the number of blocks approved by the RUC at January 2012 RUC Meeting and recommends submission of practice expense inputs to CMS.**

V. Practice Expense Recommendations

Tab	Title	PE Input Changes (Yes or No)
4	Breast Biopsy	Yes Modifications/Handout
5	Transcatheter Aortic Valve Replacement	No Approved April 2012
6	Fenestrated Endovascular Repair	Carrier Pricing Recommended
7	Retrograde Treatment Open Carotid Stent	No
8	Embolization and Occlusion Procedures	No
9	Transcatheter Placement of Intravascular Stent	Yes Minor Modifications
10	Esophagoscopy	No

11	Esophagoscopy Gastroscopy Duodenoscopy (EGD)	No
12	Endoscopic Retrograde Cholangiopancreatography (ERCP)	No
13	Cystourethroscopy	Yes Modifications/Handout
14	Insertion of Anterior Segment Device (6618X1)	No Approved Jan 2013
15	Mechanical Chest Wall Oscillation	Yes Minor Modifications
16	Ultrasonic Wound Assessment	No Carrier Pricing Recommended
17	Destruction of Premalignant Lesions	No Approved Jan 2013
18	Mohs Surgery	Yes Modifications/Handout
19	Nasal/Sinus Endoscopy	Yes Modifications/Handout
20	Implantation and Removal of Patient Activated Cardiac Event Recorder	Yes Minor Modifications
21	Renal Allotransplantation	No
22	Percutaneous Implantation of Neurostimulator	Yes Modifications/Handout
23	Aqueous Shunt (66180, 66185)*	No Approved Jan 2013
24	Repair of Eyelid (67914-67924)*	Yes Modifications/Handout
25	MRI-Neck and Lumbar Spine	Yes Modifications/Handout
26	CT-Angiography-Abdomen and Pelvis	No Approved Feb 2011 Approved April 2012
27	Fluoroscopic Guidance	Yes Minor Modifications

28	IMRT	No
29	Radiation Treatment Delivery	Yes Minor Modifications
30	Hyperthermia	Yes Minor Modifications
31	Continuing Medical Physics Consultation	No
32	High Dose Rate Brachytherapy	Yes Minor Modifications
33	Cytopathology	Yes Minor Modifications
34	In Situ Hybridization	Referred to CPT
35	Psychotherapy for Crisis and Interactive Complexity	No
36	Evoked Potentials and Reflex Tests	Yes Minor Modifications
37	Negative Pressure Wound Therapy	Referred to CPT

AMA/Specialty Society RVS Update Committee **Tab 39**
Administrative Subcommittee Report
April 25, 2013

Members: Doctors Michael Bishop (Chair), J. Allan Tucker (Vice Chair), Margie Andreae, Dale Blasier, Ronald Burd, John Gage, Anthony Hamm, DC, J. Leonard Lichtenfeld, William Mangold, Jr., Greg Przybylski, and James Waldorf.

I. Review Election of Rotating Seats Submission – Tab 44

The Administrative Subcommittee reviewed the internal medicine rotating seat and "any other" rotating seat nominations. The Subcommittee noted that each seat had one nominee, therefore "an election will be unnecessary in the case that there is an unchallenged seat and the seat will be awarded to the candidate by voice vote."

II. Lobbying Policy

In January 2013 a RUC member questioned if the RUC had an anti-lobbying policy. The RUC did not have an anti-lobbying policy and therefore recommended drafting one. Administrative Subcommittee reviewed the anti-lobbying policy drafted by the AMA Office of General Counsel, which was mirrored from the CPT anti-lobbying policy. The Administrative Subcommittee made one addition as outlined below. One member of the Subcommittee opposed the drafted policy, due to concern that the process outlined in the policy to review violations was not articulated, not against developing an anti-lobbying policy itself. **The Administrative Subcommittee recommends the following anti-lobbying policy:**

Lobbying Policy

Lobbying of members of the AMA/Specialty Society RVS Update Committee ("RUC"), members of the HCPAC Review Board, RUC/HCPAC Advisors or the staff or leadership of medical and healthcare professional societies (including consultants engaged by such societies), either directly or via third parties, is prohibited. *(Note: References to "RUC" herein, where appropriate, apply equally to the HCPAC Review Board as though expressly stated.)*

"Lobbying" means **unsolicited** communications of any kind made at any time (including, except as permitted below, during meetings) for the purpose of attempting to improperly influence voting by members of the RUC on valuation of CPT® codes or any other item that comes before the RUC, one of its workgroups or one of its subcommittees. **Any communication that can reasonably be interpreted as inducement, coercion, intimidation or harassment is strictly prohibited. Violation of the prohibition on lobbying may result in sanctions, such as being suspended or barred from further participation in the RUC process.**

Information that accompanies a recommendation, presentation or commentary to the RUC or a workgroup or a subcommittee during meetings of those groups, and responses to inquiries from a RUC member, RUC/HCPAC Advisor or a RUC staff member, do not constitute "lobbying."

In order for the members of the RUC and HCPAC Review Board and for RUC/HCPAC Advisors to function effectively, their review of medical specialty societies' recommendations for valuation of CPT® codes made to the RUC or to one of its workgroups or subcommittees ("RVU Submission") must be based on the information contained in the RVU Submission and the RUC members independent judgment. RUC staff is responsible for organizing and submitting information to the RUC/HCPAC Advisors, workgroups and committees, and the RUC for consideration. Information relating to a RVU Submission must be initially submitted to RUC staff no later than twenty-one (21) days prior to the start of the meeting at which the recommendation will be considered. Information submitted outside of this process or beyond the deadline will not be considered unless approved and disseminated by RUC staff.

Approved by the RUC – April 27, 2013

In some cases, the Chair of the RUC may convene a "facilitation committee" which is an informal group that meets during a RUC meeting to allow selected RUC members, with input from RUC/HCPAC Advisors and other invited participants, to confer and attempt to reach consensus on a recommendation for presentation at the RUC meeting. The expression of views during meetings of facilitation committees is not considered lobbying.

Complaints about lobbying should be reported promptly in writing to the Director, Physician Payment Policy and Systems.

AMA/Specialty Society RVS Update Committee **Tab 40**
Health Care Professionals Advisory Committee Review Board
April 25, 2013

Members: William Mangold, MD (Chair), Anthony Hamm, DC (Co-Chair), Jane White, PhD, RD, FADA (Alt. Co-Chair), Sandra Cadena, PhD, ARNP, CNE Michael Chaglasian, OD, Scott Collins, MD, Robert Fifer, PhD, CCC-A, Mary Foto, OTR, Emily Hill, PA-C, Stephen Levine, PT, DPT, MSHA, Eileen Moynihan, MD, Neil Pliskin, PhD, Timothy Tillo, DPM and Doris Tomer, LCSW

I. Co-Chair and Alternate Co-Chair Elections

The HCPAC re-elected Anthony W. Hamm, DC, FACO as the HCPAC Co-Chair and Jane V. White, PhD, RD, FADA as the Alternate Co-Chair. Both will serve their second and final terms, beginning with the October 2013 HCPAC meeting and ending in May 2015, with the provision of final recommendations to the Centers for Medicare and Medicaid Services (CMS).

II. CMS Update

Edith Hambrick, MD informed the HCPAC that the current Acting Administrator Marilynn Tavenner was nominated for CMS Administrator. Additionally, Joanna Baldwin is the Acting Deputy Director of Practitioner services. Doctor Hambrick also indicated that CMS is currently working on the Notice for Proposed Rulemaking for 2014, which will be public on or around July 1, 2013.

III. CPT Physical Medicine and Rehabilitation Workgroup Update

Stephen Levine, PT and Mary Foto, OTR informed the HCPAC that currently a CPT Workgroup is working on redefining the Physician Medicine and Rehabilitation code family. The next face-to-face meeting will be at the 2013 May CPT meeting.

IV. Audiology Update

The American Academy of Audiology (AAA) and the American Speech-Language-Hearing Association (ASHA) provided information regarding their recent meetings to come to an agreement regarding the representation of the professions of audiology and speech-language pathology on the RUC HCPAC. At this time the groups have not arrived at an agreement.

IV. Relative Value Recommendation for CPT 2014:

Pharmacologic Management with Psychotherapy (90863)
Specific psychotherapy codes were identified through the CMS High Expenditure Procedural codes screen. However, the specialties were already in the process of revising this entire section as indicated from the Fourth Five-Year Review. In April 2012, the specialty societies indicated and the RUC and HCPAC agreed that codes 90785, 90839, 90840 and 90863 be carrier priced to allow for education and experience with a significantly different coding structure. This would allow providers to gain experience with the codes prior to conducting a HCPAC survey. After a year of experience with the new coding structure the specialties would conduct surveys for these services for review of work and direct PE inputs at the April 2013 HCPAC meeting. In the Final Rule for 2013 CMS assigned interim values to the new psychotherapy codes and indicated that they will re-review all assumptions when they review all recommended values for this family of CPT codes.

The HCPAC reviewed the survey results from 32 psychologists for CPT 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).* The HCPAC noticed that the respondents chose 99213 *Evaluation and Management Office Visit* (work RVU = 0.97 and 15 minutes intra-service time) as the key reference service. The HCPAC noted that when the RUC reviewed the Psychotherapy performed with an Evaluation and Management service (E/M) codes 90833, 90836 and 90838, the RUC assumed the typical E/M would be a 99212. The HCPAC determined that the survey median work RVU of 0.98 was not appropriate as this service is an add-on code for Psychotherapy codes 90832, 90834 and 90837 and would result in a higher work RVU than the RUC recommended Psychotherapy with E/M codes. The HCPAC determined that the survey respondents 25th percentile intra-service time of 15 minutes and a crosswalk to the work of 99212 (work RVU=0.48 and 16 minutes total time) was more appropriate. Additionally, a work RVU of 0.48 would appropriately align this service relative to the Psychotherapy with E/M services. **The HCPAC recommends a work RVU of 0.48 for CPT code 90863.**

Practice Expense:
The HCPAC reviewed the direct practice expense inputs and recommends 5 minutes of L026A *Medical/Technical Assistant* to obtain vital signs (blood pressure, respiratory rate, heart rate, height, weight and temperature) and 15 minutes EFO42 *One Couch and Two Chairs* equipment time.

Members: Scott Collins, MD (Chair), M. Douglas Leahy, MD (Vice Chair), James Georgoulakis, PhD, JD, David Hitzeman, DO, Charles Koopmann, Jr, MD, Walt Larimore, MD, Brenda Lewis, DO, Lawrence Martinelli, MD, Marc Raphaelson, MD, Sandra Reed, MD, Christopher Senkowski, MD, Peter Smith, MD, George Williams, MD

I. Research Subcommittee February 25, 2013 Conference Call Meeting Report

The Research Subcommittee report from the February 25, 2013 Conference Call is included in Tab 41 of the April 2013 agenda materials for approval by the RUC.

II. Specialty Society Request for Review of Survey Methodology

Neonatal Hypothermia

American Academy of Pediatrics (AAP)

In October 2012, the CPT Editorial Panel created CPT codes 994XX1 and 994XX2 to replace CPT Category III codes, 0260T and 0261T, which describe services for hypothermia in a critically ill neonate per day. In January 2013, the RUC reviewed these codes and determined that the survey data could not be considered reliable due to the low performance rate. Furthermore, there was concern that these services overlapped with the critical care services. For these reasons, the RUC agreed that these codes should be carrier priced. After review by the RUC, the AAP confirmed that they are planning on submitting a coding change proposal to the CPT Editorial Panel in October 2013 to create one new "procedure-focused" code for the initiation of total body or selective head cooling and will request the deletion of the two current neonatal hypothermia codes.

The AAP submitted a request to use a targeted survey sample to survey the new code for the January 2014 RUC meeting. Specifically, the AAP will survey those who indicated that they perform the service.

The Research Subcommittee recommends the use of a targeted survey sample for the new neonatal hypothermia code.

III. Review of Extant Database Results

At the October 2012 RUC meeting, the Research Subcommittee was charged with exploring the use and availability of extant databases among specialty societies and how databases that meet the RUC's criteria and can be incorporated into future recommendations. Currently, the Society of Thoracic Surgeons' National Database has been approved as an extant database and The American Speech-Language and Hearing Association's National Outcome Measurement System (NOMS) database has been approved as a secondary source to complement the survey data. The Research Subcommittee solicited specialty societies to determine how many other databases are currently available or in development that may or may not meet the RUC criteria and plans to submit for approval.

At the January 2013 RUC meeting, the Research Subcommittee reviewed and approved the following questions for the survey to specialty societies:

1) Does your specialty society currently have a database that meets these criteria?
   Yes (see Q2)
   No
   No, but in development

2) If yes, does your specialty society plan on submitting your database for use and approval to the RUC?

3) If yes to Q2, when do you expect to submit your request to use the database?

4) If your specialty society currently has a database, but it does not meet the above defined criteria, please specify which standards are not met and why.

5) Are there databases available that have not been developed by the specialty society? If yes, please list below and provide specific details, if appropriate.

On March 13, 2013, an email to all specialty society staff with an attached survey was sent. A total of 38 specialty societies responded and confirmed that their societies do not currently have database that meets all RUC criteria or have plans to develop a database to be used for RUC purposes. The American Academy of Orthopaedic Surgeons (AAOS) indicated that they are part of the governance of a registry called the American Joint Replacement Registry (AJRR). The AJRR has the ability to meet the criteria listed above. However, the registry is still scaling up and likely doesn't have enough information to provide meaningful alternative data. There are no plans to further develop this registry to submit for RUC approval. The American College of Chest Physicians is developing a database that may meet the criteria and will submit for approval. However, a specific time frame has not yet been determined.

The 39 societies that responded to the survey and indicated that they do not have an extant database that currently meets the RUC criteria include:

American Academy of Dermatology
American Academy of Family Physicians
American Academy of Neurology
American Academy of Otolaryngology - Head and Neck Surgery
American Association of Oral and Maxillofacial Surgeons
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Academy of Physical Medicine & Rehabilitation
American Academy of Sleep Medicine
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Medical Genetics
American College of Physicians
American College of Radiology
American College of Surgeons
American Congress of Obstetricians and Gynecologists

American Gastroenterological Association
American Geriatrics Society
American Nurses Association
American Optometric Association
American Osteopathic Association
American Orthopaedic Foot and Ankle Society
American Occupational Therapy Association
American Physical Therapy Association
American Society of Hematology
American Society of Clinical Oncology
American Society for Colon and Rectal Surgeons
American Society for Gastrointestinal Endoscopy
American Society of Plastic Surgeons
American Society for Radiation Oncology
American Society for Reproductive Medicine
American Society for Surgery of the Hand
American Thoracic Society
American Urological Association
College of American Pathologists
Heart Rhythm Society
Infectious Diseases Society of America
North American Spine Society
Society of Nuclear Medicine and Molecular Imaging

The Research Subcommittee recommends no further action at this time.

IV. Survey Cover Memos

At the January 2013 RUC meeting, the Research Subcommittee reviewed a request submitted by AAO to modify the survey instrument to require attestation from each survey respondent that the survey was completed independently of outside coaching. This request was driven after the specialty society detected a thread that encouraged survey respondents to provide higher valuations through the use of specific reference codes while monitoring list serve discussions. The specialty society immediately addressed the issue and collated two data sets. There was consensus that language should be added to ensure surveys are completed independently without external coaching; however, the Subcommittee determined that it would be more appropriate to add this language to the cover memo rather than modify the survey instrument. **The Research Subcommittee reviewed the following language and recommends that specialty societies incorporate into their survey cover memo:**

You have been selected to participate in an AMA RUC survey. As you may know, the Medicare payment schedule is based on physician work, practice expense and professional liability insurance. Our society needs your help to assure relative values will be accurately and fairly presented to the Centers for Medicare and Medicaid.

REMINDER: This survey is to be completed independently without coaching or assistance, with the exception of clarification from specialty society staff. If you are inappropriately contacted regarding this survey, please notify specialty society staff immediately.

V. Standardization of Reference Service Lists

The Research Subcommittee initially discussed strategies to streamline and improve Reference Service List (RSL) development at the January 2013 RUC meeting. The Subcommittee noted several problems with the current process including lack of comparable codes the specialties can select, especially when an entire family is under review; limited number of high and low valued codes; minimal use of Multi-Specialty Points of Comparison (MPC) codes; etc. The Research Subcommittee continued this discussion and considered developing specialty specific "fixed" RSLs or revising the current guidelines for RSL development. However, the Subcommittee decided that current guidelines are appropriate and urged specialties to follow these guidelines in developing RSLs.

The Research Subcommittee recommends further discussion regarding the standardization of reference service lists.

VI. Review of RUC Survey Presentation

During the February 2013 conference call, the Research Subcommittee agreed to review and modify the RUC survey process presentation. The presentation was revised to eliminate reference to payment/reimbursement. The Subcommittee members also suggested the following revisions:

Slide 5: "To obtain estimate of a recommended ~~professional work value~~ work relative value unit (RVU)"
Slide 7: "Oversees survey process ~~of codes~~"; Recommends ~~physician~~ work RVUs & practice expense ~~values~~ inputs to Centers for Medicare & Medicaid Services (CMS)
Slide 9: "The RUC sends its recommendations for work ~~values~~ RVUs, practice expense inputs and PLI crosswalks to CMS in May which are confidential until the CMS publication of the *Final Rule* in November.
Slide 10: "STEP 1 – Review code descriptor and vignette (a short description of the typical patient)"
Slide 13: Add the following bullet point: "This survey to be completed independently without coaching or assistance, with the exception of clarification from specialty society staff. If you are inappropriately contacted regarding this survey, please notify specialty society staff immediately."
Slide 16: "Using the vignette and the description of service periods, this section of the survey asks you to estimate how much time it takes you when you perform the procedure. These estimates should be based on personal experience and the typical patient."
Slide 17: "The pre-service period includes physician services provided from the day before the ~~operative~~ procedure or service until the time of the ~~operative~~ procedure or service"

The Research Subcommittee recommends the edits as noted above and will post a revised version(s) to the RUC participant website.

AMA/Specialty Society RVS Update Committee **Tab 42**
Relativity Assessment Workgroup
April 25, 2013

Members: Doctors Marc Raphaelson (Chair), Peter Smith (Vice-Chair), Margie Andreae, Amy Aronsky, Michael Bishop, Dale Blasier, Joel Brill, John Gage, Emily Hill, PA-C, David Hitzeman, Walt Larimore, Larry Martinelli, Gregory Przybylski and Robert Zwolak, MD.

I. Re-Review of Previous Screens

Site-of Service Anomalies

In February 2011, the RUC discussed the inpatient threshold percentage for re-reviewing codes regarding site-of-service and recommended maintaining the current 50% or less inpatient threshold. The RUC agreed and recommended that three consecutive years of data indicating 50% or less inpatient each year is appropriate in order to eliminate any annual fluctuations in the claims data.

AMA staff re-ran the site-of-service anomaly screen based on review of the 2009, 2010 and 2011 utilization data for services performed less than 50% of the time in the inpatient hospital setting, yet included hospital Evaluation and Management services within the global periods (99231, 99232, 99233 and 99238). At this time, no additional site-of-service anomalies were identified. **AMA staff will re-run the screen when 2012 final data are available.**

High Volume Growth

In 2007, The RUC reviewed High Volume Growth Services were Medicare utilization increased by at least 100% from 2004 through 2006. AMA staff assembled a list of services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2006 to 2011. The query resulted in the identification of 59 services. **The Workgroup requests that specialty societies submit an action plan for the October 2013 meeting for services identified by this screen that have not been reviewed in the last 3 years or are not in the process of review.**

CMS/Other

In April 2011, the RUC identified 410 codes with a source of "CMS/Other." "CMS/Other" source codes would not have been flagged in the Harvard only screens, therefore the Workgroup recommended that a list of all "CMS/Other" codes be developed and reviewed. CMS/Other codes are services which were not reviewed by either Harvard or the RUC and were either gap filled (most likely by crosswalk) by CMS or were part of radiology schedule. The Workgroup established the threshold for CMS/Other source codes with Medicare utilization of 500,000 or more, which resulted in 19 codes. The Workgroup then requested that specialty societies submit an action plans that articulated how the code values and times were originally developed and future steps.

AMA staff lowered the threshold to CMS/Other source codes with 2011 Medicare utilization of 250,000 or more, which results in 42 services, 13 of which have already been identified and will be addressed in CPT 2014 and 10 of which are currently G codes. **The Workgroup requests that the specialty societies submit an action plan for the October 2013 meeting for services not reviewed in the last 3 years or are not in the process of review.**

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

In October 2009, the RUC identified 21 services that had originally been surveyed by one specialty, but according to 2008 utilization data were dominantly being performed by other specialties. The top two dominant specialties performing this service were examined and services with Medicare utilization more than 1,000 and zero work RVUs were deleted.

AMA staff re-examined the dominant specialties for services surveyed by one specialty and now performed by a different specialty based on 2011 Medicare utilization, which resulted in the identification of two services. **The Workgroup requests that the specialty societies submit an action plan at the October 2013 meeting for the two services (CPT code 96103 and 96372).**

Additional Screens

The Workgroup had a robust discussion regarding additional proactive screens that may be reviewed to identify potentially misvalued services. The Workgroup recommends that AMA staff gather data and conduct the following analysis to determine possible future screens:

1. *Pre-time* – identify services RUC reviewed prior to the implementation of the pre-service packages, identify these older services that have a pre-time greater than pre-time package 4 Facility – Difficult Patient/Difficult procedure. This is intended to screen for procedures that may include incorrectly high pre-service time, for further review.
2. *Post-Operative Visits* – identify 010 and 090-day global services that have a large number of post-operative services. Conduct a frequency analysis of the number of post-operative visits and post-operative time to determine outlier codes. This is intended to allow the Workgroup to identify services that may include excessive postoperative visits, for further review.
3. *Conscious Sedation* – request that CMS provide data for each procedure in Appendix G (CPT Codes that include Moderate (Conscious) Sedation), to determine the frequency for conscious or other sedation performed by another provider the same day. This is intended to allow the Workgroup to identify services for which moderate sedation may not be typical and the resource inputs assumed by the RUC may be incorrect.
4. *Conscious Sedation Appendix G List* – Identify each procedure in Appendix G for which the work of conscious sedation is included in the intra-service work rather than the pre-service work. This is intended to identify services for which the physician time allocation, and perhaps work, may be misvalued.
5. The RAW recognizes that RUC has addressed significant anomalies in work values as nearly 1500 services have now been reviewed under the potentially misvalued services project. The RAW recommends that further analysis be prepared to review the impact of this work in addressing the relativity of work values across families of services in the RBRVS. This analysis will be beneficial in evaluating future work plans to address work value relativity.

II. Other Issues

The following informational items were provided: a list of CPT Editorial Panel Referrals, CPT Assistant Referrals, the progress of Relativity Assessment Workgroup of Potentially Misvalued Services and a full status report of the Relativity Assessment Workgroup (CD only).

High Volume Screen - 2011 Utilization over 10,000

CPT Code	Long Descriptor	2006 Medicare Util	2011 Medicare Util	Pct Difference	Work RVU	Screen	RUC Meeting
70310	Radiologic examination, teeth; partial examination, less than full mouth	392	20,877	5226%	0.16		August 1995
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions	77,173	1,535,990	1890%	0.70		August 2005
17111	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions	4,471	79,166	1671%	0.97		August 2005
88356	Morphometric analysis; nerve	925	15,225	1546%	3.02		CMS/Other
97597	Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound	71,595	1,090,458	1423%	0.51	Site of Service Anomaly	April 2010
31620	Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure[s])	1,063	14,300	1245%	1.40		April 2004
77014	Computed tomography guidance for placement of radiation therapy fields	79,012	1,035,950	1211%	0.85	CMS Request - Practice Expense Review / CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes	October 2010 (Referred to CPT in January 2012 - CCP submitted for review at May 2013 CPT and October 2013 RUC meeting)
97598	Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound	8,359	86,030	929%	0.24	Site of Service Anomaly	April 2010
64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed	1,989	17,378	774%	7.15	CMS Fastest Growing	April 2001
95251	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report	2,899	22,976	693%	0.85		February 2005
29200	Strapping; thorax	1,553	12,069	677%	0.65		Harvard
92526	Treatment of swallowing dysfunction and/or oral function for feeding	5,520	42,307	666%	1.34	CMS Request/Speech Language Pathology Request	April 2009
96120	Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report	2,535	15,636	517%	0.51		January 2005
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	21,143	118,677	461%	1.30	CMS Request/Speech Language Pathology Request	February 2010
29520	Strapping; hip	2,796	14,798	429%	0.54		Harvard
77421	Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy	265,180	1,322,597	399%	0.39	Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes	January 2012

High Volume Screen - 2011 Utilization over 10,000

CPT Code	Long Descriptor	2006 Medicare Util	2011 Medicare Util	Pct Difference	Work RVU	Screen	RUC Meeting
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)	2,404	11,917	396%	3.38		February 2004
92626	Evaluation of auditory rehabilitation status; first hour	3,418	15,982	368%	1.40	CMS Request - Audiology Services	October 2008
95928	Central motor evoked potential study (transcranial motor stimulation); upper limbs	4,125	18,701	353%	1.50	Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request Final Rule 2013	April 2013
95929	Central motor evoked potential study (transcranial motor stimulation); lower limbs	4,454	19,344	334%	1.50	Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request Final Rule 2013	April 2013
96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report	4,712	19,054	304%	0.51		January 2005
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	4,189	16,832	302%	1.48		April 2000
64412	Injection, anesthetic agent; spinal accessory nerve	2,763	10,917	295%	1.18		Harvard
67028	Intravitreal injection of a pharmacologic agent (separate procedure)	532,912	2,054,115	285%	1.44	High Volume Growth / CMS Fastest Growing, Harvard Valued - Utilization over 100,000 / CMS High Expenditure Procedural Codes	Jan11, Oct09
70100	Radiologic examination, mandible; partial, less than 4 views	7,606	27,928	267%	0.18		August 1995
64416	Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)	3,732	13,398	259%	1.81	Site of Service Anomaly	April 2008
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	16,152	53,467	231%	6.72		February 2004
29530	Strapping; knee	15,839	51,168	223%	0.57		Harvard
97532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes	69,404	221,691	219%	0.44		July 2000
69801	Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal	3,550	11,176	215%	2.06	CMS Fastest Growing, Site of Service Anomaly (99238-Only)	April 2010
96920	Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm	17,258	53,418	210%	1.15	CMS Fastest Growing	January 2012
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	22,417	63,428	183%	6.72		February 2004
29240	Strapping; shoulder (eg, Velpeau)	10,096	28,419	181%	0.71		Harvard
27370	Injection procedure for knee arthrography	11,136	31,045	179%	0.96	High Volume Growth / CMS Fastest Growing	Harvard (Clinical Examples of Radiology bulletin published in 2010)

High Volume Screen - 2011 Utilization over 10,000

CPT Code	Long Descriptor	2006 Medicare Util	2011 Medicare Util	Pct Difference	Work RVU	Screen	RUC Meeting
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	27,444	75,855	176%	0.96	High Volume Growth / CMS Fastest Growing / Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1	April 2012
93613	Intracardiac electrophysiologic 3-dimensional mapping (List separately in addition to code for primary procedure)	12,353	33,827	174%	6.99	CMS Fastest Growing	October 2008
92610	Evaluation of oral and pharyngeal swallowing function	4,353	11,531	165%	1.30	CMS Request/Speech Language Pathology Request	February 2009
97606	Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	4,311	11,115	158%	0.60		September 2003
35475	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel	16,225	41,260	154%	5.75	CMS Fastest Growing / CMS High Expenditure Procedural Codes	April 2012
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes	9,909	25,088	153%	0.45		February 1995
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	4,298	10,876	153%	23.53		April 1995
92973	Percutaneous transluminal coronary thrombectomy mechanical (List separately in addition to code for primary procedure)	6,076	15,288	152%	3.28		April 2001
95972	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, first hour	26,458	65,019	146%	1.50	Harvard Valued - Utilization over 100,000	May 1998
63650	Percutaneous implantation of neurostimulator electrode array, epidural	18,492	45,391	145%	7.15	Site of Service Anomaly / CMS Fastest Growing / Public Comment Requests NPRM for 2013	October 2010/April 2013
97605	Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	16,348	40,040	145%	0.55		September 2003
93990	Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)	33,589	80,234	139%	0.25	CMS Fastest Growing	September 1994
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	6,532	15,315	134%	32.06	New Technology / CMS Fastest Growing	October 2009
96921	Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm	6,470	15,059	133%	1.30	High Volume Growth / CMS Fastest Growing	January 2012
93224	External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional	234,713	522,889	123%	0.52	Harvard Valued - Utilization over 100,000	April 2010

High Volume Screen - 2011 Utilization over 10,000

CPT Code	Long Descriptor	2006 Medicare Util	2011 Medicare Util	Pct Difference	Work RVU	Screen	RUC Meeting
69401	Eustachian tube inflation, transnasal; without catheterization	4,920	10,816	120%	0.63		Harvard
64448	Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)	30,513	66,934	119%	1.63	Site of Service Anomaly / High Volume Growth / CMS Fastest Growing	April 2008
72125	Computed tomography, cervical spine; without contrast material	341,336	746,334	119%	1.07	CMS Fastest Growing	October 2009
70496	Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing	66,597	145,505	118%	1.75	High Volume Growth / CMS Fastest Growing	April 2000
76819	Fetal biophysical profile; without non-stress testing	4,796	10,378	116%	0.77		April 2000
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))	12,931	27,872	116%	22.13	CMS Fastest Growing	April 2012
97016	Application of a modality to 1 or more areas; vasopneumatic devices	143,279	307,630	115%	0.18	Codes Reported Together 75% or More-Part1	May 1994
64450	Injection, anesthetic agent; other peripheral nerve or branch	228,996	470,454	105%	0.75	Harvard Valued - Utilization over 100,000 / Harvard-Valued Annual Allowed Charges Greater than $10 million	September 2011
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	6,571	13,306	102%	5.19	Site of Service Anomaly / CMS Fastest Growing	October 2010
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	5,369	10,836	102%	0.78	Harvard Valued - Utilization over 100,000	April 2004/April 2010

CMS-Other Source - 2011 Utilization over 250,000

CPT Code	Long Descriptor	2011 Medicare Util	2013 Work RVU	Screen	RUC Meeting
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care	6,692,526	0.18	Low Value-High Volume	February 2011
70450	Computed tomography, head or brain; without contrast material	5,279,897	0.85	CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes	October 2012
G0202	Screening mammography, producing direct digital image, bilateral, all views	5,204,212	0.70	CMS Fastest Growing	April 2008
88342	Immunohistochemistry (including tissue immunoperoxidase), each antibody	3,890,485	0.85	CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes	October 2012
93880	Duplex scan of extracranial arteries; complete bilateral study	2,912,731	0.60	Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes	October 2012
G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit	1,936,494	2.43		
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	1,517,153	0.67	CMS-Other - Utilization over 500,000	January 2013
G0180	Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial imple	1,424,333	0.67	CMS Fastest Growing	February 2010
G0179	Physician re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial im	1,391,816	0.45	CMS Fastest Growing	February 2010
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	1,172,929	1.48	CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes	April 2013
76770	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete	1,142,994	0.74	CMS-Other - Utilization over 500,000	October 2013
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	1,115,657	0.45	Low Value-High Volume	February 2011
77014	Computed tomography guidance for placement of radiation therapy fields	1,035,950	0.85	CMS Request - Practice Expense Review / CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes	January 2012 - Refer to CPT; CCP submitted for May 2013 CPT and Oct 2013 RUC meetings
76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)	979,219	0.59	CMS-Other - Utilization over 500,000	October 2013
70553	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences	964,941	2.36	CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes	January 2013
76645	Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation	843,786	0.54	CMS-Other - Utilization over 500,000	October 2013
G0206	Diagnostic mammography, producing direct digital image, unilateral, all views	804,312	0.70	CMS Fastest Growing	April 2008
76775	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited	746,716	0.58	CMS-Other - Utilization over 500,000	October 2013
G0204	Diagnostic mammography, producing direct digital image, bilateral, all views	628,776	0.87	CMS Fastest Growing	April 2008
73550	Radiologic examination, femur, 2 views	550,549	0.17	CMS-Other - Utilization over 500,000	January 2012 - Refer to CPT to bundle for Feb 2015
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete	538,090	0.69	CMS-Other - Utilization over 500,000	October 2013
99183	Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session	521,258	2.34		
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material	510,360	1.60	CMS High Expenditure Procedural Codes	April 2013

CMS-Other Source - 2011 Utilization over 250,000

CPT Code	Long Descriptor	2011 Medicare Util	2013 Work RVU	Screen	RUC Meeting
73500	Radiologic examination, hip, unilateral; 1 view	506,017	0.17	CMS-Other - Utilization over 500,000 / Codes Reported Together 75% or More-Part2	January 2012 - Refer to CPT to bundle for Feb 2015
73590	Radiologic examination; tibia and fibula, 2 views	488,199	0.17		
93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)	470,360	0.07	CMS Request - Practice Expense Review	PE February 2009
70486	Computed tomography, maxillofacial area; without contrast material	458,489	1.14		
G0181	Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of	445,037	1.73	CMS Fastest Growing	
74230	Swallowing function, with cineradiography/videoradiography	391,085	0.53		
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording	361,175	0.10	Codes Reported Together 95% or More / Low Value-High Volume	
73520	Radiologic examination, hips, bilateral, minimum of 2 views of each hip, including anteroposterior view of pelvis	355,422	0.26		
73060	Radiologic examination; humerus, minimum of 2 views	353,425	0.17		
G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit	341,564	1.50		
73565	Radiologic examination, knee; both knees, standing, anteroposterior	341,084	0.17		
72070	Radiologic examination, spine; thoracic, 2 views	336,854	0.22		
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study	290,299	0.65		
88346	Immunofluorescent study, each antibody; direct method	286,027	0.86		
75978	Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation	274,840	0.54		
71100	Radiologic examination, ribs, unilateral; 2 views	273,836	0.22		
73600	Radiologic examination, ankle; 2 views	269,137	0.16		
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar	268,597	2.36		April 2013
76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)	256,219	0.38		

Surveyed by One Specialty - Now Performed by A Different Specialty

CPT Code	Short Descriptor	Specialty 1	2011 Spec Frequency 1	Spec % 1	Specialty 2	2011 Spec Frequency 2	Spec % 2	2011 Frequency	Surveying Specialty	RUC Meeting Date	work RVU
96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report	Neurology	5,295	28%	Family Practice	2,224	12%	19,054	Psychology	HCPAC	0.51
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Family Practice	2,467,276	27%	Internal Medicine	2,327,881	25%	9,170,707	Rheumatology, Hematology and Clinical Oncology	Oct04	0.17

AMA/Specialty Society RVS Update Committee **Tab 43**
Post Time Workgroup
April 25, 2013

Members: Members: Greg Przybylski, MD (Chair), M.Douglas Leahy, MD, Brenda Lewis, DO, George Williams, MD, Peter Smith, MD, J.Allan Tucker, MD, James C. Waldorf, MD

I. Determine Post-Time Packages

The Post-Time Workgroup members continued to have a robust discussion regarding the development of post-time packages. After review of both immediate post time by pre service packages and global periods, the Workgroup determined to continue to assign post-time based on survey data for non-facility procedures without the development of packages. However, for all facility based procedure, the Workgroup identified the following post-service activities and discussed time as follows:

Dressing: 2 minutes
Operative note: 5 minutes
Recovering/Stabilization of patient:
- Local: 1 minute
- IV Sedation: 5 minutes
- General Anesthesia: 10 minutes

Communication with patient/family: 5 minutes
Written post-op note:
- Simple procedure: 2 minutes
- Complex procedure: 5 minutes

Based on these estimates discussed, post time for facility based procedures ranged between 14 and 27 minutes, current survey data medians reflect 15-30 minutes. Therefore, there is no evidence that the survey data is overstated.

The Workgroup will continue to discuss and refine post time and prepare recommendations for the October 2013 RUC meeting.

II. Review Pre-Time Packages Relating to Local Anesthesia

In the 2013 Final Rule CMS requested that the RUC consider assigning services that require only local anesthesia without sedation to the ‘‘no sedation/anesthesia care’’ pre-service time package, or that the AMA RUC create one or more new pre-service time packages to reflect the pre-service time typically involved in furnishing local anesthesia without sedation.

The Workgroup members reviewed pre-service time packages and determined that procedures that require only local anesthesia should be assigned to packages 1A and 2A when performed in the facility. The Workgroup noted that package 5 currently does not have time allocated for local anesthesia. However, it was noted that package 6 does include 5 minutes for the administration of local anesthesia. The Workgroup will review the pre-service time packages for office procedures (package 5 and 6) to determine appropriate designation for local anesthesia or to develop a new package.

AMA/Specialty Society RVS/Update Committee
BETOS Workgroup
Progress Report to RUC
April 2013

Workgroup Members: Doctors Chad, Rubin, MD (Chair); Gregory Barkley, MD; Albert Bothe, MD; Kenneth Brin, MD; William Gee, MD; Katharine Krol, MD; Geraldine B. McGinty, MD; Eileen M. Moynihan, MD; Jennifer Wiler, MD; George Williams, MD

Background on BETOS:

The Berenson-Eggers Type of Service (BETOS) coding system is used by CMS and other researchers primarily for the purposes of tracking utilization of Medicare services and analyzing growth in Medicare expenditures. The BETOS coding system collapses the Health Care Financing Administration Common Procedure Coding System (HCPCS) procedure codes into generally agreed upon clinically meaningful groupings of procedures and services. There are seven BETOS categories: 1) Evaluation and Management; 2) Procedures; 3) Imaging; 4) Tests; 5) Durable Medical Equipment; 6) Other; and 7) Exceptions/Unclassified.

Importance of BETOS:

The current BETOS classifications are considerably inaccurate as, over time, new/revised CPT codes have been arbitrarily added to categories based off decisions made by non-clinical CMS staff. Additionally, surgical services have been classified as either Major or Minor further adding inconsistencies between service categories. There are several critical factors that necessitate revising the current BETOS system to more accurately identify classifications of current physician services. Most importantly, as CMS continues to research and prescribe methods for bundling similar physician services together, the use of incorrect BETOS classifications would make these efforts clinically inaccurate and potentially unnecessary. BETOS is also used in health science literature to discuss service shifts in utilization and specialty usage, which can then cause policymakers and other stakeholders to hold incorrect assumptions about the utilization of entire groups of services.

Workgroup History and Charge:

In October 2011, the American College of Surgeons (ACS) submitted a letter to the RUC stating their concerns over the inaccuracies within the current BETOS classifications and offering several suggestions for refining the system. In a letter sent to CMS as part of the RUC's recommendations in March 2012, the RUC noted that they agreed with the ACS request to offer CMS the RUC's expertise and recommendations to review, revise and maintain BETOS as deemed necessary by the Agency. Finally, RUC leadership met with CMS in Baltimore to discuss these concerns and the Agency responded that they would be receptive to recommendations by the RUC offering suggestions/revisions to BETOS.

The BETOS Workgroup was formed in December 2012, consisting of both RUC members and CPT Editorial Panel members. The Workgroup is tasked with three charges:

1. Review- Conduct a comprehensive review of the current BETOS system, including input from specialty societies.
2. Revise- Provide CMS with suggested changes to BETOS using both Workgroup and specialty society feedback.
3. Maintain- Provide a mechanism to accurately classify new CPT codes into the most accurate BETOS classifications.

Workgroup Progress:

The Workgroup has had two conference calls and one face-to-face meeting to discuss the BETOS classifications. On March 3, 2013 specialty societies were given the opportunity to review the current BETOS classifications and provide suggestions on improvements to the system. The specialty societies replied back with thousands of comments on both specific code reclassifications and broad general issues with the current system. The Workgroup was pleased with both the quantity and quality of the responses. After reviewing the comments, the Workgroup had general agreement that the current BETOS system does not accurately reflect physicians' current practice. The Workgroup has included several recommendations resulting from the initial review of BETOS. *The Workgroup submits this report to keep the RUC updated on the group's activities to date but will continue to work on the charges as outlined and will update the RUC as the progress continues.*

Workgroup Recommendations:

1. To ensure the BETOS system is properly maintained, **the BETOS Workgroup recommends that the RUC add a question to the Summary of Recommendation (SOR) form requesting a suggested BETOS category for all new CPT codes.** These recommendations will be forwarded to CMS with the RUC submission each May.
2. The Workgroup received many comments from specialty societies that the current Ambulatory classification is severely flawed. First, there is no identifiable definition of what CMS considers Ambulatory for classification purposes. Second, simply reviewing site-of-service information shows wide variability within the classification. For example, 21% of the services classified as Ambulatory were primarily performed in the Inpatient setting in 2011. **Therefore, the BETOS Workgroup recommends that the Ambulatory sub-classification be removed from BETOS and the services currently classified as such be reclassified.** Several specialty societies have offered revised classifications for many of the current Ambulatory procedures. However, AMA staff will work over the summer with specialties to obtain comments on codes without a suggested reclassification and also work out issues where separate societies have offered different classifications for the same code.

AMA/Specialty Society RVS/Update Committee **Tabs 08 & 09**
Facilitation Committee #2
April 27, 2013

Members Present: Doctors Sandra Reed (Chair); Scott Collins; John Gage; Anthony Hamm; Walt Larimore; Timothy Laing; Brenda Lewis; Stanley Stead; J. Allan Tucker

Tab 09 Transcatheter Placement Intravascular Stent

The Facilitation Committee noted that 372XX5 was approved by the RUC at this meeting with a work RVU of 9.00.

372XX6

The Committee then discussed the add-on code 372XX6 and agreed with the specialty society that 1 minute of pre and 1 minute of post time is appropriate. The Committee was comfortable with this time since when a physician stents two vessels more explanation to the patient is required. Also, there are several ZZZ global codes in the vascular family that have these pre/post time elements (e.g. 37222, 37223 and 37232). The Committee also discussed the work RVU for this code and agreed that the 25th percentile work RVU of 4.25 is appropriate. To ensure relativity, the Committee reviewed two add-on codes: 35685 *Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit* (work RVU= 4.04) and 60512 *Parathyroid autotransplantation* (work RVU= 4.44) and noted that both have identical intra times as the surveyed code, 45 minutes, and provide appropriate brackets to validate the recommended work RVU. **The Facilitation Committee recommends 4.25 work RVUs for CPT code 372XX6.**

372XX7

The Committee then discussed the additional base procedure 372XX7 and agreed with the specialty society that a direct crosswalk to CPT code 36247 *Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU= 6.29, 41/60/30), slightly higher than the survey 25th percentile, is appropriate. The Committee agreed that the value is appropriate because the surveyed code would create a rank order anomaly if valued lower than CPT code 35460 *Transluminal balloon angioplasty, open; venous* (work RVU= 6.03) because 372XX7 includes not only the work of an angioplasty but also a stent. **The Facilitation Committee recommends 6.29 work RVUs for CPT code 372XX7.**

372XX8

The Committee discussed the add-on code 372XX8 and agreed with the specialty that 1 minute of pre and 1 minute of post time were appropriate, for the reasons explained above. To value the procedure, the Committee determined that a direct crosswalk to CPT code 35686 *Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis)* (work RVU= 3.34, 35 intra) accurately accounted for the work involved in this service. The Committee also compared the recommended value to 372XX6 and agreed that since this surveyed code has 15 minutes less intra time, it is appropriately valued lower than 372XX6. **The Facilitation Committee recommends 3.34 work RVUs for CPT code 373XX8.**

Tab 08 Embolization and Occlusion Procedures

The Facilitation Committee agreed to discuss this family of codes in reverse code order, from the most intense to the least.

372XX4

The Committee reviewed the survey data for CPT code 372XX4 and agreed that the survey 25th percentile work RVU of 14.00 accurately values this service. While the intra-service time of 90 minutes, is lower than some of the other codes in this family, this is the most intense procedure in the family. To validate this value, the Committee reviewed CPT code 37229 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed* (work RVU= 14.05, 48/120/30) and agreed that while the reference code has more intra time, the service includes catheterization and is therefore a less intense service. **The Facilitation Committee recommends 14.00 work RVUs for CPT code 372XX4.**

372XX3

The Committee reviewed CPT code 372XX3 and compared the intra times from 372XX3, 120 minutes, to 372XX4, 90 minutes. The Committee agreed that since the X4 code is a more intense procedure, a work RVU of 14.00 is also appropriate for CPT code 372XX3, given the intensity difference. To validate a work RVU of 14.00, the Committee reviewed CPT code 11005 *Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure* (work RVU= 14.24, 60/120/30) and agreed that the recommendation is relative to other services. **The Facilitation Committee recommends 14.00 work RVUs for CPT code 372XX3.**

372XX2

The Committee reviewed CPT code 372XX2 and agreed that a direct crosswalk to CPT code 34833 *Open iliac artery exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral* (work RVU= 11.98, 75/100/27) is appropriate. Both services have identical intra times and should have identical values. To validate this value, the Committee reviewed CPT codes 61640 *Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel* (work RVU= 12.32, 77/90/60) and 37228 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 11.00, 48/90/30) and noted that while catheterization is included in both these reference codes, the resulting values provide an adequate level of relativity across similar services. **The Facilitation Committee recommends 11.98 work RVUs for CPT code 3722X2.**

372XX1

The Committee discussed 372XX1 and noted that this code was voted down by the RUC, necessitating this facilitation review. Given 90 minutes of intra-service time and relatively low intensity compared to the other services in this family, the Committee agreed that the survey 25th percentile (9.00 work RVUs) is appropriate for this service, setting an appropriate floor for this family. **The Facilitation Committee recommends 9.00 work RVUs for CPT code 372XX1.**

AMA/Specialty Society RVS Update Committee
Facilitation Committee #2
Destruction of Premalignant Lesions

Members Present: David C. Han, MD (Chair), Michael Bishop, MD, David Hitzeman, DO, Margie Andreae, MD, Edward Vates, MD, Marc Raphaelson, MD, James Waldorf, MD

The Facilitation Committee discussed the physician work and time associated with CPT Code 17000 *Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion*, 17003 *Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (List separately in addition to code for first lesion)* and 17004 *Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions* after the work RVU of 0.61 for CPT code 17000 presented by the specialty society was rejected by the RUC. In addition, the Facilitation Committee confirmed that the use of a camera is typical in this procedure and reaffirmed the practice expense inputs reviewed at the January RUC meeting.

17000
The Facilitation Committee reviewed 17000 and determined that a work RVU of 0.61 is appropriate. The RUC questioned whether or not an office visit was typical for this procedure. The Facilitation Committee suggested that the specialty society consider submitting a request to CMS to reclassify 17000 as a 000 day global procedure. The specialty society confirmed that 70% of survey respondents reported that an office visit is performed. In addition, the survey respondents indicated 2 minutes less pre service time than the current pre-time. The specialty societies reduced the work RVU to 0.61 to account for this difference using a reverse building block methodology. The Committee compared this service to similar service, 88302 *Level II - Surgical pathology, gross and microscopic examination Appendix, incidental Fallopian tube, sterilization Fingers/toes, amputation, traumatic Foreskin, newborn Hernia sac, any location Hydrocele sac Nerve Skin, plastic repair Sympathetic ganglion Testis, castration Vaginal mucosa, incidental Vas deferens, sterilization* (intra time=11 minutes, work RVU=0.13) and 73140 *Radiologic examination, finger(s), minimum of 2 views* (intra time=4 minutes, work RVU=0.13) and added a 99212 office visit (work RVU=0.48) which results in a work RVU of 0.61. The Committee also reviewed service 95018 *Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests* (intra time = 2 minutes, work RVU=0.14) and added a 99212 office visit (work RVU=0.48) resulting in a work RVU of 0.62. **Therefore, the Committee recommends a work RVU of 0.61 for CPT code 17000.**

17003
The Facilitation Committee also reviewed CPT code 17003.The Committee noted that based on the survey the time was reduced from 2 minutes to 1 minute; therefore, a 50% reduction in work RVU from current value of 0.07 equals 0.04. To further support this value, the Committee reviewed CPT code *95017Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests* (work RVU=0.07, total time =1.86 minute) which equates to 0.038 RVU per 1 minute. **The Facilitation Committee recommends a work RVU of 0.04 for CPT code 17003.**

17004

The Committee reviewed 17004 and determined that a direct cross walk to CPT code 17270 *Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less* (work RVU=1.37) appropriately accounts for the physician work. Although, CPT code 17004 requires less pre service time compared to 17270, the Committee members agreed this was acceptable since 17004 is typically billed with an E/M. Additionally, the results of the survey from the specialty society suggested that the typical number of lesions treated is 20. Treating 20 lesions using the values for 17000 and 17003 would result in 0.61 + (0.04 x 19) = 1.37. **The Facilitation Committee recommends a work RVU of 1.37 for CPT code 17004.**

AMA/Specialty Society RVS Update Committee
Facilitation Committee #2
Renal Allotransplantation

Members Present: Sandra Reed, MD (Chair), Scott Collins, MD, John Gage, MD, Walt Larimore, MD, Brenda Lewis, DO, Peter Smith, MD, J. Allan Tucker, MD

The Facilitation Committee discussed the physician work and time associated with CPT Code 50360 *Renal allotransplantation, implantation of graft; without recipient nephrectomy*, after the work RVU of 43.00 presented by the specialty society was rejected by the RUC. However, compelling evidence was presented and accepted by the RUC. Due to time constraints at the table, the presenter was unable to fully articulate the pre and intra service physician work descriptions. The members determined that 90 minutes of pre service evaluation time is appropriate due to the extensive time required to coordinate with the anesthesiologists and nephrologists. In addition, it was noted that the patient has typically not been seen in a number of years and therefore, evaluation time is required to ensure that the patient is a suitable recipient. Moreover, the quality of the grafts has worsened significantly since the original valuation due to older age of decease donors and more desperate need for organs. The members reviewed the intra service time and agreed that 210 minutes is appropriate for this procedure. The typical age of the recipient has increased in the last 15 years. The patient now typically presents with multiple co-morbidities, has been on dialysis and on multiple anti-coagulation medications which can result in an increased risk of bleeding.

The Facilitation Committee noted that current value and time have not been RUC surveyed, but rather are based on derived visits as assigned by Dan Dunn. Therefore, current time was imputed and not supported by survey data. Furthermore, the extensive level of post-op visits were also imputed based on Harvard data not surveyed data. This survey represents the first time that this procedure has received actual surveyed physician data for both time and physician work. Given this, the Facilitation Committee was persuaded that the 25th percentile of 43.00 work RVUs and median physician times accurately represent the work involved in this service. To further support this work RVU, the Committee reviewed key reference code 47780 *Anastomosis, Roux-en-Y, of extrahepatic biliary ducts and gastrointestinal tract* (work RVU=42.32) and CPT code 33512 *Coronary artery bypass, vein only; 3 coronary venous grafts* (work RVU=43.98) and agreed that the physician work and times are comparable, and therefore, these services should be valued similarly. **The Facilitation Committee members recommend a work RVU of 43.00 with 113 of pre-service time, 210 minutes of intra service time and 45 minutes of post time.**

Repair of the Eyelid
Facilitation Committee #3

Doctors James Blankenship (Chair), Dale Blasier, Jeffrey Edelstein, William Gee, Charles Koopmann, Leonard Lichtenfeld, Larry Martinelli, John Seibel, Holly Stanley and Jane White, PhD, RD.

The Committee noted that for all the codes, current values were below the 25th percentile of the survey. The Committee evaluated potential cross-walk codes for each code and considered whether they supported the current value, a lower value, or a higher value. For many of the codes, the Committee determined that the current value under-valued the service, but lack of compelling evidence for an increase above current values removed that option from further consideration. After considering the codes, the Committee determined that most of the current values were appropriate and identified cross-walk codes to justify current values. Deliberations of the Committee were made more difficult by a scarcity of RUC-surveyed cross-walk codes with the same global period and similar intra times and total times.

67914 Repair of ectropion; suture
Prior to referral to facilitation, the RUC had voted to maintain the current work RVU of 3.75 for CPT code 67914. The Committee felt this was appropriate and recommended that the RUC's decision on this should stand.

67921 Repair of entropion; suture
The Committee reviewed CPT code 67921 and determined that the current work RVU of 3.47 and survey time of 15 minutes intra-service time appropriately account for the work and time required to perform this service. For additional support to maintain the current value the Committee referenced similar service 21073 *Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)* (work RVU=3.45). **The Committee recommends a work RVU of 3.47 for CPT code 67921.**

67915 Repair of ectropion; thermocauterization
67922 Repair of entropion; thermocauterization
The Facilitation Committee reviewed CPT codes 67915 and 67922 and determined that the survey respondents overestimated the work required to perform these services. Therefore, the Committee recommends a crosswalk to CPT code 28470 *Closed treatment of metatarsal fracture; without manipulation, each* (work RVU = 2.03 and 15 minutes of intra-service time). CPT codes 67915 and 67922 require 10 minutes less intra-service time than 28470, but are more intense involving a procedure on the eye compared to the foot. **The Facilitation Committee recommends a work RVU of 2.03 for CPT codes 67915 and 67922.**

67916 Repair of ectropion; excision tarsal wedge
The Facilitation Committee reviewed CPT code 67916 and determined that the current work RVU of 5.48 appropriately accounts for the work required to perform this service. The Committee compared 67916 to 28525 *Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation,*

when performed, each (work RVU = 5.62 and 30 minutes intra-service time) and determined that 28525 requires 5 more minutes of intra-service time and slightly more physician work than the surveyed service. **Thus, using magnitude estimation the Committee recommends maintaining the current work RVU of 5.48 for CPT code 67916.**

67923 Repair of entropion; excision tarsal wedge
The Facilitation Committee reviewed CPT code 67923 and determined it requires the same intra-service time of 25 minutes and physician work as 67916 (recommending a work RVU of 5.48). The Committee compared 67923 to 28525 *Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each* (work RVU = 5.62 and 30 minutes intra-service time) and determined that 28525 requires 5 more minutes of intra-service time and slightly more physician work than the surveyed service. **The Committee recommends reducing the work RVU to 5.48 for CPT code 67923, the same as 67916.**

67924 Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)
The Committee reviewed 67924 and determined that the current work RVU of 5.93 and survey intra-service time of 40 minutes appropriately accounts for the physician time and work required to perform this service. The Committee supported maintaining the current work RVU comparing 67924 to similar services 58600 *Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral* (work RVU 5.91 and 35 minutes intra-service time) and 23071 *Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater* (work RVU=5.91 and 45 minutes intra-service time). **The committee recommends a work RVU of 5.93 for CPT code 67924.**

67917 Repair of ectropion; extensive (eg, tarsal strip operations)
The Committee reviewed 67917 and compared it to 67924 (recommended work RVU = 5.93). The Committee noted that 67917 requires 33 minutes intra-service time compared to 40 minutes intra-service time for 67924, however it is more intense as it is harder to perform extensive repair to the ectropion. The Committee compared 67917 to similar services 58600 *Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral* (work RVU 5.91 and 35 minutes intra-service time) and 23071 *Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater* (work RVU=5.91 and 45 minutes intra-service time). **The Committee recommends a work RVU of 5.93 for CPT code 67917.**

CPT Code	Pre	Intra	Post	99238	99212	99213	Current wRVU	Rec RVU
67914	25	20	10	0.5	2	1	3.75	**3.75**
67921	25	15	10	0.5	2	1	3.47	**3.47**
21073	*30*	*20*	*20*	*0*	*4*	*0*	*Reference*	***3.45***
67915	23	10	5	0	2	0	3.26	**2.03**
67922	23	10	10	0	2	0	3.14	**2.03**
28470	*14*	*15*	*5*	*0*	*3*	*0*	*Reference*	***2.03***
67916	25	25	10	0.5	2	1	5.48	**5.48**
67923	25	25	10	0.5	2	1	6.05	**5.48**
28525	*60*	*30*	*20*	*0.5*	*2*	*2*	*Reference*	***5.62***
67917	25	33	10	0.5	2	1	6.19	**5.93**

67924	25	40	10	0.5	2	1	5.93	**5.93**
58600	*50*	*35*	*20*	*1*	*0*	*1*	*Reference*	***5.91***

AMA/Specialty Society RVS Update Committee
Facilitation Committee #3
MRI Spine

Members: James Blankenship, MD (Chair), William Gee, MD, J. Leonard Lichtenfeld, MD, Larry Martinelli, MD, George Williams, MD, Jane White, PhD, RD, FADA, LDN, Dan Nagle, MD, William Donovan, MD

The Facilitation Committee discussed the physician work and time associated with CPT Codes 72141 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material*; 72142 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material with contrast material(s);* 72146 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material*; 72147 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material with contrast material(s);* 72148 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material;* 72149 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material with contrast material(s)* 72156 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical;* 72157 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic;* 72158 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar.*

The facilitation committee agreed that the work and intensity of spine codes are similar across lumbar, thoracic and cervical regions. The facilitation committee also discussed that the MRI brain CPT codes were recently reviewed at the January 2013 RUC meeting. The MRI spine codes have similar work and intensity and should maintain rank order with the MRI brain codes. The facilitation committee discussed a work RVU of 1.48 which is the lowest current RVU for the family without contrast material and the same as brain MRI codes without contrast material. Similarly the facilitation committee discussed a work RVU of 1.78 which is the lowest current RVU for the family with contrast material and the same as brain MRI codes with contrast material. In addition it is between the survey 25th and median. Lastly the facilitation committee discussed a work RVU of 2.29 for the family with and without contrast material. This value is the lowest value of the survey medians, is lower than the current value and is slightly lower than the brain MRI with and without contrast which has a work RVU of 2.36. The lower value is justified because the spine MRI with and without contrast requires less time and intensity than the brain MRI codes with and without contrast. **The Facilitation Committee members recommend the following work RVUs for this family of codes.**

Code	Short Desc	Work RVU
72148	MRI L-Spine w/o	1.48
72141	MRI C-Spine w/o	1.48
72146	MRI T-Spine w/o	1.48
72149	MRI L-Spine w/	1.78
72142	MRI C-Spine w/	1.78
72147	MRI T-Spine w/	1.78

72156	MRI C-Spine w/o&w/	2.29
72157	MRI T-Spine w/o&w/	2.29
72158	MRI L-Spine w/o&w/	2.29