AMA/Specialty RVS Update Committee
Meeting Minutes
April 24-27, 2014

I. Welcome and Call to Order

Doctor Barbara Levy called the meeting to order on Thursday, April 24, 2014 at 1:00 pm. The following RUC Members were in attendance:

Barbara Levy, MD
Margie C. Andreae, MD
James Blankenship, MD
Dale Blasier, MD
Albert Bothe, MD
Ronald Burd, MD
Scott Collins, MD
Thomas Cooper, MD
John Gage, MD
Anthony Hamm, DC
David F. Hitzeman, DO
Charles F. Koopmann, Jr., MD
Walt Larimore, MD
Alan Lazaroff, MD
M. Douglas Leahy, MD, MACP
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 Reed, MD
David Regan, MD
Peter Smith, MD
Samuel D. Smith, MD
Stanley W. Stead, MD, MBA
J. Allan Tucker, MD
James C. Waldorf, MD
George Williams, MD
James C. Waldorf, MD
George Williams, MD
Amr Abouleish, MD, MBA*
Allan A. Anderson, MD*
Gregory L. Barkley, MD*
Eileen Brewer, MD*
Gregory DeMeo, MD*
Jane Dillon, MD*
Verdi DiSesa, MD*
William D. Donovan, MD, MPH, FACR*
Jeffrey Paul Edelstein, MD*
Yul Ejnes, MD*
William E. Fox, MD, FACP*
William F. Gee, MD*
Mollie MacCormack, MD*
Daniel McQuillen, MD*
Eileen Moynihan, MD*
Daniel J. Nagle, MD*
Margaret Neal, MD*
Scott D. Oates, MD*
Chad A. Rubin, MD, FACS*
M. Eugene Sherman, MD*
Samuel Silver, MD*
Holly Stanley, MD*
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 Centers for Medicare & Medicaid Services (CMS) staff and representatives attending the meeting:
    - Edith Hambrick, MD – CMS Medical Officer
    - Steve E. Phurrough, MD – CMS Medical Officer
    - Ryan Howe, PhD – Deputy Director for the Division of Practitioner
    - Kathy Kersell – Health Insurance Specialist (practice expense)

  - Jessica Bruton, MPA – Health Insurance Specialist (physician work and PLI) – *via telephone*
- Doctor Levy welcomed the following Contractor Medical Directors:
  - Charles Haley, MD, MS, FACP
- Doctor Levy welcomed the following MedPAC Representative:
  - Kevin Hayes, PhD – Principal Policy Analyst
- Doctor Levy thanked the following departing RUC members for their years of service:
  - John Gage, MD (American College of Surgeons). Doctor Gage is the last of the founding RUC members and has volunteered to serve on the RUC for 23 years!
  - M. Douglas Leahy, MD, MACP (Primary Care)
  - Lawrence Martinelli, MD (Infectious Diseases Society of America)
- Doctor Levy gave the following report of the Financial Disclosure Review Workgroup
  - **Tab 21 & 37**
    - Doctor Lee Hilborne from the American Society for Clinical Pathology (ASCP) indicated a financial interest. The Workgroup determined Doctor Hilborne may provide a brief (less than 5 minutes) description of how the procedure is performed. The presenter must then leave the RUC table, but may answer questions from the floor limited to the procedure itself.
  - **Tab 38 Endovenous Ablation (36475, 36476, 36478 & 36479)**
    - Doctor Mark Forrestal from the American College of Phlebology indicated a financial interest. The Workgroup discussed the disclosure and voted that Doctor Forrestal may provide a brief (less than 5 minutes) description of how the procedure is performed. He must then leave the RUC table, but may answer questions from the floor limited to the procedure itself.
- Doctor Levy laid out the following RUC established thresholds for the number of survey responses required:
  - Codes with $\geq$1 million Medicare Claims = **75 respondents**
  - Codes with Medicare Claims from 100,000 to 999,999 = **50 respondents**
  - Codes with <100,000 Medicare = **30 respondents**
  - Surveys below the established thresholds for services with Medicare claims of 100,000 or greater will be reviewed as interim and specialty societies will need to resurvey for the next meeting.
- Doctor Levy laid out the following guidelines related to confidentiality:
  - All RUC attendees/participants are obligated to adhere to the RUC confidentiality policy. (All signed an agreement at the registration desk)
  - This confidentiality is critical because CPT® codes and our deliberations are preliminary. It is irresponsible to share this information with media and others until CMS has formally announced their decisions in rulemaking.
- Doctor Levy laid out the following procedural issues for RUC members:
  - Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue and it will be reflected in the minutes
  - RUC members or alternates sitting at the table may not present or debate for their society
  - Expert Panel – RUC Members exercise their independent judgment and are not advocates for their specialty
- Doctor Levy laid out the following procedural guidelines related to commenting specialty societies:

  - In October 2013, the RUC implemented that the metric to determine who may be "conflicted" to speak to an issue before the RUC be:
    - If a specialty surveyed (LOI=1) or
    - submitted written comments (LOI=2)
    - RUC members from these specialties are not assigned to review those tabs.
  - The RUC also recommended that the RUC Chair welcome the RUC Advisor for any specialty society that submitted written comments (LOI=2), to come to the table to verbally address these written comments. It is the discretion of that society if they wish to sit at the table and provide further verbal comments.
- Doctor Levy laid out the following guidelines related to voting:
  - RUC votes are published annually on the AMA RBRVS web site each November for the previous CPT cycle.
  - We vote on every work RVU, including facilitation reports
  - Please share voting remotes with your alternate if you step away from the table
  - To insure we have 28 votes, may necessitate re-voting throughout the meeting
  - If members are going to abstain from voting or leave the table please notify AMA staff so we may account for all 28 votes
- Please note that all meetings are recorded for staff to summarize recommendations to CMS.

III. Director's Report

Sherry L. Smith, MS, CPA, provided the director's report and indicated:

- We have two new RUC staff:
  - Mike Morrow, Senior Policy Analyst I
  - Maurine Spillman Dennis, Senior Policy Analyst I
- The following RUC members have been reappointed by their specialties to serve another term on the RUC:
  - American Academy of Dermatology Association (AADA) - Scott Collins, MD
  - American Academy of Orthopaedic Surgeons (AAOS) - Robert Dale Blasier, MD
  - American College of Physicians (ACP) - J. Leonard Lichtenfeld, MD
  - American College of Surgeons (ACS) - Chad Rubin, MD, FACS
  - American Osteopathic Association (AOA) - David F. Hitzeman, DO
  - American Society of Plastic Surgeons (ASPS) - James Waldorf, MD
  - College of American Pathologists (CAP) - J. Allan Tucker, MD

IV. Approval of Minutes of the January 31-February 1, 2014 RUC Meeting

The RUC approved the January 2014 RUC Meeting Minutes as submitted.

V. CPT Editorial Panel Update (Informational)

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

- In the agenda you will find the usual updated CPT status reports: the new and revised codes for CPT 2015; the CMS requests and RAW issues report; and a new addition, the codes potentially impacted by the OPPS/ASC payment cap.

- At the last CPT Editorial Panel meeting the panel again endorsed the concept of reciprocal visits between CPT and RUC. We were pleased to have Doctor Mangold at the February meeting. CPT Editorial Panel member Doctor Chris Jagmin is here. He represents the American Society of Interventional Pain Physicians and is a family practice physician. He works for Aetna and is a content expert in all coding matters.
- 109 tabs were considered at the last CPT Editorial Panel meeting. That is the reason for the volume of the agenda being reviewed here.
- There were a number of Workgroups including, the Evaluation and Management (E/M) Workgroup, which will refine and make more precise the language around E/M coding, especially related to medical decision making. There is another workgroup that is updating the literature requirements for category I and III codes, dealing with issues such as a level of evidence literature validation and the relation of the literature requirements to domestic vs. foreign articles. The Molecular Pathology Workgroup is coming up with taxonomy and a structure for categorizing the proliferation of new lab tests, especially in the genetic field. Lastly, there is a Spinal Surgery Workgroup that will clarify the CPT language.
- Doctor Levy added that the joint RUC/CPT Moderate Sedation Workgroup is being formed and the members of that group will be sent out after this meeting.

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

Doctor Edith Hambrick provided the report of the Centers for Medicare & Medicaid Services (CMS):

- Kathleen Sebelius announced that she is resigning as the Secretary of the Department of Health & Human Services (HHS) and Sylvia Mathews Burwell, currently the Director of the Office of Management and Budget (OMB) has been recommended by the President to take the position.
- Jonathon Blum, Centers for Medicare & Medicaid Services Principal Deputy Administrator, has announced that he will be resigning effective May 16. Sean Cavanaugh of CMMI, will be taking over the position.
- Ryan Howe, PhD has been promoted to the position of Deputy Director for the Division of Practitioner Services.
- The Agency is completing the proposed rule now, but if you need to discuss anything with the Agency you are welcome to do so.

VII. Contractor Medical Director Update (Informational)

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

- About a decade ago Medicare changed from having one multifunction contractor in each state to several single function contractors that provide services throughout the nation.
- Medicare contracts consists of:
    - The Administrative Contractors, who process the claims
    - The Medicare Secondary Payer Recovery Contractor (MSPRC)
    - One contract for the Beneficiary Contact Center (BCC)
    - One contract for the Healthcare Integrated General Ledger Accounting System (HIGLAS)
    - State based Quality Improvement Organization (QIC)

  - One contract for the Enterprise Data Centers (EDCs), there are three centers on two electrical grids
  - Zone Program Integrity Contractors (ZPICs), several states in each jurisdiction
  - Recovery Auditors (RACs)
  - Qualified Independent Contractors (QIC)
- Contracting environment: In 1997 there were between 50-60 claims paying contractors in the Medicare program and now there are 8 A/B MAC contracts serving 12 jurisdictions:
  - Novitas, has jurisdictions JH and JL with 24.1% of claims
  - NGS has jurisdictions JK and J6 with 21.6% of claims
  - Noridian has jurisdictions JE and JF with 14.7% of claims
  - WPS has jurisdictions J5 and J8 with 10.5% of claims
  - Palmetto has jurisdiction J11 with 8.9% of claims
  - First Coast has jurisdiction J9 with 8.4% of claims
  - Cahaba has jurisdiction J10 with 7.2% of claims
  - CGS has jurisdiction J15 with 5.9% of claims
- Last year (2012) these eight A/B MACs:
  - Processed 1.23 billion Medicare claims
  - Paid $345 billion to one million physicians, non-physician practitioners and suppliers and 300,000 facilities
  - Made payments on behalf of 37 million beneficiaries
- Represents about 12.3% of national healthcare expenditures or a little more than 2% of total GDP
- Assuming a 365 day year, each contractor:
  - Processed about 400,000 claims each day
  - Paid about $118 million in benefits each day or about $82,000 per minute
- The average A/B MAC is paid (2010):
  - 62¢ per Part A (institutional) claim
  - 29¢ per Part B (professional) claim
- Requests for medical records to support claims could come from the following:
  - A/B MAC - reduce payment error rates.
  - Recovery Auditor - recover incorrect payments.
  - ZPIC - fraud and abuse.
  - CERT - calculate claims payment error rate.
  - SMRC - special CMS directed studies.
  - Less Frequent:
    - QIO – quality.
    - OIG, GAO - program evaluation.
    - OIG, DOJ - civil, criminal investigations.
- Each contractor is processing just short of a half million claims every day. 99% is performed electronically with edits and audits. The contractors look at approximately 2-3% of the claims.

VIII. Washington Update (Informational)

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

- The permanent SGR Repeal Bill (HR 4015/S2000) was not enacted. The Bill called for:
  - 2014-2018 annual updates = 0.5%
  - 2019-2023 = freeze

- 2024 & thereafter = 0.5%
- New Merit-Based Incentive Payment Program
  - Blended PQRS, MU, VBM & New Clinical Practice Improvement Option
  - Penalty (-4% to -9%) or bonus based on comparison to national mean
- Alternative Payment Model Incentives
  - 5% bonus 2018-2023
  - 1% update 2024 & thereafter
- Provisions to "improve" valuation of services
  - Misvalued code target = 0.5% a year 2015-2018
  - Cuts of 20% or more phased in over 2 years
  - Appropriateness Use Criteria Requirement
    - Must consult advanced diagnostic imaging criteria as of 2017
    - Prior Authorization for outliers starting 2020
    - GAO report on expansion to other services (lab/radiation therapy)
  - Expanded Claims Data Availability with Safeguards
    - Required data use agreement and ability to correct data
  - Other Extenders (GPCI Floor, Therapy Cap Exceptions, etc.)

- What it took to get to the Permanent SGR Repeal bill:
  - 2 years and 16 temporary fixes to get this far
  - A year of work by committees & medicine
  - Took only 24 seconds to kill it
    - Congressional leaders unwilling to tackle the pay-fors
    - Pushed SGR patch number 17
    - House adopted 3-27-2014; Senate followed 3-31-2014
    - Medicine vigorously opposed temporary fix
  - Bill continues current payment rates for 12 months
  - Extends many programs including work GPCI floor
  - Delays ICD-10 until 10-1-2015
  - Took savings from the SGR repeal bill
    - Appropriate use criteria
    - Misvalued codes etc.
- Cost of 17 temporary fixes = $169.5 billion
- Repeal Bill with extenders = $138.4 billion
- 10-year freeze = $124 billion
- The AMA must continue to fight to repeal the SGR because it will only get worse
- Medicare Data Release
  - On April 9, 2014, CMS posted interactive physician-specific claims data
  - Includes: average charges, payments, number of patients by code, site of service and in the aggregate
  - Data can be searched by last name or NPI
  - It is available in 12 separate spread sheets at www.cms.gov
  - A new "patient-friendly" version is available
  - NYT, WSJ and Washington Post have similar tools
  - Why Now?
    - Aggregated regional data posts since 2010; Hospital specific data a year ago.
    - Injunction barring physician specific data vacated last May
    - Pressure from Congress and media

        - AMA wanted safeguards:
            - Right to correct data;
            - Conformance to certain standards
            - Disclosure of methodology and limitations
        - SGR repeal bill included safeguards
    - CMS and reporters hyped it as a "treasure trove"
        - Initial reports were all about "Medicare millionaires" with no physician response, because of embargo which meant that the media coverage had already been written before the data was released. Most early stories did not explain that many of the top billers, especially ophthalmologists and oncologists, were billing for other physicians and/or high drug and equipment costs had been lumped in.
    - AMA President called it a data dump
        - Pressed CMS prior to release to include limitations list
        - Provided limitations list to press
        - Materials for physicians to use with patients are coming
- Limitations of Medicare Data
    - Errors: wrong addresses, specialty, affiliation, coding mistakes
    - No quality or appropriateness measures
    - These are charges not payment, beneficiaries may not understand that payers do not pay the full charge, but something less.
    - Drug reimbursement and costs of running the practice are revenues, but look like income.
    - Missing data:
        - 11 patient minimum to protect identity of patient
        - billed under another NPI
        - Medicare Advantage is not included
        - Other payers are not included
    - Misleading data:
        - multiple users of same NPI
        - surgical modifiers
        - professional/technical services
        - no GPCI or risk adjustments
    - Site of Service Issues (no facility fee)
    - Specialty identifications (too general)
    - Coding and billing issues
        - regional variation
        - annual changes
- Tried to pre-empt some of the problems
    - Sign-on letter last fall calling for safeguards
    - Recent letter urges CMS to:
        - Abandon plans to publish data for prior years
        - Reformat the data
        - Redirect its efforts to providing timely, accurate and useful data to physicians
    - Continuing to analyze data/identify flaws

IX. SGR Spending and Utilization Growth for 2013 (Informational)

Kurt Gillis, Senior Economist, 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, 2013. 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 of overall growth did not change at all.
  - Use Medicare Physician/Supplier Procedure Summary file (PSPS)
  - Spending changes broken down into changes in pay, utilization and site of service.
- Medicare Physician Fee Schedule (MFS) spending:
  - Accounts for 89% of SGR spending. The other 11% is mostly clinical lab fee schedule spending. Medicare also includes bonus payments such as e-prescribing as SGR spending.
  - Accounts for 29% of Medicare Part B spending
  - Accounts for 12% of total Medicare spending
- Results for 2013 – Overall
  - SGR spending is down 0.4%, despite 1% increase in enrollment. Per enrollee SGR spending went down by 1.3 %. This is low by historical standards; the average growth from 1997 to 2011 has been 6% per year.
  - MFS spending change down by 0.6%
  - Change in MFS spending was due to:
    - Decrease in MFS pay (-0.4%)
    - Decrease in Utilization per enrollee (-0.4%)
  - 2 consecutive years of zero growth in MFS spending and utilization (2012-2013)
- Results for 2013 – Imaging
  - Spending change for imaging is -4% due to:
    - -3% pay change
    - -2% change in utilization per enrollee
    - Much the same as last year, but there was no spending change due to site of service. The shift that we have seen to the facility setting in recent years did not occur in 2013.
  - Double-digit decrease in spending for:
    - Nuclear Medicine (11% decrease due to decrease in utilization for CPT 78452)
    - MRI: Other (11% decrease due to pay, e.g., CPT 73221,73721)
    - Echography: Heart (13% decrease due to decrease in pay for CPT 93306)
  - Shift in site of service to office for Echography: Other (CPT 76942)
- Results for 2013 – Evaluation and Management (E/M)
  - 2% increase in spending with 0% change in utilization per enrollee and 2% pay increase
  - Significant coding change for Psychiatry
    - 23% decrease in spending
    - may have affected utilization for office visits and other E/M
  - 2% increase in utilization of established patient office visits
  - 18% increase in spending for wellness visits ($500 million for 2013)

  - Decrease in utilization of hospital and ED visits, 1-4 % per enrollee
- Procedures
  - 1% decrease in spending with 1% decrease in utilization per enrollee
  - 12 % decrease in spending for cataract surgery (pay cut for CPT 66982, 66984)
  - 9% decrease in spending for radiation therapy (pay cut for CPT 77418)
- Other notable results
  - Physical therapy, previously there has been a lot of growth (10% average for 2008, 2009). This year there was a 8% decrease in spending (combination of decrease in pay and utilization)
  - Lab and other tests: decrease in spending.
- Change in utilization of MFS services 2013:
  - Stable and declining utilization of physician services across the board, with a sharper decline in imaging and a slight increase for E/M.
  - Reduction is across the board. 2001-2004 peak was 4-6% and has been falling to current.
- However CMS results are different
  - Current CMS estimate of growth in "Carrier" SGR spending for 2013 = 3.3%
  - Comparable rate here is -0.4%
  - Not clear why estimates are so different, they have not been in the past

X. Relative Value Recommendations for CPT 2015:

Cryoablation Treatment of the Bone Tumors (Tab 4)
Gerald Niedzwiecki, MD (SIR); Michael Hall, MD (SIR); Sean Tutton, MD (SIR); Bob Vogelzang, MD (SIR); Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR)

At the February 2014 CPT Editorial Panel meeting, the Panel created one new CPT Category I code (20983) to describe percutaneous cryosurgical ablation of bone tumor(s). The Panel also revised the descriptor for one CPT Category I code (20982) for percutaneous radiofrequency ablation of bone tumor(s) to incorporate all modalities of imaging, instead of only computed tomography.

20982 ***Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency***
The RUC noted that the specialty societies chose not to survey 20982, since it is a very low volume procedure (204 Medicare claims for 2013). The specialties expressed concern that running a concurrent survey could jeopardize the validity of the RUC surveys for the new cryoablation codes (20983 and 47383).

20983 ***Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation***
The RUC reviewed the survey results from 38 radiologists and interventional radiologists and agreed that the following physician time components are accurate for this new technology procedure: pre-service time of 53 minutes, with 14 additional minutes of positioning over the standard 2b pre-service time package, intra-service time of 115 minutes and post-service time of 28 minutes (the standard post-service package to 8B). The RUC agreed that 14 additional minutes of pre-service position time over the standard pre-service time package are necessary to account for the time for placement of three ablation probes, as well as to verify that the patient is safe and that the equipment and

tethered probes can transit safely when the patient is transported on a moving gantry in and out of the scanner multiple times while also maintaining a sterile field.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey's median work RVU of 7.13 is appropriate. The RUC compared the surveyed code to CPT code 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* (work RVU= 6.20, intra-time of 110 minutes) and noted that both services have similar intra-service times (115 minutes versus 110 minutes), whereas the surveyed code has a higher total time (196 minutes versus 138 minutes), which supports a higher work value for the surveyed code. To further support a work RVU of 7.13, the RUC compared the surveyed code to CPT code 11012 *Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone* (work RVU= 6.87, intra-time of 90 minutes) and noted that the surveyed code has a higher intra-service time (115 minutes versus 90 minutes) and a lower total time (210 minutes versus 196 minutes), which supports a work valuation slightly higher than the reference code. **The RUC recommends a work RVU of 7.13 for CPT code 20983.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct PE inputs for this new service and noted that several of the inputs crosswalk from the radiofrequency ablation of bone tumor code 20982. The PE Subcommittee noted that the 'assist physician' section of the PE recommendation for 20983 includes time for the radiologic technologist (L041B) to *acquire the image* (line 46 – 75% of total physician time) and time for the RN/LPN/MTA (L037D) to circulate during the procedure (line 47 – 25% of total physician time). An input for CT room (EL007) was included as CT guidance is inherent for 20983.

There are three new equipment items specifically related to these types of procedures: the cryosurgery system, helium tanks and argon tanks. Appropriate invoices are attached. The RUC reviewed and approved the direct practice expense inputs with minor modifications as approved by the PE Subcommittee.

New Technology
CPT code 20983 will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

<u>Internal Fixation of Rib Fracture (Tab 5)</u>
Christopher Senkowski, MD, FACS (ACS); Charles Mabry, MD (ACS); James Levett, MD, FACS (STS); William Creevy, MD (AAOS)

In the Notice for Proposed Rulemaking for 2014, CMS proposed CPT codes 21800, 22305 and 27193 for review. CMS indicated that the Agency is considering the appropriateness of having a 90-day global surgical package for a procedure that is performed in settings other than the inpatient setting 33 percent of the time. CMS believes it is unlikely that it is appropriate for a procedure performed outside of the

inpatient hospital setting at this frequency to have such a long global period. The codes that CMS identified regarding the site of service issue will no longer be an issue as they have been or will be deleted by CPT 2016. In October 2013, the CPT Editorial Panel converted four Category III codes into three Category I codes to report internal fixation of rib fracture and deleted CPT code 21810 *Treatment of rib fracture requiring external fixation (flail chest*).

In January 2014, the RUC reviewed the survey responses for CPT codes 21811, 21812 and 21813 and confirmed that a combined targeted and random sample survey was conducted. The RUC noted that less than 30 responses were received for each of the three surveys. In order to achieve more robust data, the specialty societies requested, and the RUC agreed, to allow the survey process to continue. The RUC instructed the specialty societies to send the surveys to an additional (different) random sample from the society's membership. **The RUC referred low volume CPT codes 21800 and 21805 to the CPT Editorial Panel for deletion. CPT Code 21800 was deleted at the February 2014 CPT meeting. In addition, the RUC noted that a coding change proposal has been submitted to delete CPT code 21805 *Open treatment of rib fracture without fixation, each* for CPT 2016.**

In April 2014 the RUC reviewed the complete survey results for CPT codes 21811-21813. The specialty societies presented combined data and data separated by random/non-random as before.

21811 *Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs*
The RUC reviewed the survey results from 45 surgeons for CPT code 21811 and determined that the survey median work RVU of 19.55 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time components: 70 minutes pre-service time, 120 minutes intra-service time and 30 minutes immediate post-service time. The RUC determined an additional 12 minutes of positioning time is necessary to account for posterolateral positioning/padding of the patient and testing of the dual lumen tube positioning and one lung exclusion prior to the operation. The RUC compared 21811 to key reference service 32654 *Thoracoscopy, surgical; with control of traumatic hemorrhage* (work RVU = 20.52) and noted that although the surveyed code requires more intra-service time it requires less total time and is less intense than 32654, accounting for the lower work value. The RUC also referenced MPC codes that bracketed the recommendation: 58150 *Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);* (work RVU = 17.31) and 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection* (work RVU = 19.68). Additionally, the RUC reviewed other services with the same intra-service time of 120 minutes such as CPT code 38101 *Splenectomy; partial (separate procedure)* (work RVU = 19.55) and 27415 *Osteochondral allograft, knee, open* (work RVU = 20.00) and noted that a work RVU of 19.55 for CPT code 21811 maintains the correct relativity among similar services in the Medicare Physician Payment Schedule. **The RUC recommends a work RVU of 19.55 for CPT code 21811.**

21812 *Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 4-6 ribs*
The RUC reviewed the survey results from 46 surgeons for CPT code 21812 and determined that the survey median work RVU of 25.00 appropriately accounts for the

work required to perform this service. The RUC recommends the following physician time components: 70 minutes pre-service time, 150 minutes intra-service time and 30 minutes immediate post-service time. The RUC determined an additional 12 minutes of positioning time is necessary to account for posterolateral positioning/padding of the patient and testing of the dual lumen tube positioning and one lung exclusion prior to the operation. The RUC noted that 21812 requires an additional post-operative office visit compared to 21811, primarily for increased pain management associated with breathing and movement as the fracture repair site cannot be immobilized. The RUC compared 21812 to key reference service 32663 *Thoracoscopy, surgical; with lobectomy (single lobe)* (work RVU = 24.64 and 155 minutes intra-service time) and noted that the reference code requires less post-operative service work but both services require approximately the same amount of total time. The RUC noted that the survey code was more work than MPC code 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection* (work RVU = 19.68) and should be valued higher. The RUC also reviewed other services with the same intra-service time of 150 minutes such as CPT code 35351 *Thromboendarterectomy, including patch graft, if performed; iliac* (work RVU = 24.61) and 35506 *Bypass graft, with vein; carotid-subclavian or subclavian-carotid* (work RVU = 25.33) and noted that a work RVU of 25.00 for CPT code 21812 maintains the correct relativity among similar services in the Medicare Physician Payment Schedule. **The RUC recommends a work RVU of 25.00 for CPT code 21812.**

21813 ***Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs***
The RUC reviewed the survey results from 44 surgeons for CPT code 21813 and determined that the survey median work RVU of 35.00 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time components: 70 minutes pre-service time, 210 minutes intra-service time and 30 minutes immediate post-service time. The RUC determined an additional 12 minutes of positioning time is necessary to account for posterolateral positioning/padding of the patient and testing of the dual lumen tube positioning and one lung exclusion prior to the operation. The RUC noted that 21813 requires an additional post-operative visit compared to 21811, primarily for increased pain management associated with breathing and movement as the fracture repair site cannot be immobilized. The RUC compared 21813 to key reference service 44146 *Colectomy, partial; with coloproctostomy (low pelvic anastomosis), with colostomy* (work RVU = 35.30) and noted that the reference code is more intense and complex to perform, accounting for the slightly higher work value. The RUC also noted that the survey code was less work than MPC code 33426 *Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring* (work RVU = 43.28). The RUC reviewed other services with the same intra-service time of 210 minutes such as CPT code 35081 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta* (work RVU = 23.53) and 34830 *Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis* (work RVU = 35.23) and noted that a work RVU of 35.00 for CPT code 21813 maintains the correct relativity among similar services in the Medicare Physician Payment Schedule. **The RUC recommends a work RVU of 35.00 for CPT code 21813.**

New Technology
The RUC recommends that codes 21811-21813 be placed on the new technology list.

Practice Expense
The RUC recommends the reduced 090-day global direct practice expense inputs as 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.

Sternal Fracture Codes
In January 2014, the specialty societies noted, and the RUC agreed, that CPT codes 21820 and 21825 are sternal fracture codes, whereas the new codes are rib fracture codes and not part of the same family of services. CPT codes 21820 and 21825 are both low volume codes. In addition, CPT code 21820 is typically performed by different groups of physicians (eg, emergency medicine) and in different places of service (ie, emergency department or office) compared to the new rib fixation codes. CPT code 21825 would typically be reported for sternal injuries post cardiac surgery and treatment by cardiothoracic surgeons, whereas trauma surgeons treat the rib injuries represented by the three new codes. These internal fixation of rib fracture codes are typically for lateral trauma to the side of the chest causing the ribs to be flailed, whereas the open sternal fracture codes are treated by a thoracic surgeon, possibly with the sternal debridement code. Reporting of the two services together is rare.

Percutaneous Vertebroplasty and Augmentation (Tab 6)
Gerald Niedzwiecki, MD (SIR); Michael Hall, MD (SIR); Sean Tutton, MD (SIR); Bob Vogelzang, MD (SIR); Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); Greg Nicola, MD (ASNR); John Ratliff, MD (AANS); Alex Mason, MD (CNS); Karin Swartz, MD (NASS) John Heiner, MD (AAOS) and William Creevy, MD (AAOS)

The CPT/RUC Joint Workgroup recommended that CPT code 72291 *Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance* be bundled with CPT codes 22520 *Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic,* 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*, 22524 *Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar* and 72292 *Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under CT guidance* be bundled with *22521Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar* by the 2015 CPT cycle. In February 2014, the CPT Editorial Panel replaced eight Category I codes with six new codes to bundle the percutaneous vertebroplasty with imaging guidance.

22510 ***Percutaneous vertebroplasty (bone biopsy included when performed), 1vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic***
This code is part of a family of codes that was recently bundled by CPT to include imaging guidance that was previously separately reportable. The RUC reviewed the survey results from 47 physicians for CPT code 22510 and determined that the survey 25th percentile work RVU of 8.15 appropriately accounts for the work required to perform this service. The RUC compared 22510 to key reference code 20245 *Biopsy, bone, open; deep (eg, humerus, ischium, femur)* (work RVU = 8.95) and determined that 20245 requires similar work to perform, however, the intra-service time is 90 minutes compared to 45 minutes for 22510. For additional support, the RUC referenced similar 010-day global period code 39400 *Mediastinoscopy, includes biopsy(ies), when performed* (work RVU = 8.05 and 45 minutes intra-service time) and MPC codes 55706 *Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance* (work RVU = 6.28) and 50593 *Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy* (work RVU = 9.13). **The RUC recommends a work RVU of 8.15 for code 22510.**

22511 ***Percutaneous vertebroplasty (bone biopsy included when performed), 1vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral***
This code is part of a family of codes that was recently bundled by CPT to include imaging guidance that was previously separately reportable. The RUC reviewed the survey results from 46 physicians and determined that the survey respondents overestimated the work required to perform this service. The RUC compared 225X1 to CPT code 39400 *Mediastinoscopy, includes biopsy(ies), when performed* (work RVU of 8.05 and 70 minutes pre-service, 45 minutes intra-service and 25 minutes immediate post-service) and determined that based on similar work RVUs and intra-service time, it was an appropriate crosswalk for code 22511. For additional support, the RUC referenced similar MPC codes 55706 *Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance* (work RVU = 6.28) and 50593 *Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy* (work RVU = 9.13).**The RUC recommends a work RVU of 8.05 for code 22511.**

22512 ***Percutaneous vertebroplasty (bone biopsy included when performed), 1vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)***
This code is part of a family of codes that was recently bundled by CPT to include imaging guidance that was previously separately reportable. The RUC reviewed the survey results from 44 physicians for CPT code 22512 and determined that the 25th percentile work RVU of 4.00 appropriately accounts for the work required to perform this service. The RUC compared 22512 to the key reference service CPT code 37223 *Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)* (work RVU = 4.25) which has a similar work RVU as the 25th percentile to the surveyed code. For additional support the RUC referenced CPT code 63621 *Stereotactic Radiosurgery (particle beam, gamma ray, linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)* (work RVU = 4.00) which has the same work RVU as the survey 25th percentile. **The RUC recommends a work RVU of 4.00 for code 22512.**

22513 ***Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic***

This code is part of a family of codes that was recently bundled by CPT to include imaging guidance that was previously separately reportable. The RUC reviewed the survey results from 44 physicians for CPT code 22513 and determined that the survey 25th percentile work RVU of 8.90 appropriately accounts for the work required to perform this service. The RUC compared 22513 to a similar service CPT code 20245 *Biopsy, bone, open; deep (eg, humerus, ischium, femur)* (work RVU = 8.95) and determined that 20245 requires similar work to perform, however, the intra-service time is 90 minutes compared to 45 minutes for 22513. For additional support, the RUC referenced similar 010-day global period code 39400 *Mediastinoscopy, includes biopsy(ies), when performed* (work RVU = 8.05 and 45 minutes intra-service time) and MPC codes 55706 *Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance* (work RVU = 6.28) and 50593 *Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy* (work RVU = 9.13). **The RUC recommends a work RVU of 8.90 for code 22513.**

22514 ***Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar***

This code is part of a family of codes that was recently bundled by CPT to include imaging guidance that was previously separately reportable. The RUC reviewed the survey results from 44 physicians for CPT code 22514 and determined that the survey 25th percentile work RVU of 8.24 appropriately accounts for the work required to perform this service. The RUC compared 22514 to a similar service CPT code 20245 *Biopsy, bone, open; deep (eg, humerus, ischium, femur)* (work RVU = 8.95) and determined that 20245 requires similar work to perform, however, the intra-service time is 90 minutes compared to 45 minutes for 22510. For additional support, the RUC referenced similar 010-day global period code 39400 *Mediastinoscopy, includes biopsy(ies), when performed* (work RVU = 8.05 and 45 minutes intra-service time) and MPC codes 55706 *Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance* (work RVU = 6.28) and 50593 *Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy* (work RVU = 9.13). **The RUC recommends a work RVU of 8.24 for code 22514.**

22515 ***Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)***

This code is part of a family of codes that was recently bundled by CPT to include imaging guidance that was previously separately reportable. The RUC reviewed the survey results from 45 physicians for CPT code 22512 and determined that the 25th percentile work RVU of 4.00 appropriately accounts for the work required to perform this service. The RUC compared 22515 to CPT code 57267 *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach* (work RVU = 4.88) which has a similar work RVU as the 25th

percentile to the surveyed code. For additional support the RUC referenced CPT code 63621 *Stereotactic Radiosurgery (particle beam, gamma ray, linear accelerator); each additional spinal lesion (List separately in addition to code for primary procedure)* (work RVU = 4.00) which has the same work RVU as the survey 25th percentile. **The RUC recommends a work RVU of 4.00 for code 22515.**

Practice Expense
The RUC reviewed and approved the direct Practice Expense inputs with minor modifications.

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.

Total Disc Arthroplasty Additional Cervical Level Add-On Code (Tab 7)
John Ratliff, MD (AANS); William Creevy, MD (AAOS); John Heiner, MD (AAOS); Karin Swartz, MD (NASS)

In February 2014, the CPT Editorial Panel approved a new add-on code for second level cervical disc arthroplasty. In addition, the base code 22856 was also revised by the panel. These codes describe procedures that are used to treat patients with spinal cord compression and/or cervical disc herniation.

22856 ***Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical***
The RUC reviewed survey results from 47 physicians specializing in spinal surgery. The RUC determined that the current work RVU of 24.05, which is slightly less than the 25th percentile appropriately accounts for the work required to perform this service. The RUC determined that this code compares well with the key reference service CPT code *22551 Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2* (work RVU = 25.00, 60 minutes pre-time, 120 intraservice time, 30 minutes post-time) with a similar work RVU and the same pre, intra, and post service times. The RUC determined that the current times of 80 minutes pre-service, 120 intra service and 30 minutes of post-time are appropriate. For additional support, the RUC noted that MPC codes 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protectio*n (work RVU = 19.68) and 55866 *Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed* (work RVU =32.06), suitably bracket this code in terms of physician time and work.. **The RUC recommends a work RVU of 24.05 for CPT code 22856 which maintains the current value.**

22858 ***Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)***
The RUC reviewed the survey data from physicians specializing in spinal surgery. The RUC determined that the median work RVU of 8.40 appropriately accounts for the work required to perform this service The RUC noted that this procedure involves the use of a new technology that replicates the biomechanics of a disc. The RUC compared CPT

code 22858 to the key reference code 22552 Arthrodesis*, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)* (work RVU = 6.50) and noted that the surveyed code requires 30 more minutes of intra-service time and is appropriately valued higher than 22552. The RUC spent considerable time discussing the correct approach to maintain relativity between the base code 22856 and the new add-on code. For additional support, the RUC noted that CPT code 61642 *Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular family (List separately in addition to code for primary procedure)* (work RVU = 8.66) compares well to CPT code 22858. Although 22858 requires 15 more minutes of intra-service time it is slightly less intense and is appropriately valued lower. **The RUC recommends a work RVU of 8.40 for CPT code 22858.**

New Technology
The RUC recommends that CPT code 22858 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

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

Sacroiliac Joint Fusion (Tab 8)
John Ratliff, MD (AANS); Karin Swartz, MD (NASS) John Heiner, MD (AAOS); William Creevy, MD (AAOS)

In February 2014, the CPT Editorial Panel converted one Category III code to a Category I code to report minimally invasive sacroiliac joint, fusion which includes image guidance. Additionally, the CPT Editorial Panel revised CPT code 27280 to include the word "open."

27279 ***Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device***
The specialty societies indicated and agreed that the survey respondents overestimated the work required to perform CPT code 27279. The specialty societies noted that the survey process was interfered with by an outside party. Therefore, the specialty societies recommended and the RUC agreed that directly crosswalking 27279 to 62287 *Decompression procedure, percutaneous, of nucleus pulpous of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with the use of an endoscope, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar* (work RVU=9.03, 70 minutes pre-time, 60 minutes intra-time, 30 minutes post-time) is appropriate. The RUC recommends 55 minutes pre-service, 60 minutes intra-service and 30 minutes immediate post-service time for 27279. The RUC noted that both 27279 and 62287 require the same physician work and time to perform and therefore should be valued the same. For additional support, the RUC referenced MPC codes 49507 *Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated* (work RVU= 9.09). and 54530 *Orchiectomy, radical, for tumor; inguinal approach* (work RVU = 8.46), which require similar physician work and time and

support the recommended work RVU of 9.03 for CPT code 27279, **The RUC recommends a work RVU of 9.03 for CPT code 27279.**

27280 ***Arthrodesis, open, sacroiliac joint including obtaining bone graft***
The specialty societies presented a letter to the RUC requesting that this code be referred back to the CPT Editorial Penal so that language can be added to the code clarifying that instrumentation is included in this procedure. The RUC agreed that this request is reasonable and referred this issue back to the CPT Editorial Panel to revise the descriptor to "includes instrumentation when performed". In the interim, the RUC recommends maintaining the current value of work RVU= 14.64 for this code. Specifically, the specialties believe that during the survey process for CPT code 27280 led some respondents to believe that instrumentation could be reported separately even though it cannot, causing significant confusion. The specialty societies believe that a new survey using a revised descriptor will yield more accurate results. **The RUC referred CPT Code 27280 to the CPT Editorial Panel. The RUC recommends that the current work RVU of 14.64 be maintained and that this service be resurveyed after revisions from the CPT Editorial Panel.**

New Technology
The RUC recommends CPT code 27279 be placed on the New Technology list and be re-reviewed by the RUC to ensure correct valuation and utilization assumptions.

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

<u>Subcutaneous Implantable Defibrillator Procedures (Tab 9)</u>
Richard Wright, MD (ACC); Mark Schoenfeld, MD (HRS) and David Slotwiner, MD (HRS)
Facilitation Committee #1

At the May 2012 CPT Editorial Panel meeting, the Panel created several Category III CPT codes describing the insertion, removal and/or replacement of subcutaneous implantable defibrillator devices. At the February 2014 CPT Editorial Panel meeting, the Category III codes were deleted and replaced with CPT Category I codes describing the same procedures. In addition, editorial changes to the descriptors were approved to include the word "implantable."

33270 ***Insertion or replacement of permanent subcutaneous implantable defibrillator system; with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed***
The RUC reviewed the survey results from 33 cardiologists and agreed with the specialty societies that the following physician time components are accurate for this new technology procedure: pre-service time of 39 minutes (the standard pre time package of 2b Difficult patient/straightforward procedure in a facility), intra-service time of 90 minutes and immediate post-service time of 25 (the standard post time package of 8A). The RUC noted that one 99214 post-operative office visit is appropriate for this procedure as these patients have heart failure with low ejection fraction and other concomitant comorbid states. Furthermore, these devices are three times larger than the

current defibrillator devices and require three incisions, which are larger. Finally, the physician must evaluate the patient's severe pain due to defibrillation under general anesthesia. The RUC also agreed that a full-day discharge (99238) is appropriate as the patient is discharged the following day and patient explanation of the device is complex.

The RUC reviewed the survey respondents' estimated work values and agreed that the survey's 25th percentile work RVU of 9.10 is appropriate. To justify a work RVU of 9.10, the RUC compared the surveyed code to CPT code 64570 *Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator* (work RVU= 9.10) and noted that both services have comparable physician work and identical intra-service time, 90 minutes. Therefore, the two codes should be valued identically. The RUC also reviewed code 61886 *Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays* (work RVU= 9.93, intra time = 100 minutes) and agreed that since the reference code has more intra-service time compared to 33270, it is justly valued higher. **The RUC recommends a work RVU of 9.10 for CPT code 33270.**

Staff Note
The specialty societies do not agree with the RUC's recommended work RVU of 9.10 for CPT code 33270, noting that 9.10 undervalues the work of this service.

33271 ***Insertion of subcutaneous implantable defibrillator electrode***
The RUC reviewed the survey results from 30 cardiologists and agreed with the specialty societies that the following physician time components are accurate for this new technology procedure: pre-service time of 39 minutes (the standard pre time package of 2b Difficult patient/straightforward procedure in a facility), intra-service time of 60 minutes and immediate post-service time of 25 (the standard post time package of 8A). The RUC noted that one 99214 post-operative office visit is appropriate for this procedure as these patients have heart failure with low ejection fraction and other concomitant comorbid states. Furthermore, these devices are three times larger than the current defibrillator devices and require three incisions, which are larger. Finally, the physician must evaluate the patient's severe pain due to defibrillation under general anesthesia. The RUC also agreed that a full-day discharge (99238) is appropriate as the patient is discharged the following day and patient explanation of the device is complex.

The RUC reviewed the survey respondents' estimated work values and agreed that the survey's 25th percentile work RVU of 7.50 is appropriate. To justify a work RVU of 7.50, the RUC compared the surveyed code to CPT code 33207 *Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular* (work RVU= 8.05) and noted that both these services have identical intra-service time, 60 minutes and analogous physician work. Since the reference code has slightly more total time, 33271 is appropriately valued slightly less than this reference code. The RUC also reviewed MPC code 49505 *Repair initial inguinal hernia, age 5 years or older; reducible* (work RVU= 7.96, intra time= 70 minutes) and agreed that since the reference code has greater intra-service time compared to 33271, it is appropriately valued slightly higher. **The RUC recommends a work RVU of 7.50 for CPT code 33271.**

33272 ***Removal of subcutaneous implantable defibrillator electrode***
The RUC reviewed the survey results from 29 cardiologists and agreed with the specialty societies that the following physician time components are accurate for this new technology procedure: pre-service time of 39 minutes (the standard pre time package of

2b Difficult patient/straightforward procedure in a facility), intra-service time of 45 minutes and immediate post-service time of 25 (the standard post time package of 8A). The RUC noted that one 99213 post-operative office visit is appropriate for this procedure as the post-operative care is not as complex as the post-operative care for the insertion of the device. Furthermore, a half-day discharge (99238) is more appropriate given that the patient has already received instructions about the device following the insertion procedure.

The RUC reviewed the survey respondents' estimated work values and agreed that the values were too high at the 25th percentile (work RVU= 6.05). The RUC compared the surveyed code to CPT code 28039 *Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater* (work RVU= 5.42) and agreed that since both services have identical intra-service times and nearly identical total times, they should be directly crosswalked. The Committee agreed that since 33272 has 15 fewer minutes of intra-time compared to the insertion procedure (33271), a work value of 5.42 is appropriate within the relativity of the family of services. **The RUC recommends a work RVU of 5.42 for CPT code 33272.**

33273 ***Repositioning of previously implanted subcutaneous implantable defibrillator electrode***
The RUC reviewed the survey results from 30 cardiologists and agreed with the specialty societies that the following physician time components are accurate for this new technology procedure: pre-service time of 39 minutes (the standard pre time package of 2b Difficult patient/straightforward procedure in a facility), intra-service time of 60 minutes and immediate post-service time of 25 (the standard post time package of 8A). The RUC noted that one 99214 post-operative office visit is appropriate for this procedure as the patient is still complex and needs incisions to remove the device and reposition. Finally, the physician must evaluate the patient's severe pain due to defibrillation under general anesthesia. The RUC also agreed that a half-day discharge (99238) is more appropriate given that the patient has already received instructions about the device following the insertion procedure.

The RUC reviewed the survey respondents' estimated work values and agreed that the median work RVU of 6.50 is an accurate value for 33273. The RUC reviewed the key reference service 33215 *Repositioning of previously implanted transvenous pacemaker or pacing cardioverter-defibrillator (right atrial or right ventricular) electrode* (work RVU= 4.92) and agreed that while both services have identical intra-service time, 60 minutes, 33273 is a much more complex procedure than 33215 because the size of the device is three times larger and there are a greater number of longer incisions. The RUC also reviewed CPT code 21552 *Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater* (work RVU= 6.49, intra time= 60 minutes) and agreed that with identical intra-time and similar total time, 33273 should be valued similarly to this reference code. **The RUC recommends a work RVU of 6.50 for CPT code 33273.**

93260 ***Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis; implantable subcutaneous lead defibrillator system***
The RUC reviewed the survey results from 31 cardiologists and agreed with the specialty societies that the following physician time components are accurate for this new technology procedure: pre-service time of 10 minutes, intra-service time of 15 minutes and post-service time of 10 minutes.

The RUC reviewed the survey respondents' estimated work values and agreed that the 25th percentile work RVU of 0.85 is an accurate value for 93260. The RUC compared the surveyed code to the key reference service 93282 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead implantable cardioverter-defibrillator system* (work RVU= 0.85) and agreed that the work to program the standard cardioverter-defibrillator system is no different than programming a subcutaneous lead defibrillator system. Since the intra-service time is identical, 15 minutes, the RUC agreed that both services should be valued identically. **The RUC recommends a work RVU of 0.85 for CPT code 93260.**

93261 ***Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator system***
The RUC reviewed the survey results from 32 cardiologists and agreed with the specialty societies that the following physician time components are accurate for this new technology procedure: pre-service time of 10 minutes, intra-service time of 15 minutes and post-service time of 10 minutes.

The RUC reviewed the survey respondents' estimated work values and agreed that the 25th percentile work RVU of 0.74 is an accurate value for 93261. The RUC compared the surveyed code to the key reference service 93289 *Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead implantable cardioverter-defibrillator system, including analysis of heart rhythm derived data elements* (work RVU= 0.92) and noted that while both services have identical intra-service time, 15 minutes, 93261 should be valued slightly less than the reference code given the survey responses indicated that the surveyed code is slightly less intense to perform. **The RUC recommends a work RVU of 0.74 for CPT code 93261.**

93644 ***Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)***
The RUC reviewed the survey results from 33 cardiologists and agreed with the specialty societies that the following physician time components are accurate for this new technology procedure: pre-service time of 39 minutes (the standard pre time package of 2b Difficult patient/straightforward procedure in a facility), intra-service time of 20 minutes and immediate post-service time of 25 (the standard post package of 8A).

The RUC reviewed the survey respondents' estimated work values and agreed that the values were too high at the 25th percentile (work RVU= 4.65). To determine an appropriate work value, the RUC compared the surveyed code to CPT 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) and noted that while the reference code has greater pre-service time, the codes have identical intra-service times and should thus be valued identically. The

RUC recommends a direct crosswalk of work RVUs between 15002 and 93644. To justify a value of 3.65, the RUC also reviewed CPT code 16035 *Escharotomy; initial incision* (work RVU= 3.74, intra time= 20 minutes) and noted that both services have identical intra-service time and should be valued similarly. **The RUC recommends a work RVU of 3.65 for CPT code 93644.**

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

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

Vignette Revision - 33273
The RUC noted that the vignette for 33273 indicates that this service is typically performed the day after the device is inserted. This however was in error. The repositioning of the device is not typically performed, but when it is it would fall outside the global period for the insertion procedure. The RUC agreed with the specialty societies that this error did not seem to confuse the respondents in valuing this service. The societies will work with the RUC and the CPT Editorial Panel to revise the vignettes for publication.

Moderate Sedation
The RUC noted that these services were indicated to have moderate sedation in the Code Change Proposal (CCP) approved by the CPT Editorial Panel, but did not receive the Appendix G symbol in the CPT language. These services mimic many other Cardiology services which have moderate sedation inherent in the procedure. The RUC did note that the survey respondents reported a low percentage of these procedures are done with moderate sedation, however the median survey performance rate was 0 and the specialty societies agreed that the respondents may not have enough experience performing the procedure. Therefore, the RUC agreed that these procedures are typically performed with moderate sedation and should be placed in Appendix G.

<u>Transcatheter Mitral Valve Repair (Tab 10)</u>
Richard Wright, MD (ACC); Cliff Kavinsky, MD (SCAI)

At the February 2014 CPT Editorial Panel meeting, the Panel approved the deletion of two Category III CPT codes and created two CPT Category I codes to describe Transcatheter mitral valve repair.

33418 ***Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis***
The RUC reviewed the survey results from 30 cardiologists and agreed with the specialty societies that the following physician time components are accurate for this new technology procedure: pre-service time of 63 minutes (the standard pre time package of 4 Difficult patient/difficult procedure in a facility), intra-service time of 180 minutes and immediate post-service time of 33 (the standard post time package of 9B). The specialty societies explained that the typical patient is discharged from the hospital after three days. The physician performs one critical care visit (99291) on the same day as the procedure. This critical care visit is necessary because the patient is critically ill due to heart failure

and needs minute to minute monitoring. Over the next two days the physician performs two non-critical hospital visits (99232). The physician also performs a full-day discharge (99239). This level of discharge is warranted because of the complexity of the patient's condition due to anticoagulation and medication management following the procedure. Finally, two 99214 office visits are performed within the 90-day global period. The level of visits are appropriate because the physician must manage the patients' medications, care for the wound site, manage their underlying heart failure, and check for recurrent or severe mitral regurgitation, arrhythmias, paravalvular complications, and vascular complications.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey's median work RVU of 32.25 is appropriate. The RUC compared the surveyed code to the following two reference codes: 33647 *Repair of atrial septal defect and ventricular septal defect, with direct or patch closure* (work RVU= 33.00) and 35536 *Bypass graft, with vein; splenorenal* (work RVU= 33.73) and noted that both these services have identical intra-service time, 180 minutes, to code 33418, as well as similar total times, therefore the recommended work value is correctly valued relative to services across the RBRVS. **The RUC recommends a work RVU of 32.25 for CPT code 33418.**

33419 ***Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis (es) during same session***
The RUC reviewed the survey results from 30 cardiologists and agreed with the specialty societies that the respondents overestimated the intra-service time with a median of 120 minutes. This service is new technology and the respondents had limited familiarity with the service. Therefore, the RUC accepted the specialty societies' expert panel recommendation of 90 minutes of intra-service time for this add-on service. The expert panel included individuals with experience performing this service.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 7.93 accurately values this service. To justify a work RVU of 7.93, the RUC compared the surveyed code to CPT code 37235 *Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed* (work RVU= 7.80) and noted that while 33419 has slightly more intra-service time, 90 minutes compared to 80 minutes, the two services have comparable physician work and should be valued similarly. In addition, the RUC reviewed add-on code 35683 *Bypass graft; autogenous composite, 3 or more segments of vein from 2 or more locations* (work RVU= 8.49, intra time= 90 minutes) and noted that with similar times, the RUC recommended work value is appropriate for 33419. **The RUC recommends a work RVU of 7.93 for CPT code 33419.**

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

New Technology
CPT codes 33418 and 33419 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.

Do Not Use to Validate Physician Work
Due to the use of expert panel derived time, a flag will be placed in the RUC database to not use CPT code 33419 to validate physician work.

ECMO-ECLS (Tab 11)
Jim Levett, MD, (STS); Jeffrey Jacobs, MD (STS); Kirk Kanter, MD, (STS); Stephen Lahey, MD (STS); Joseph Cleveland, MD (STS); Richard Wright, MD (ACC); Katina Nicolacakis, MD (ATS); Robert DeMarco, MD (ACCP); Steve Krug, MD (AAP); David Notrica, MD (AAP)

In the Proposed Rule for the 2014 Medicare Physician Payment Schedule, CMS identified codes 33960 and 33961 as potentially misvalued codes. The codes were listed in TABLE 11: Codes Identified in Consultation with Contractor Medical Directors (CMDs) as Potentially Misvalued of the proposed rule. The comments stated that the services were originally valued when they were used primarily in premature neonates; but the services are now being furnished to adults with severe influenza, pneumonia and respiratory distress syndrome. In response, the involved specialty societies reviewed the family of codes and issued a code change proposal (CCP) to the CPT Editorial Panel in February 2014, to create an entirely new family of codes to facilitate proper determination of physician work and allow appropriate payment for multiple providers who are involved in the treatment of these complex patients.

33946 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician; initiation, veno-venous***
The RUC reviewed the survey results from 182 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 40 minutes, intra-service time of 73 minutes and immediate post-service time of 20 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 6.00 accurately values CPT code 33946. To justify this value, the RUC compared the surveyed code to CPT code 99477 *Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or younger, who requires intensive observation, frequent interventions, and other intensive care services* (work RVU= 7.00) and agreed that since the reference code has slightly more intra-service, 77.5 minutes compared to 73 minutes, it should be valued higher than 33946. The RUC also reviewed CPT code 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU= 4.50, intra-service time= 40 minutes) and agreed that while the surveyed code is a slightly less intense procedure, it has considerably more total time and is accurately valued higher than 99291. **The RUC recommends a work RVU of 6.00 for CPT code 33946.**

33947 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician; initiation, veno-arterial***
The RUC reviewed the survey results from 187 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 40 minutes, intra-service time of 75 minutes and immediate post-service time of 20 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 6.63 accurately values CPT code 33947. To justify this value, the RUC compared the surveyed code to CPT code 99477 *Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or younger, who requires intensive observation, frequent interventions, and other intensive care services* (work RVU= 7.00) and agreed that since the reference code has slightly more intra-service, 77.5 minutes compared to 73 minutes, it should be valued higher than 33946. The RUC also compared this veno-arterial initiation to the veno-venous initiation service (33946) and agreed that these services have comparable physician work, but since 33947 has two additional minutes of intra-service time, it is correctly valued slightly higher than 33946. **The RUC recommends a work RVU of 6.63 for CPT code 33947.**

33948 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician; daily management, each day, veno-venous***
The RUC reviewed the survey results from 176 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 20 minutes, intra-service time of 40 minutes and immediate post-service time of 20 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 4.73 accurately values CPT code 33948. To justify this value, the RUC compared the surveyed code to MPC code 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU= 4.50) and agreed that while both services have identical intra-service time, 33948 has additional pre-service and post-service time and should thus be valued slightly higher than this reference code. The RUC also reveiwed MPC code 99285 *Emergency department visit for the evaluation and management of a patient* (work RVU= 3.80) and again agreed that since 33948 has more total time it is appropriately valued higher than this reference code. **The RUC recommends a work RVU of 4.73 for CPT code 33948.**

33949 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician; daily management, each day veno-arterial***
The RUC reviewed the survey results from 179 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 20 minutes, intra-service time of 40 minutes and immediate post-service time of 20 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 4.60 accurately values CPT code 33949. To justify this value, the RUC compared the surveyed code to MPC code 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU= 4.50) and agreed that while both services have identical intra-service time, 33949 has additional pre-service and post-service time and should thus be valued slightly higher than this reference code. The RUC also compared this veno-arterial daily management service to the veno-venous daily management service and note that both services have idetnical physician time components and are accurately valued analogous to each other. **The RUC recommends a work RVU of 4.60 for CPT code 33949.**

33951 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance when performed)***
The RUC reviewed the survey results from 62 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 60 minutes, intra-service time of 60 minutes and immediate post-service time of 30 minutes. The RUC agreed that 12 additional minutes of pre-service positioning time over the standard pre-time package is necessary to properly align the patient as the anterior neck approach is used for this procedure. The RUC also noted that the specialty societies received approval from the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The results showed that 100% of the survey respondents indicated that the patient stayed overnight in the hospital and 98% of the respondents indicated that they provided a visit to the patient on the same day as the procedure. Therefore, a 99231 hospital visit was included in this 000 global day service. This service is necessary because the physician must evaluate the cannulation site for bleeding, cannula position and function. It is also imperative to assure that cannulation related arterial and/or venous obstruction (compartment syndrome) is not affecting the related extremity. The results and further care plans are communicated to other health care professionals and to the patient and/or family.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 8.15 accurately values CPT code 33951. To justify this value, the RUC compared the surveyed code to MPC code 33990 *Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial access only* (work RVU= 8.15) and agreed that both these service have identical intra-service time, 60 minutes, and comparable physician work. Therefore, both 33951 and 33990 should be valued identically. The RUC also reviewed CPT code 37220 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 8.15) and agreed that since this reference code and the surveyed code have identical intra-service time and comparable physician work, 33951 is accurately valued the same as this reference code. **The RUC recommends a work RVU of 8.15 for CPT code 33951.**

33952 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance when performed)***
The RUC reviewed the survey results from 107 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 48 minutes, intra-service time of 60 minutes and immediate post-service time of 30 minutes. The RUC also noted that the specialty societies received approval from the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The results showed that 98% of the survey respondents indicated that the patient stayed overnight in the hospital and 99% of the respondents indicated that they provided a visit to the patient on the same day as the procedure. Therefore, a 99231 hospital visit was included in this 000 global day service. This service is necessary because the physician must evaluate the cannulation site for bleeding, cannula position and function. It is also imperative to assure that cannulation related arterial and/or venous obstruction (compartment syndrome) is not affecting the related extremity. The results

and further care plans are communicated to other health care professionals and to the patient and/or family.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 8.43 accurately values CPT code 33952. To justify this value, the RUC compared the surveyed code to MPC code 33990 *Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial access only* (work RVU= 8.15) and agreed that while both services have identical intra-service time, 60 minutes, 33952 is a more intense procedure and is accurately valued slightly higher. The RUC also reviewed CPT code 52346 *Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 8.58) and noted that both services have similar physician time components, 140 minutes compared to 138 minutes, and should be valued similarly. **The RUC recommends a work RVU of 8.43 for CPT code 33952.**

33953 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician;insertion of peripheral (arterial and/or venous) cannula(e), open birth, through 5 years of age***
The RUC reviewed the survey results from 49 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 60 minutes, intra-service time of 60 minutes and immediate post-service time of 30 minutes. The RUC agreed that 12 additional minutes of pre-service positioning time over the standard pre-time package is necessary to properly align the patient as the anterior neck approach is used for this procedure. The RUC also noted that the specialty societies received approval from the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The results showed that 100% of the survey respondents indicated that the patient stayed overnight in the hospital and 100% of the respondents indicated that they provided a visit to the patient on the same day as the procedure. Therefore, a 99232 hospital visit was included in this 000 global day service. This service is necessary because the physician must evaluate the cannulation site for bleeding, cannula position and function. It is also imperative to assure that cannulation related arterial and/or venous obstruction (compartment syndrome) is not affecting the related extremity. The results and further care plans are communicated to other health care professionals and to the patient and/or family. The RUC agreed that the post-operative work is more intense for the open approach compared to the percutaneous approach and justifies a higher level hospital level visit.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 9.83 accurately values CPT code 33953. To justify this value, the RUC compared the surveyed code to the key reference code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral* (work RVU= 6.74, 45 minutes intra-service time) and noted that while the reference code has 15 minutes less intra-service time, both services have comparable intensity and complexity. Therefore, given the time differences, the recommended value for 33953 appropriately values the procedure greater than 34812. The RUC also reviewed CPT code 59072 *Fetal umbilical cord occlusion, including ultrasound guidance* (work RVU= 8.99) and agreed that since the surveyed code has more total time than the reference code, 190 minutes compared to 175 minutes, 33953 is accurately valued higher. **The RUC recommends a work RVU of 9.83 for CPT code 33953.**

33954 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older***
The RUC reviewed the survey results from 79 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 48 minutes, intra-service time of 60 minutes and immediate post-service time of 30 minutes. The RUC also noted that the specialty societies received approval from the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The results showed that 99% of the survey respondents indicated that the patient stayed overnight in the hospital and 99% of the respondents indicated that they provided a visit to the patient on the same day as the procedure. Therefore, a 99232 hospital visit was included in this 000 global day service. This service is necessary because the physician must evaluate the cannulation site for bleeding, cannula position and function. It is also imperative to assure that cannulation related arterial and/or venous obstruction (compartment syndrome) is not affecting the related extremity. The results and further care plans are communicated to other health care professionals and to the patient and/or family. The RUC agreed that the post-operative work is more intense for the open approach compared to the percutaneous approach and justifies a higher level hospital level visit.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 9.43 accurately values CPT code 33954. To justify this value, the RUC compared the surveyed code to the key reference code 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral* (work RVU= 6.74, 45 minutes intra-service time) and noted that while the reference code has 15 minutes less intra-service time, both services have comparable intensity and complexity. Therefore, given the time differences, the recommended value for 3399XX8 appropriately values the procedure greater than 34812. The RUC also reviewed the surveyed code in comparison to the child open peripheral cannula code (33953) and agreed that since 33953 has greater total time, it should be valued slightly higher than 33954. **The RUC recommends a work RVU of 9.43 for CPT code 33954.**

33955 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age***
The RUC reviewed the survey results from 47 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 60 minutes, intra-service time of 90 minutes and immediate post-service time of 30 minutes. The RUC agreed that 12 additional minutes of pre-service positioning time over the standard pre-time package is necessary to position the patient for central access for surgery on the heart and great vessels. The RUC also agreed with the specialty societies that the survey respondents' underestimated the intra-service time with a median time of 70 minutes. The 75th percentile time of 90 minutes is a better representation of the actual time it takes to perform this service and is consistent with all major cardiac procedures where sternotomy is typically employed and equal to the median time for 33956 and the other central access ECMO codes in this family of services.

The RUC also noted that the specialty societies received approval from the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The

results showed that 100% of the survey respondents indicated that the patient stayed overnight in the hospital and 91% of the respondents indicated that they provided a visit to the patient on the same day as the procedure. Therefore, a 99291 critical care visit, which represents the survey median visit, was included in this 000 global day service. This service is necessary because the physician must evaluate the patient for bleeding, cannula position and function. The initial postoperative course following central cannulation is similar to postoperative cardiac surgery, as the great vessels are operated upon and occult bleeding and cardiac tamponade are possible complications. The results and further care plans are communicated to other health care professionals and to the patient and/or family. The RUC agreed that the post-operative work is more intense for the insertion of central cannula services and warrants this level of critical care visit.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 16.00 accurately values CPT code 33955. To justify this value, the RUC compared the surveyed code to the CPT code 37244 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation* (work RVU= 14.00) and noted that while both codes have identical intra-service time, 90 minutes, 33955 has more total time and is accurately valued greater than the reference code. The RUC also reviewed the key reference service 35820 *Exploration for postoperative hemorrhage, thrombosis or infection; chest* (work RVU= 18.57, with removal of post-op visits to value as a 000-day global) and noted that since the reference code has more total time than the surveyed code, 291 minutes compared to 250 minutes, 35820 is accurately valued higher than 33955. **The RUC recommends a work RVU of 16.00 for CPT code 33955.**

33956 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older***

The RUC reviewed the survey results from 76 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 60 minutes, intra-service time of 90 minutes and immediate post-service time of 30 minutes. The RUC agreed that 12 additional minutes of pre-service positioning time over the standard pre-time package is necessary to position the patient for central access for surgery on the heart and great vessels. The RUC also noted that the specialty societies received approval from the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The results showed that 99% of the survey respondents indicated that the patient stayed overnight in the hospital and 86% of the respondents indicated that they provided a visit to the patient on the same day as the procedure. Therefore, a 99291 critical care visit, which represents the survey median visit, was included in this 000 global day service. This service is necessary because the physician must evaluate the patient for bleeding, cannula position and function. The initial postoperative course following central cannulation is similar to postoperative cardiac surgery, as the great vessels are operated upon and occult bleeding and cardiac tamponade are possible complications. The results and further care plans are communicated to other health care professionals and to the patient and/or family. The RUC agreed that the post-operative work is more intense for the insertion of central cannula services and warrants this level of critical care visit.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 16.00 accurately values CPT code 33956. To justify this value, the RUC compared the surveyed code to MPC code 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection* (work RVU= 16.46, with removal of post-op visits to value as a 000-day global; 103 minutes intra-service time) and noted that the reference code has 13 additional minutes of intra-service time and thus warrants a slightly higher work value. The RUC also compared this service to the identical child insertion of central cannula code (33955) and noted that both services have identical physician time components and should thus be valued identically. **The RUC recommends a work RVU of 16.00 for CPT code 33956.**

33957 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician: reposition peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance when performed)***

The RUC reviewed the survey results from 59 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 60 minutes, intra-service time of 30 minutes and immediate post-service time of 20 minutes. The RUC agreed that 12 additional minutes of pre-service positioning time over the standard pre-time package is necessary to properly align the patient as the anterior neck approach is used for this procedure. The RUC also noted that the specialty societies received approval from the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The results showed that 100% of the survey respondents indicated that the patient stayed overnight in the hospital and 81% of the respondents indicated that they provided a visit to the patient on the same day as the procedure. Therefore, a 99231 hospital visit was included in this 000 global day service. This service is necessary because the physician must evaluate the cannulation site for bleeding, cannula position and function and communication of results and further care plans to other health care professionals and to the patient and/or family.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's median work RVU of 4.00 accurately values CPT code 33957. The RUC noted that the survey's 25th percentile work value (3.51) would place this service too low compared to the key reference service 33993 *Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion* (work RVU= 3.51). While both these services have identical intra-service time, 30 minutes, the key reference code is an XXX global code and does not have post-operative visits. If the identical post-operative visit is added to the reference code (99231, work RVU= 0.79), the reference code's resultant work value would be 4.27. Therefore, the recommended median work RVU of 4.00 more accurately values 33957 in relation to this reference service. In addition, the RUC reviewed MPC code 52224 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy* (work RVU= 4.05) and noted that since both codes have identical intra-service time, they should both be valued nearly identically. **The RUC recommends a work RVU of 4.00 for CPT code 33957.**

33958 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance when performed)***
The RUC reviewed the survey results from 103 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 48 minutes, intra-service time of 30 minutes and immediate post-service time of 20 minutes. The RUC noted that the specialty societies received approval from the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The results showed that 100% of the survey respondents indicated that the patient stayed overnight in the hospital and 79% of the respondents indicated that they provided a visit to the patient on the same day as the procedure. Therefore, a 99231 hospital visit was included in this 000 global day service. This service is necessary because the physician must evaluate the cannulation site for bleeding, cannula position and function and communication of results and further care plans to other health care professionals and to the patient and/or family.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's median work RVU of 4.00 accurately values CPT code 33958. The RUC noted that the survey's 25th percentile work value (3.51) would place this service too low compared to the key reference service 33993 *Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion* (work RVU= 3.51). While both these services have identical intra-service time, 30 minutes, the key reference code is an XXX global code and does not have post-operative visits. If the identical post-operative visit is added to the reference code (99231, work RVU= 0.79), the reference code's resultant work value would be 4.27. Therefore, the recommended median work RVU of 4.00 more accurately values 33958 in relation to this reference service. In addition, the RUC compared this adult percutaneous reposition code to the identical child reposition code and agreed that while 33957 has more pre-service time, 33958 is a slightly more intense procedure and warrants an almost identical value. **The RUC recommends a work RVU of 4.05 for CPT code 33958.**

33959 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes fluoroscopic guidance when performed)***
The RUC reviewed the survey results from 52 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 60 minutes, intra-service time of 30 minutes and immediate post-service time of 20 minutes. The RUC agreed that 12 additional minutes of pre-service positioning time over the standard pre-time package is necessary to properly align the patient as the anterior neck approach is used for this procedure. The RUC also noted that the specialty societies received approval from the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The results showed that 100% of the survey respondents indicated that the patient stayed overnight in the hospital and 81% of the respondents indicated that they provided a visit to the patient on the same day as the procedure. Therefore, a 99231 hospital visit was included in this 000 global day service. This service is necessary because the physician must evaluate the cannulation site for bleeding, cannula position and function and communication of results and further care plans to other health care professionals and to the patient and/or family.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 4.69 accurately values CPT code 33959. To justify this value, the RUC compared the surveyed code to the key reference service 33993 *Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion* (work RVU= 3.51) and noted that both services have identical intra-service time, 30 minutes, and comparable physician work. However, since 33959 has more total time, the recommended value of 4.69 work RVUs accurately values 33959 in relation to this reference code. In addition, the RUC compared the surveyed code to CPT code 47490 *Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation* (work RVU= 4.76) and agreed that since both codes have similar total times, both should be valued similarly as well. **The RUC recommends a work RVU of 4.69 for CPT code 33959.**

33962 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance when performed)***
The RUC reviewed the survey results from 52 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 48 minutes, intra-service time of 30 minutes and immediate post-service time of 20 minutes. The RUC also noted that the specialty societies received approval from the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The results showed that 99% of the survey respondents indicated that the patient stayed overnight in the hospital and 85% of the respondents indicated that they provided a visit to the patient on the same day as the procedure. Therefore, a 99231 hospital visit was included in this 000 global day service. This service is necessary because the physician must evaluate the cannulation site for bleeding, cannula position and function and communication of results and further care plans to other health care professionals and to the patient and/or family.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 4.73 accurately values CPT code 33962. To justify this value, the RUC compared the surveyed code to the key reference service 33993 *Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion* (work RVU= 3.51) and noted that both services have identical intra-service time, 30 minutes, and comparable physician work. However, since 33962 has more total time, the recommended value of 4.73 work RVUs accurately values 33962 in relation to this reference code. In addition, the RUC reviewed MPC code 52235 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)* (work RVU= 5.44, 45 minutes intra-service time) and noted that while the reference code has less total time compared to the surveyed code, 52235 has 15 additional minutes of intra-service time and is accurately valued higher than 33962. Finally, the RUC compared this adult open reposition code to the identical child reposition code and agreed that while 33959 has more pre-service time, 33962 is a slightly more intense procedure and warrants an almost identical value. **The RUC recommends a work RVU of 4.73 for CPT code 33962.**

33963 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician;reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance when performed)***
The RUC reviewed the survey results from 46 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 60 minutes, intra-service time of 48 minutes and immediate post-service time of 20 minutes. The RUC agreed that 12 additional minutes of pre-service positioning time over the standard pre-time package is necessary to position the patient for central access for surgery on the heart and great vessels. The RUC also noted that the specialty societies received approval from the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The results showed that 100% of the survey respondents indicated that the patient stayed overnight in the hospital and 93% of the respondents indicated that they provided a visit to the patient on the same day as the procedure. Therefore, a 99233 hospital visit was included in this 000 global day service. This service is necessary because the physician must evaluate the cannulation site for bleeding, cannula position and function. It is also imperative to assure that cannulation related arterial and/or venous obstruction (compartment syndrome) is not affecting the related extremity. The results and further care plans are communicated to other health care professionals and to the patient and/or family. The RUC agreed that the post-operative work is more intense for the central cannula approach compared to the percutaneous or open approaches and justifies a higher level hospital level visit.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 9.00 accurately values CPT code 33963. To justify this value, 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= 8.25, with removal of post-op visits to value as a 000-day global) and noted that while both codes have nearly identical intra-service time, 33963 has greater total time and is accurately valued slightly higher than the reference code. In addition, the RUC compared 33963 to CPT code 52400 *Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds* (work RVU= 8.69, 40 minutes intra-service time, 197.5 total time) and agreed that while the reference code has more total time, the surveyed code has 8 additional minutes of intra-service time and should thus be valued slightly higher. **The RUC recommends a work RVU of 9.00 for CPT code 33963.**

33964 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician;reposition central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance when performed)***
The RUC reviewed the survey results from 73 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 60 minutes, intra-service time of 60 minutes and immediate post-service time of 20 minutes. The RUC agreed that 12 additional minutes of pre-service positioning time over the standard pre-time package is necessary to position the patient for central access for surgery on the heart and great vessels. The RUC also noted that the specialty societies received approval from the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The results showed that 99% of the survey respondents indicated that the patient stayed overnight in the hospital and 85% of the respondents indicated that they provided a visit to the patient on the same day as the

procedure. Therefore, a 99233 hospital visit was included in this 000 global day service. This service is necessary because the physician must evaluate the cannulation site for bleeding, cannula position and function. It is also imperative to assure that cannulation related arterial and/or venous obstruction (compartment syndrome) is not affecting the related extremity. The results and further care plans are communicated to other health care professionals and to the patient and/or family. The RUC agreed that the post-operative work is more intense for the central cannula approach compared to the percutaneous or open approaches and justifies a higher level hospital level visit.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 9.50 accurately values CPT code 33964. To justify this value, the RUC compared the surveyed code to CPT code 37220 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 8.15) and noted that while both procedures have identical intra-service time, 60 minutes, 33964 has more total time and thus is appropriately valued greater. The RUC also compared 33964 to the analogous child central reposition code (33963) and agreed that it should be valued slightly higher due to having 12 additional minutes of intra-service time. **The RUC recommends a work RVU of 9.50 for CPT code 33964.**

33965 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age***

The RUC reviewed the survey results from 59 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 60 minutes, intra-service time of 30 minutes and immediate post-service time of 20 minutes. The RUC agreed that 12 additional minutes of pre-service positioning time over the standard pre-time package is necessary to properly align the patient as the anterior neck approach is used for this procedure. The RUC also noted that the specialty societies received approval from the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The results showed that 100% of the survey respondents indicated that the patient stayed overnight in the hospital and 81% of the respondents indicated that they provided a visit to the patient on the same day as the procedure. Therefore, a 99231 hospital visit was included in this 000 global day service. This service is necessary because the physician must evaluate the cannulation site for bleeding, cannula position and function and communication of results and further care plans to other health care professionals and to the patient and/or family.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 3.51 accurately values CPT code 33965. To justify this value, the RUC compared the surveyed code to MPC code 52214 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands* (work RVU= 3.50) and noted that both services have identical intra-service time, 30 minutes, and should be valued similarly. In addition, the RUC reviewed CPT code 33993 *Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion* (work RVU= 3.51) and again noted that this reference code has identical intra time compared to 33965 and agreed that the same value should be applied to both services. **The RUC recommends a work RVU of 3.51 for CPT code 33965.**

33966 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older***
The RUC reviewed the survey results from 103 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 48 minutes, intra-service time of 45 minutes and immediate post-service time of 20 minutes. The RUC noted that the specialty societies received approval from the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The results showed that 100% of the survey respondents indicated that the patient stayed overnight in the hospital and 77% of the respondents indicated that they provided a visit to the patient on the same day as the procedure. Therefore, a 99231 hospital visit was included in this 000 global day service. This service is necessary because the physician must evaluate the cannulation site for bleeding, evaluation of distal limb perfusion including possible compartment syndrome and communication of results and further care plans to other health care professionals and to the patient and/or family.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 4.50 accurately values CPT code 33966. To justify this value, the RUC compared the surveyed code to MPC code 15004 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children* (work RVU= 4.58) and noted that both services have identical intra-service time, 45 minutes, and comparable total time and should thus be valued similarly. In addition, the RUC compared 33966 to the analogous child percutaneous removal code (33965) and agreed that since the adult code has 15 additional minutes of intra-service time, it accurately valued higher than the child code. **The RUC recommends a work RVU of 4.50 for CPT code 33966.**

33969 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age***
The RUC reviewed the survey results from 50 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 60 minutes, intra-service time of 43 minutes and immediate post-service time of 20 minutes. The RUC agreed that 12 additional minutes of pre-service positioning time over the standard pre-time package is necessary to properly align the patient as the anterior neck approach is used for this procedure. The RUC also noted that the specialty societies received approval from the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The results showed that 100% of the survey respondents indicated that the patient stayed overnight in the hospital and 94% of the respondents indicated that they provided a visit to the patient on the same day as the procedure. Therefore, a 99232 hospital visit was included in this 000 global day service. This service is necessary because the physician must evaluate the cannulation site for bleeding, cannula position and function and communication of results and further care plans to other health care professionals and to the patient and/or family. The RUC agreed that the post-operative work is more intense for the open approach compared to the percutaneous approach and justifies a higher level hospital level visit.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 6.00 accurately values CPT code 33969. To justify this value, the RUC compared the surveyed code to the key reference service 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral* (work RVU= 6.74) and noted that both services have nearly identical intra-service time and comparable total time, 163 minutes compared to 150 minutes. Therefore, the RUC agreed that both codes should be valued similarly. The RUC also reviewed MPC code 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* (work RVU= 6.75) and again agreed that since both codes have identical intra-service time, they should be valued analogously. **The RUC recommends a work RVU of 6.00 for CPT code 33969.**

33984 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, 6 years and older***

The RUC reviewed the survey results from 76 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 48 minutes, intra-service time of 45 minutes and immediate post-service time of 20 minutes. The RUC also noted that the specialty societies received approval from the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The results showed that 99% of the survey respondents indicated that the patient stayed overnight in the hospital and 84% of the respondents indicated that they provided a visit to the patient on the same day as the procedure. Therefore, a 99232 hospital visit was included in this 000 global day service. This service is necessary because the physician must evaluate the cannulation site for bleeding, cannula position and function and communication of results and further care plans to other health care professionals and to the patient and/or family. The RUC agreed that the post-operative work is more intense for the open approach compared to the percutaneous approach and justifies a higher level hospital level visit.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 6.38 accurately values CPT code 33984. To justify this value, the RUC compared the surveyed code to the key reference service 34812 *Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral* (work RVU= 6.74) and noted that both services have nearly identical intra-service time and comparable total time, 153 minutes compared to 150 minutes. Therefore, the RUC agreed that both codes should be valued similarly. The RUC also compared 33984 to the analogous child open removal service (33969) and noted that while both these services are highly similar, 33984 has 2 additional minutes of intra-service time and warrants a slightly higher value. **The RUC recommends a work RVU of 6.38 for CPT code 33984.**

33985 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age***

The RUC reviewed the survey results from 46 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 60 minutes, intra-service time of 55 minutes and immediate post-service time of 30 minutes. The RUC agreed that 12 additional minutes of pre-service positioning time over the standard pre-time package is necessary to position the patient

for central access for surgery on the heart and great vessels. The RUC also noted that the specialty societies received approvalfrom the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The results showed that 100% of the survey respondents indicated that the patient stayed overnight in the hospital and 96% of the respondents indicated that they provided a visit to the patient on the same day as the procedure. Therefore, a 99233 hospital visit was included in this 000 global day service. This service is necessary because the physician must evaluate the patient for bleeding, cannula position and function and communication of results and further care plans to other health care professionals and to the patient and/or family. The RUC agreed that the post-operative work is more intense for the central cannula approach compared to the percutaneous or open approaches and justifies a higher level hospital level visit.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 9.89 accurately values CPT code 33985. To justify this value, the RUC compared the surveyed code to CPT code 58260 *Vaginal hysterectomy, for uterus 250 g or less* (work RVU= 9.64, with removal of post-op visits to value as a 000-day global) and noted that since both services have nearly identical intra-service time, 60 minutes compared to 55 minutes, their physician work should also be valued similarly. The RUC also reviewed CPT code 52346 *Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 8.58, 60 minutes pre-, 60 minutes intra-, 20 minutes immediate post-service) and noted that both services have similar physician time components and should be valued similarly. **The RUC recommends a work RVU of 9.89 for CPT code 33985.**

33986 ***Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support ECLS) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older***

The RUC reviewed the survey results from 71 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 60 minutes, intra-service time of 60 minutes and immediate post-service time of 30 minutes. The RUC agreed that 12 additional minutes of pre-service positioning time over the standard pre-time package is necessary to position the patient for central access for surgery on the heart and great vessels. The RUC also noted that the specialty societies received approval from the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The results showed that 99% of the survey respondents indicated that the patient stayed overnight in the hospital and 85% of the respondents indicated that they provided a visit to the patient on the same day as the procedure. Therefore, a 99233 hospital visit was included in this 000 global day service. This service is necessary because the physician must evaluate the patient for bleeding, cannula position and function and communication of results and further care plans to other health care professionals and to the patient and/or family. The RUC agreed that the post-operative work is more intense for the central cannula approach compared to the percutaneous or open approaches and justifies a higher level hospital level visit.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 10.00 accurately values CPT code 33986. To justify this value, the RUC compared the surveyed code to CPT code 58260 *Vaginal hysterectomy, for uterus 250 g or less* (work RVU= 9.64, with removal of post-op visits to value as a 000-day global) and noted that since both services have nearly intra-service time, 60 minutes, their physician work should also be

valued similarly. The RUC also compared 33986 to the analogous child central removal code (33985) and noted that the adult code has 5 additional minutes of intra-service time and warrants a slightly higher value. **The RUC recommends a work RVU of 10.00 for CPT code 33986.**

33987 ***Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ECMO/ECLS (List separately in addition to code for primary procedure)***

The RUC reviewed the survey results from 115 physicians and agreed with the specialty societies that 45 minutes of intra-service time is appropriate for this add-on service. The RUC reviewed the survey respondents' estimated physician work values and agreed that the estimates were overvalued, with a 25th percentile work RVU of 9.75. To properly value this service, the RUC reviewed CPT code 35685 *Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (List separately in addition to code for primary procedure)* (work RVU= 4.04) and noted that both codes are vascular surgery procedures, with identical intra-service time, 45 minutes. Therefore, the RUC directly crosswalked the physician work for 35685 to CPT code 33987. To justify a work RVU of 4.04, the RUC also reviewed CPT code 57267 *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)* (work RVU= 4.88, 45 minutes intra-service time) and agreed that with identical intra-service time, these codes should be valued similarly. **The RUC recommends a work RVU of 4.04 for CPT code 33987.**

33988 ***Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS***

The RUC reviewed the survey results from 45 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 60 minutes, intra-service time of 90 minutes and immediate post-service time of 30 minutes. The RUC agreed that 12 additional minutes of pre-service positioning time over the standard pre-time package is necessary to position the patient for central access for surgery on the heart and great vessels. The RUC also agreed with the specialty societies that the survey respondents' underestimated the intra time with a median time of 60 minutes. The 75th percentile time of 90 minutes is a better representation of the actual time it takes to perform this service and is consistent other recently valued thoracic surgery codes: 32100 *Thoracotomy; with exploration* and 32505 *Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial*. In addition, this would provide an appropriate time differential from 33989, removal of the same vent surveyed at 60 minutes of intraservice time (median) and should take less time as this involves reopening a recent incision, removing the vent and securing hemostasis.

The RUC also noted that the specialty societies received approval from the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The results showed that 100% of the survey respondents indicated that the patient stayed overnight in the hospital and 100% of the respondents indicated that they provided a visit to the patient on the same day as the procedure. Therefore, a 99291 critical care visit, which represents the survey median visit, was included in this 000 global day service. This service is necessary because the physician must evaluate the cannulation site for bleeding, cannula position and function. The initial postoperative course is similar to postoperative cardiac surgery. Because the heart is operated upon occult bleeding and cardiac tamponade are possible complications that must but evaluated by the operating

surgeon. The results and further care plans are communicated to other health care professionals and to the patient and/or family.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 15.00 accurately values CPT code 33988. To justify this value, the RUC compared the surveyed code to MPC code 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection* (work RVU= 16.46, with removal of post-op visits to value as a 000-day global) and noted that the reference code has slightly more intra-service time, 103 minutes compared to 90 minutes, and thus warrants a higher value. In addition, the RUC reviewed code 37244 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation* (work RVU= 14.00) and noted that while both codes have identical intra-service time, 90 minutes, the surveyed code is a more complex service, with more total time. **The RUC recommends a work RVU of 15.00 for CPT code 33988.**

33989 ***Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ECMO/ECLS***
The RUC reviewed the survey results from 45 physicians and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 60 minutes, intra-service time of 60 minutes and immediate post-service time of 30 minutes. The RUC agreed that 12 additional minutes of pre-service positioning time over the standard pre-time package is necessary to position the patient for central access for surgery on the heart and great vessels. The RUC also noted that the specialty societies received approval from the Research Subcommittee to survey for a post-operative visit for this 000-day global service. The results showed that 100% of the survey respondents indicated that the patient stayed overnight in the hospital and 80% of the respondents indicated that they provided a visit to the patient on the same day as the procedure. Therefore, a 99233 hospital visit was included in this 000 global day service. This service is necessary as the typical visit involves examination of incision used to place ventricular vent, evaluation of the patient's hemodynamic status and particular attention to bleeding and the possibility of cardiac tamponade. The results are communicated with other health professionals and the family.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey's 25th percentile work RVU of 9.50 accurately values CPT code 33989. To justify this value, the RUC compared the surveyed code to 37220 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 8.15) and noted that while both procedures have identical intra-service time, 60 minutes, 33989 has more total time and thus is appropriately valued higher. The RUC also compared this service to the adult central reposition code (33964) and noted that both services have identical physician time components and comparable physician work. Therefore, the RUC agreed that both codes should be valued identically. **The RUC recommends a work RVU of 9.50 for CPT code 33989.**

Practice Expense
The RUC approved the standard 090-day global practice expense (PE) inputs for the appropriate services in the family. CPT codes 33946-4, 33965, 33966 and 33987 do not

have direct PE inputs. The RUC approved the direct PE inputs as accepted by the Practice Expense Subcommittee.

CPT Parentheticals
The RUC recommends that exclusionary instructions be added to the CPT code set directing users: (1) not to report daily management on the same day of initiation; and (2) not to report initiation in association with repositioning on the same day. The rationale for these instructions is to clarify these codes should not be reported together on the same day by anyone on the healthcare "team". A statement will be added to the introductory guidelines and exclusionary parenthetical notes be added to the appropriate codes.

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.

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

Transcatheter Placement of Carotid Stents (Tab 12)
Gerald Niedzwiecki, MD (SIR); Michael Hall, MD (SIR); Sean Tutton, MD (SIR); Bob Vogelzang, MD (SIR); Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); Greg Nicola, MD (ASNR); John Ratliff, MD (AANS); Alex Mason, MD (CNS); Gary Seabrook, MD; (SVS) and Richard Wright, MD (ACC)
Facilitation Committee #3

In February 2013, the CPT Editorial Panel approved the creation of CPT code 37217 to describe retrograde transcatheter placement of an intravascular stent. Following this, the specialty societies noted this new code does not address antegrade stent placement in the innominate artery or the intrathoracic carotid artery. In February 2014, the Panel created CPT code 37218 to describe the antegrade treatment of the innominate artery or the intrathoracic common carotid artery. Additionally, the Panel added the words "open or" to the 37215 and 37216 CPT code descriptions to make them consistent with all other endovascular bundled coding.

37218 ***Transcatheter placement of an intravascular stent(s), intrathoracic common carotid artery or innominate artery via open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation***
The RUC reviewed the survey results from 33 practicing radiologists, interventional radiologists, neurosurgeons, vascular surgeons and cardiologists and agreed with the specialty societies that the following physician time components are accurate for this new technology procedure: pre-service time of 43 minutes, with 4 additional minutes of positioning over the standard 2b pre time package, intra-service time of 90 minutes and immediate post-service time of 28 minutes (the standard post time package of 8B). The RUC agreed that 4 additional minutes of pre-service positioning time over the standard pre-time package are necessary to account for positioning the patient on the angiographic table and optimizing EKG and monitoring lead placement to ensure adequate imaging and that the monitoring leads do not enter the imaging field on oblique projections. The RUC also agreed that one 99231 hospital visit and a full-day discharge are appropriate for this inpatient procedure. These visits are similar to the other services in the family, 37215 and 37216, which each have one hospital visit and a full-day discharge day management

service. Finally, two 99213 office visits were allocated to adequately assess for post procedural complications and medication compliance in the 90 day global period.

The RUC reviewed the survey respondents' estimated physician work values and agreed that they were overvalued, with a 25th percentile work RVU of 18.50. To determine an appropriate work value, the RUC compared the surveyed code to CPT code 29915 *Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)* (work RVU = 15.00) and agreed that since both services have identical intra-service time, 90 minutes, and nearly identical total time, they should be valued the same. Therefore, the RUC recommends a direct work RVU crosswalk from code 29915 to code 37218. To further justify a work RVU of 15.00 for 37218, the RUC reviewed CPT code 19303 *Mastectomy, simple, complete* (work RVU= 15.85, intra time= 90 minutes) and noted that while both services have identical intra time, the reference code has more post-operative visits, and therefore, is correctly valued slightly higher than 37218. **The RUC recommends a work RVU of 15.00 for CPT code 37218.**

The RUC discussed that the specialty societies did not survey CPT codes:

- 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection*,
- 37216 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection*,
- 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*,
- 37235 *Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed*,
- 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* and
- 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*

For the following five codes, the RUC did not recommend surveying: 37216 because it is a non-covered Medicare service, 37217 because it was reviewed by the RUC in April 2013 and codes 37235-7 because they are not considered part of the family of services. The RUC noted that code 37215 has been performed consistently since its creation in 2006 and most recently was performed 8,455 times in 2013. **Therefore, the RUC recommends that the specialty societies survey CPT code 37215 and present recommendations for physician work and practice expense at the September 2014 RUC meeting.**

Practice Expense
The RUC recommends the standard 090-day global direct practice expense inputs as approved by the Practice Expense Subcommittee.

New Technology
CPT code 37218 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.

Flexible Sigmoidoscopy (Tab 13)
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Several specific CPT codes identified by CMS through the MPC List screen were scheduled for review at the September 2011 RUC meeting. The RUC review of the codes led to significant concerns with the survey data, and in some cases, coding and payment policy for the individual codes. The specialty societies representing gastroenterology indicated that appropriate surveys could not be conducted until after the specialty societies had an opportunity to clarify the coding and update the descriptors via the CPT Editorial Panel Process. The specialty societies worked with the CPT Editorial Panel and CMS to resolve this coding and payment policy question as it relates to over 100 GI endoscopy services.

In the CPT 2014 cycle, the RUC reviewed all the esophagoscopy, EGD and ERCP families of codes. For the CPT 2015 cycle, the RUC reviewed the illeoscopy, pouchoscopy and flexible sigmoidoscopy services in October 2013 and reviewed colonoscopy and colonoscopy through the stoma procedures in January 2014. (Note, a few of the flexible sigmoidoscopy services were reviewed in January 2014 and April 2014 as well.) Given that this process will require the RUC and specialty societies to survey and review the entire family of endoscopy procedures, the RUC has consistently maintained that relativity within both the immediate and larger family is of paramount importance. As was done in the previous set of codes, the RUC used an incremental methodology to value the additional physician work above the base diagnostic procedure. The RUC noted that this methodology was necessary for three reasons. First, given that an entire genre of services is being reviewed, 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. Therefore, the RUC determined that these new codes should continue to 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. In fact, endoscopy is listed as an example of this methodology in the RUC's instructions for specialty societies developing work value recommendations.

45330 Sigmoidoscopy, flexible; diagnostic, collection of specimen(s) by brushing or washing when performed
The RUC reviewed the survey results of 103 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 21 minutes, intra-service time of 10 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1A Facility straightforward patient and procedure without sedation was appropriate with two

additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient.

The RUC reviewed the estimated work values and agreed with the specialty societies that 45330 is currently overvalued, with a work RVU of 0.96. Since the survey respondents overestimated the physician work, the RUC reviewed CPT code 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU= 0.84) and agreed that since both these services have identical intra-service time and similar work intensity, they should be valued identically. The RUC agreed that a work RVU of 0.84, a direct crosswalk to code 12001, appropriately valued 45330 to similar services across the RBRVS.

To justify a work RVU of 0.84, the RUC compared the surveyed code to MPC codes 45300 *Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing* (work RVU= 0.80, intra time= 10 minutes) and 43760 *Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance* (work RVU= 0.90, intra time= 10 minutes) and noted that both these services are similar services with highly analogous times. Therefore, a recommended value of 0.84 appropriately values 45330 in between these MPC services. Finally, to ensure relativity within the endoscopic family, the RUC noted that the recommended RVU of 0.84 places diagnostic flexible sigmoidoscopy appropriately below diagnostic ileoscopy (RUC recommended work RVU= 0.97) and diagnostic esophagoscopy (RUC recommended work RVU= 1.59) in terms of comparative physician work. **The RUC recommends a work RVU of 0.84 for CPT code 45330.**

45331 Sigmoidoscopy, flexible; with biopsy, single or multiple
The RUC reviewed the survey results of 100 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 21 minutes, intra-service time of 15 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 1A Facility straightforward patient and procedure without sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45331. The RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy biopsy code, 43202 (RUC recommended work RVU= 1.89) should be maintained in this flexible sigmoidoscopy biopsy code. Therefore, the established increment for the physician work related to the biopsy, 0.30 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 1.14 for CPT code 45331. The RUC agreed with the specialty that the physician work related solely to biopsy is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 1.14, the RUC compared the surveyed code to CPT codes 56605 *Biopsy of vulva or perineum (separate procedure); 1 lesion* (work RVU= 1.10)

and 36584 *Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access* (work RVU= 1.20) and agreed that since both codes have identical intra-service time to 45331, 15 minutes, and similar total time, the recommended value appropriately values the surveyed code between these two reference codes. Finally, the RUC reviewed MPC code 11042 *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less* (work RVU= 1.01) in comparison to 45331and noted that while both services have 15 minutes of intra-service time, the surveyed code has more total time than this reference code, 46 minutes compared to 36 minutes, and is thus appropriately valued more. **The RUC recommends a work RVU of 1.14 for CPT code 45331.**

45332 Sigmoidoscopy, flexible; with removal of foreign body(s)
The RUC reviewed the survey results of 64 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends 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 pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because FB removal involves removal of a stent, or devices of various sizes and shapes, in a patient with a narrowing or obstruction of the lumen of the bowel typically resulting from a neoplasm, ischemia, radiation, inflammatory bowel disease, or severe angulation of the bowel.

The RUC first considered three compelling evidence arguments to consider a change in the current work RVU of 1.79 for this service: Change in site-of-service, change in technology and change in types of foreign bodies. There has been a change in the site-of-service for this procedure as 25 years ago, removal of rectal foreign bodies that often required removal under General Anesthesia in the operating room using a rigid proctoscope are now removed in the outpatient setting using a flexible sigmoidoscope. Additionally, new technology for retrieval of rectal foreign bodies is now in use since the prior valuation, including retrieval nets and foreign body balloons. Finally, there are now medical devices requiring removal which did not exist at the prior valuation, including fully coated removable self-expanding metal stents and prostate massage devices for treatment of lower urinary tract symptoms such as benign prostatic hyperplasia, chronic prostatitis/chronic pelvic pain syndrome or bladder conditions such as interstitial cystitis. The variety of rectal foreign bodies inserted by patients are larger, more complex, and more numerous since the prior valuation of this code. The RUC agreed with the specialty societies that there is compelling evidence to consider a change in the current work value for 45332.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45332. The RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy removal of foreign body code, 43215 (RUC recommended work RVU= 2.60) should be maintained in this flexible sigmoidoscopy hot biopsy code. Therefore, the established increment for the physician work related to removal of a foreign body, 1.01 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 1.85 for CPT code 45332. The RUC agreed with the

specialty that the physician work related solely to foreign body removal is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 1.85, the RUC compared the surveyed code to CPT codes 32554 *Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance* (work RVU= 1.82) and 45317 *Proctosigmoidoscopy, rigid; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)* (work RVU= 2.00) and agreed that since both services have identical intra-service time, 20 minutes, and comparable physician work, the recommended work RVU of 1.85 appropriately values 45332 in between these two reference services. The RUC also reviewed MPC code 55876 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple* (work RVU= 1.73, intra time= 20 minutes) and agreed that this reference code should be valued slightly less than the surveyed code due to less total time, 59 minutes and 63 minutes). **The RUC recommends a work RVU of 1.85 for CPT code 45332.**

45333 Sigmoidoscopy, flexible; 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 59 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends 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 and procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45333. The RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy hot biopsy code, 43216 (RUC recommended work RVU= 2.40) should be maintained in this flexible sigmoidoscopy hot biopsy code. Therefore, the established increment for the physician work related to the hot biopsy, 0.81 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 1.65 for CPT code 45333. The RUC agreed with the specialty that the physician work related solely to hot biopsy is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 1.65, the RUC compared the surveyed to CPT code 64448 *Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)* (work RVU= 1.63, total time= 55 minutes) and agreed that since both services have identical intra-service time, 15 minutes, and analogous total time, the two services should be valued similarly. The RUC also reviewed two MPC codes 57452 *Colposcopy of the cervix including upper/adjacent vagina* (work RVU= 1.50) and 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 agreed that since both codes have identical intra-service time, and similar total time, compared to 45333, the recommended work value of 1.65 appropriately values this

surveyed code between these two reference codes. **The RUC recommends a work RVU of 1.65 for CPT code 45333.**

45334 Sigmoidoscopy, flexible; with control of bleeding, any method
The RUC reviewed the survey results of 71 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends 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 pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the patient, who may have significant comorbidity, coagulation defects and/or hemodynamic instability, has active gastrointestinal bleeding typically resulting from diverticula, neoplasia, ischemia, radiation, or inflammatory bowel disease.

The RUC reviewed the estimated work values and agreed with the specialty societies that the current work RVU of 2.73 overstates the physician work involved in 45334. Since there is no previously established increment for control of bleeding, the RUC reviewed the survey's 25th percentile and determined that a work RVU of 2.10 accurately values this service relative to similar codes in the endoscopic family. To justify a work RVU of 2.10, the RUC compared the surveyed code to CPT codes 49084 *Peritoneal lavage, including imaging guidance, when performed* (work RVU= 2.00) and 57421 *Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix* (work RVU= 2.20) and agreed that since both codes have identical intra-service time, 20 minutes, and similar total time, compared to 45334, the recommended work value of 2.10 appropriately values this surveyed code between these two reference codes. The RUC also reviewed MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU= 2.70, total time= 60 minutes) and agreed that while the two services have identical intra time and analogous total time, the MPC code should be valued higher than 45334 due to greater physician and intensity to perform the service. **The RUC recommends a work RVU of 2.10 for CPT code 45334.**

45335 Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance
The RUC reviewed the survey results of 63 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends 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 and procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45335. The RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy submucosal injection code, 43201 (RUC recommended work RVU= 1.90) should be maintained in this flexible sigmoidoscopy submucosal injection code. Therefore, the established increment for the physician work related to the submucosal injection, 0.31 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU=

0.84), for a recommended work RVU of 1.15 for CPT code 45335. The RUC agreed with the specialty that the physician work related solely to submucosal injection is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 1.15, the RUC compared the surveyed CPT code 11042 *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less* (work RVU= 1.01) and MPC code 55876 *Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple* (work RVU= 1.73) and agreed that since these codes all have identical intra-service time, 15 minutes, and provide appropriate reference codes, from across the RBRVS, to bracket the recommended work RVU of 1.15 for 45335. The RUC also reviewed CPT code 57500 *Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)* (work RVU= 1.20, intra time= 15 minutes) and noted that even though the reference code has less pre- and post-service time than 45335, it should still be valued slightly higher due to greater intensity and complexity in the physician work. **The RUC recommends a work RVU of 1.15 for CPT code 45335.**

45337 Sigmoidoscopy, flexible; with decompression of volvulus, any method
The RUC reviewed the survey results of 63 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 38 minutes, intra-service time of 25 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the patient, who may have debility, comorbidity, altered mental status, and/or neurologic deterioration, has a severe megacolon typically resulting from neoplasia, ischemia, strictures, or intestinal motility dysfunction.

The RUC reviewed the estimated work values and agreed with the specialty societies that the current work RVU of 2.36 overstates the physician work involved in 45337. Since there is no established increment for this procedure, the RUC reviewed the survey's 25th percentile and determined that a work RVU of 2.20 accurately values this service relative to similar codes in the endoscopic family. To justify a work RVU of 2.20, the RUC compared the surveyed code to CPT codes 49083 *Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance* (work RVU= 2.00) and 64517 *Injection, anesthetic agent; superior hypogastric plexus* (work RVU= 2.20) and agreed that since both codes have identical intra-service time, 25 minutes, and similar total time, compared to 45337, the recommended work value of 2.20 appropriately values this surveyed code between these two reference codes. The RUC also reviewed CPT code 45321 *Proctosigmoidoscopy, rigid; with decompression of volvulus* (work RVU= 1.75, intra time= 20 minutes) and noted that while the physician work is comparable, the reference code is appropriately valued less than 45337 because it has 5 minutes less intra-service time. **The RUC recommends a work RVU of 2.20 for CPT code 45337.**

45338 Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
The RUC reviewed the survey results of 67 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 33 minutes, intra-service time of 15 minutes and post-service time of 10 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the patient has polypoid lesions typically resulting from a neoplasia, pre-neoplasia, or inflammatory bowel disease.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45338. The RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy snare code, 43217 (RUC recommended work RVU= 2.90) should be maintained in this flexible sigmoidoscopy snare code. Therefore, the established increment for the physician work related to the snare, 1.31 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 2.15 for CPT code 45338. The RUC agreed with the specialty that the physician work related solely to the snare is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 2.15, the RUC compared the surveyed code to CPT codes 69801*Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal* (work RVU= 2.06) and 92960 *Cardioversion, elective, electrical conversion of arrhythmia; external* (work RVU= 2.25) and agreed that since both codes have identical intra-service time, 15 minutes, and similar total time, compared to 45338, the recommended work value of 2.15 appropriately values this surveyed code between these two reference codes. The RUC also reviewed MPC code 52000 *Cystourethroscopy (separate procedure)* (work RVU= 2.23, total time= 42 minutes) and noted that while this reference code has less pre- and post-service time compared to 45338, this reference code is appropriately valued higher because the service requires greater intensity and complexity to perform. **The RUC recommends a work RVU of 2.15 for CPT code 45338.**

45346 Sigmoidoscopy, flexible; 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 of 49 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends 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 pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the patient has lesions typically resulting from neoplasia, pre-neoplasia, inflammatory bowel disease, or radiation.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45346. The RUC noted that the identical increment between the esophagoscopy gastroscopy duodenoscopy (EGD) base code, 43235 (RUC recommended work RVU= 2.26) and the EGD ablation code, 43270 (RUC recommended work RVU= 4.39) should be maintained in this flexible sigmoidoscopy ablation code. Therefore, the established increment for the physician work related to the ablation, 2.13 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 2.97 for CPT code 45346. The RUC agreed with the specialty that the physician work related solely to ablation is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 2.97, the RUC compared the surveyed code 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 32551 *Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open* (work RVU= 3.29) and agreed that since both codes have identical intra-service time, 20 minutes, and similar total time, compared to 45346, the recommended work value of 2.97 appropriately values this surveyed code between these two reference codes. The RUC also reviewed MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU= 2.70, total time= 60 minutes) and agreed that while the two services have identical intra time and analogous total time, the surveyed code should be valued slightly higher than this MPC code due to greater physician and intensity to perform the service. **The RUC recommends a work RVU of 2.97 for CPT code 45346.**

45340 Sigmoidoscopy, flexible; with transendoscopic balloon dilation
The RUC reviewed the survey results of 58 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 33 minutes, intra-service time of 20 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the patient has an intermittent bowel obstruction typically resulting from a neoplasm, ischemia, or inflammatory bowel disease.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45340. The RUC noted that the identical increment between the esophagoscopy base code, 43200 (RUC recommended work RVU= 1.59) and the esophagoscopy balloon dilation less than 30 mm code, 43220 (RUC recommended work RVU= 2.10) should be maintained in this flexible sigmoidoscopy balloon dilation code. Therefore, the established increment for the physician work related to balloon dilation, 0.51 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 1.35 for CPT code 45340. The RUC agreed with the specialty that the physician work related solely to balloon dilation is not correlated to the

work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 1.35, the RUC compared the surveyed code to CPT codes 91010 *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report* (work RVU= 1.28) and 32560 *Instillation, via chest tube/catheter, agent for pleurodesis (eg, talc for recurrent or persistent pneumothorax)* (work RVU= 1.54) and agreed that since both codes have identical intra-service time, 20 minutes, and similar total time, compared to 45340, the recommended work value of 1.35 appropriately values this surveyed code between these two reference codes. Finally, the RUC reviewed MPC code 12002 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm* (work RVU= 1.14) and agreed that that since this code has less intra-service time, 15 minutes, compared to 45340, the recommended value of 1.35 accurately values this surveyed code higher than this MPC code. **The RUC recommends a work RVU of 1.35 for CPT code 45340.**

45341 Sigmoidoscopy, flexible; with endoscopic ultrasound examination
The RUC reviewed the survey results of 36 gastroenterologists and recommends the following physician time components: pre-service time of 38 minutes, intra-service time of 30 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the typical patient has previously found squamous cell carcinoma of the anus and flexible sigmoidoscopy with EUS is needed to stage the lesion.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45341. The RUC noted that the identical increment between the esophagoscopy gastroscopy duodenoscopy (EGD) base code, 43235 (RUC recommended work RVU= 2.26) and the EGD EUS code, 43237 (RUC recommended work RVU= 3.85) should be maintained in this flexible sigmoidoscopy equivalent code. Therefore, the established increment for the physician work related to EUS, 1.59 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 2.43 for CPT code 45341. The RUC agreed with the specialty that the physician work related solely to EUS is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 2.43, 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 since both codes have identical intra-service time, 30 minutes, and analogous total time, both services should be valued nearly identically. In addition, the RUC reviewed CPT code to MPC code 11043 *Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less* (work RVU= 2.70) and noted that since the reference code has slightly more total time and more physician work intensity, code 11043 is appropriately valued greater than 45341. **The RUC recommends a work RVU of 2.43 for CPT code 45341.**

45342 Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
The RUC reviewed the survey results of 36 gastroenterologists and recommends the following physician time components: pre-service time of 41 minutes, intra-service time of 45 minutes and post-service time of 20 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the typical patient has previously found squamous cell carcinoma of the anus and flexible sigmoidoscopy with EUS and FNA is needed to stage the lesion.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45342. The RUC noted that the identical increment between the esophagoscopy gastroscopy duodenoscopy (EGD) base code, 43235 (RUC recommended work RVU= 2.26) and the EGD EUS with FNA code, 43238 (RUC recommended work RVU= 4.50) should be maintained in this flexible sigmoidoscopy equivalent code. Therefore, the established increment for the physician work related to EUS with FNA, 2.24 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 3.08 for CPT code 45342. The RUC agreed with the specialty that the physician work related solely to EUS with FNA is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 3.08, the RUC compared the surveyed code to CPT code 59001 *Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)* (work RVU= 3.00) and agreed that with identical intra-service time, 45 minutes, and similar work intensity, both codes should be valued similarly. In addition, the RUC reviewed CPT code 36595 *Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access* (work RVU= 3.59) and noted that while both codes have the same intra-service time, the reference code is more intense and justifies a higher work value than 45342. **The RUC recommends a work RVU of 3.08 for CPT code 45342.**

45347 Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
The RUC reviewed the survey results of 57 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 41 minutes, intra-service time of 35 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient. The RUC agreed that this is a difficult patient because the reason for placement of a stent is that the patient has a narrowing or obstruction of the lumen of the bowel resulting from a neoplasm.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45347. The RUC noted that the identical increment between the esophagoscopy gastroscopy duodenoscopy (EGD) base code, 43235 (RUC recommended work RVU= 2.26) and the EGD endoscopic stent placement code, 43266 (RUC recommended work RVU= 4.40) should be maintained in this flexible sigmoidoscopy endoscopic stent placement code. Therefore, the established increment for the physician work related to endoscopic stent placement, 2.14 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 2.98 for CPT code 45347. The RUC agreed with the specialty that the physician work related solely to placement of an endoscopic stent is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 2.98, the RUC compared the surveyed code to CPT code 37214 *Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method* (work RVU= 2.74) and noted that while the reference code has greater intra-service time, 38 minutes compared to 35 minutes, the physician work involved in 45347 is more intense and complex than in the reference code. Therefore, the surveyed code is accurately valued higher than this reference code. The RUC also reviewed MPC code 31628 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe* (work RVU= 3.80) and agreed that with higher intra-service time, 40 minutes, the reference code is accurately valued higher than 45347. **The RUC recommends a work RVU of 2.98 for CPT code 45347.**

45349 *Sigmoidoscopy, flexible; with endoscopic mucosal resection*
The RUC reviewed the survey results of 43 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 33 minutes, intra-service time of 30 minutes and post-service time of 15 minutes. The RUC agreed with the specialties that pre-service package 2B Facility difficult patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the standard package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45349. The RUC noted that the identical increment between the esophagoscopy gastroscopy duodenoscopy (EGD) base code, 43235 (RUC recommended work RVU= 2.26) and the EGD endoscopic mucosal resection code, 43254 (RUC recommended work RVU= 5.25) should be maintained in this flexible sigmoidoscopy endoscopic mucosal resection code. Therefore, the established increment for the physician work related to endoscopic mucosal resection, 2.99 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 3.83 for CPT code 45349. The RUC agreed with the specialties that the physician work related solely

to placement of an endoscopic mucosal resection is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 3.83, the RUC compared the surveyed code to CPT codes 43246 *Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube* (work RVU= 3.66) and 20660 *Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)* (work RVU= 4.00) and agreed that since both these reference services have identical intra-service time to the surveyed code, 30 minutes, they provide appropriate brackets around the recommended value for 45349. **The RUC recommends a work RVU of 3.83 for CPT code 45349.**

45350 ***Sigmoidoscopy, flexible; with band ligation (eg, hemorrhoids)***
The RUC reviewed the survey results of 33 gastroenterologists, general surgeons, and colon and rectal surgeons and recommends the following physician time components: pre-service time of 27 minutes, intra-service time of 20 minutes and post-service time of 13 minutes. The RUC agreed with the specialties that pre-service package 1B Facility straightforward patient and straightforward procedure with sedation was appropriate with two additional minutes of pre-service time over the standard package for lateral positioning and padding of bony prominences and to position the endoscopy equipment relative to the patient.

The RUC reviewed the estimated work values and agreed with the specialties that the consistent incremental methodology established by the RUC to value the entire endoscopic family of services should be maintained for code 45350. The RUC noted that the identical increment between the colonoscopy base code, 45378 (RUC recommended work RVU= 3.36) and the colonoscopy banding code, 45398 (RUC recommended work RVU= 4.30) should be maintained in this flexible sigmoidoscopy banding code. Therefore, the established increment for the physician work related to banding, 0.94 work RVUs, was added to the base flexible sigmoidoscopy diagnostic code, 45330 (RUC recommended work RVU= 0.84), for a recommended work RVU of 1.78 for CPT code 45350. The RUC agreed with the specialties that the physician work related solely to banding is not correlated to the work intensity of the base procedure. Therefore, maintaining the current increment across endoscopic families is appropriate.

To justify a work RVU of 1.78, the RUC compared the surveyed code to CPT codes 45321 *Proctosigmoidoscopy, rigid; with decompression of volvulus* (work RVU= 1.75) and 64416 *Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)* (work RVU= 1.81) and agreed that since both these reference services have identical intra-service time to the surveyed code, 20 minutes, they provide appropriate brackets around the recommended value for 45350. **The RUC recommends a work RVU of 1.78 for CPT code 45350.**

G0104 ***Colorectal cancer screening; flexible sigmoidoscopy***
HCPCS code G0104 was created in 1998 by CMS as a mechanism to identify a screening service for which there was a newly approved Medicare benefit, and to ensure that frequency limits could be monitored during claims adjudication. Each G-code has a matched Category I CPT code with exactly the same physician work, same practice expense details, and same payment. CMS and other third-party payors have maintained throughout the history of these codes that there is no difference in physician work between

these codes are their corresponding CPT codes. The RUC agreed with the specialty societies that colonoscopy, as defined by CPT, is the same procedure whether it is performed on a patient with a family history of cancer (ie, high risk); on an asymptomatic patient as a preventative service (ie, not meeting criteria for high risk); or on a patient with a prior history of polyp removal. For each of these patients, the same flexible sigmoidoscopy procedure is performed by the provider, as clearly defined in the revised CPT guidelines. **Therefore, the RUC recommends a work RVU of 0.84 for G0104, a direct crosswalk to CPT code 45330.**

Practice Expense:
The Practice Expense Subcommittee reviewed the direct practice expense inputs for the flexible sigmoidoscopy services and noted that these services mostly crosswalk from the EGD codes approved last year. In general, the total clinical staff times were either slightly lower or just about the same as the current inputs. The largest change was the addition of 30 minutes for staff to clean the scope. There were several modifications to supplies for a small subset of codes to match refinements made to the EGD codes approved in the previous year. Finally, the Subcommittee noted that several supplies and equipment were newly submitted to CMS for pricing just last year. Since new codes were not available prior to the meeting, they are listed as new and will be revised when CMS releases the codes. There is one new equipment item specifically related to these types of procedures (videoscope, sigmoidoscopy) and one item related to only CPT code 43270 (radiofrequency generator, endoscopy). Appropriate invoices are attached. The RUC approved the revised PE spreadsheet as modified by the PE Subcommittee.

Extant Databases:
The RUC is aware that several databases currently exist that collect physician time and other patient quality-related information for endoscopy services. The specialty societies were queried about the availability of these databases to be used to inform the RUC during this extensive review of all endoscopy procedures. The specialties explained that these databases currently do not have a standard definition of intra-service work and are not publically available at this time.

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.

Do Not Use to Validate:
The specialties requested, and the RUC agreed, that CPT code 45338 should have a note in the RUC database that states this code should not be used to validate for physician work. The specialties stated that an intra-service time of 15 minutes underrepresents the physician work involved in the snare technique, especially compared to other endoscopic snare codes.

<u>High Resolution Anoscopy (Tab 14)</u>
Guy Orangio, MD, FACS (ASCRS)

At the February 2014 CPT Editorial Panel meeting, the Panel approved the deletion of two Category III codes (0226T and 0227T) and created two CPT Category I codes (46601 and 46607) to report high resolution anoscopy.

46601 ***Anoscopy; diagnostic, with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed***
The RUC reviewed the survey results from 41 physicians and surgeons representing colorectal surgery, gynecology, infectious disease, internal medicine, and family practice. The RUC agreed with the specialty societies that pre-service time of 13 minutes, intra-service time of 20 minutes and immediate post-service time of 10 minutes were appropriate for this service. Four additional minutes of positioning time above the standard pre-time package was approved to account for positioning the patient prone or lateral decubitus with buttocks effaced.

The RUC compared 46601 to the key reference service 57420 *Colposcopy of the entire vagina, with cervix if present* (work RVU= 1.60) and noted that both services require a similar colposcopy examination and have nearly identical total time, 43 minutes compared to 42.6 minutes. The RUC agreed 46601 should be valued the same as 57420 and accepted the societies's recommendation of the 25th percentile work RVU of 1.60. The RUC also reviewed MPC codes 57452 *Colposcopy of the cervix including upper/adjacent vagina* (work RVU= 1.50) and 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 agreed that these two MPC services provide appropraite rank order references above and below the recommended value for 46601. **The RUC recommends a work RVU of 1.60 for CPT code 46601.**

46607 ***Anoscopy; with high-resolution magnification (HRA) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple***
The RUC reviewed the survey results from 40 physicians and surgeons representing colorectal surgery, gynecology, infectious disease, internal medicine, and family practice. The RUC agreed with the specialty societies that pre-service time of 27 minutes (including injected and topical anesthesia), intra-service time of 25 minutes and immediate post-service time of 10 minutes were appropriate for this service. Four additional minutes of positioning time above the standard pre-time package was approved to account for positioning the patient prone or lateral decubitus with buttocks effaced.

The RUC compared 46607 to the key reference service 57421 *Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix* (work RVU= 2.20) and noted that both services require a similar colposcopy examination with biopsy(s). The RUC discussed the difference in intraservice time, 25 minutes for the survey code compared to 20 minutes for the reference, and determine this difference may be the result of the survey sample and number of biopsies taken, but that the total work for both codes was the same. The RUC agreed 46607 should be valued the same as 57421 and accepted the societies's recommendation of the 25th percentile work RVU of 2.20. The RUC also reviewed CPT codes 64517 *Injection, anesthetic agent; superior hypogastric plexus* (work RVU= 2.20, intra time= 25 minutes) and 43226 *Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire* (work RVU= 2.34, intra time= 25 minutes) and agreed that these two services provide appropriate rank order references at and above the recommended value for 46607. **The RUC recommends a work RVU of 2.20 for CPT code 46607.**

Practice Expense
The RUC reviewed the direct practice expense inputs and noted that these new codes were mostly crosswalked from similar codes 57420 *Colposcopy of the entire vagina, with*

cervix if present and code 57421 *Colposcopy of the entire vagina, with cervix if present; with biopsy(s) of vagina/cervix.* Several changes were made to the surveyed code input to adjust to standards and an additional piece of equipment was added- suction machine (Gomco) (EQ235). The RUC approved the direct practice expense with minor modifications as approved by the Practice Expense Subcommittee.

New Technology:
CPT codes 46601 and 46607 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.

Cryoablation Treatment of Liver Tumor (Tab 15)
Gerald Niedzwiecki, MD (SIR); Michael Hall, MD (SIR); Sean Tutton, MD (SIR); Bob Vogelzang, MD (SIR); Zeke Silva, MD (ACR); and Kurt Schoppe, MD (ACR)

At the February 2014 CPT Editorial Panel meeting, the Panel created one new CPT Category I code to describe percutaneous cryosurgical ablation of liver tumor(s).

47383 ***Ablation, 1 or more liver tumor(s), percutaneous, cryoablation***
The RUC reviewed the survey results from 30 radiologists and interventional radiologists and agreed that the following physician time components are accurate for this new technology procedure: pre-service time of 53 minutes, with 14 additional minutes of positioning over the standard 2b pre time package, intra-service time of 90 minutes and immediate post-service time of 28 minutes (the standard post-service package to 8B). The RUC agreed that 14 additional minutes of pre-service position time over the standard pre-time package are necessary to account for the time for placement of three to four ablation probes, as well as to verify that the patient is safe and that the equipment and tethered probes can transit safely when the patient is transported on a moving gantry in and out of the scanner multiple times while also maintaining a sterile field. The RUC also agreed that a half discharge day (99238) is appropriate. Finally, the RUC agreed that one 99212 office visit during the 10-day global period was justified for reviewing biopsy results, examining wounds and assessing pain and functional status.

The RUC reviewed the survey respondents' estimated physician work values and agreed that they were not appropriate for this service. To determine an appropriate work value, the RUC compared the surveyed code to MPC code 50593 *Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy* (work RVU= 9.13) and agreed that since both services have identical intra-service time of 90 minutes and similar total times (206 minutes versus 217 minutes), they should be valued the same. Therefore, the RUC recommends a direct crosswalk to code 50593. To further justify a work RVU of 9.13 for 47383, the RUC reviewed CPT code 20245 *Biopsy, bone, open; deep (eg, humerus, ischium, femur)* (work RVU= 8.95, intra-time of 90 minutes) and noted that the surveyed code has identical intra-service time and slightly more intensity, and should therefore be valued slightly higher than the reference code. **The RUC recommends a work RVU of 9.13 for CPT code 47383.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct PE inputs for this new service and noted that several of the inputs crosswalk from the radiofrequency ablation of liver tumor code 47382. The PE Subcommittee noted that image guidance codes 76940, 77013 or 77022 will be reported separately from 47383.

The assist physician section of the PE recommendation for 47383 includes time for the RN/LPN/MTA (L037D) to circulate (line 47 – 25% of total physician time). An input for CT room (EL007) was included as that is the most common form of image guidance use for cryoablation of liver tumors, though there is no typical imaging modality as it can also be performed with MR or ultrasound.

There are three new equipment items specifically related to these types of procedures: the cryosurgery system, helium tanks and argon tanks. Appropriate invoices are attached. The RUC reviewed and approved the direct practice expense inputs with minor modifications as approved by the revised PE spreadsheet as modified by the PE Subcommittee.

New Technology
CPT code 47383 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.

Cystourethroscopy Insertion Transprostatic Implant (Tab 16)
Norm Smith, MD (AUA); Tom Turk, MD (AUA); Phil Wise, MD (ASAPS) and Martin Dineen, MD (AUA)

At the February 2014 CPT Editorial Panel meeting two new codes were created to describe the endoscopic placement of a transprostatic implant for the treatment of obstructive uropathy from benign prostatic hyperplasia (BPH).

52441 ***Cystorurethroscopy, Insertion of Transprostatic implant, single implant***
The specialty society indicated and the RUC agreed that the survey respondents overestimated the work required to perform CPT code 52441. The specialty society recommended that CPT code 52441 be crosswalked to CPT code 43244 *Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices* (work RVU = 4.50), as both services require the same physician work and time to perform. The RUC recommends 42 minutes pre-service, 30 minutes intraservice and 21 minutes immediate post-service time for 52441.

For additional support the RUC referenced the following codes, all of which require similar intra-service time, work and have recently reviewed by the RUC: 43243*Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices* (work RVU = 4.37, 30 minutes intraservice time), 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, 30 minutes intraservice time) 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, 30 minutes intraservice time). **The RUC recommends a work RVU of 4.50 for CPT code 52441.**

52442 ***Cystourethroscopy, insertion of transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure***
The specialty society indicated and the RUC agreed that the survey respondents overestimated the work required to perform CPT code 52442. The specialty society recommended that CPT code 52442 be crosswalked to 64480 *Injection(s), anesthetic*

agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure) (work RVU = 1.20). CPT code 64480 has similar time and intensity measures to CPT code 52442 and appropriately accounts for the work required to perform this service. The urologists reported to the RUC that at a minimum of 4 implants are used on a typical patient during this procedure.
For additional support the RUC referenced the following CPT code 15136 *Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 1.50, 15 minutes of intraservice time), which has the same intraserivce time and a similar work RVU. **The RUC recommends a work RVU of 1.20 for CPT code 52442.**

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

New Technology
CPT codes 52441 and 52442 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.

Myelography (Tab 17)
Zeke Silva, MD (ACR); Kurt Schoppe, MD (ASNR); Greg Nicola, MD (ASNR); Joshua Hirsch, MD (ASNR)

The RAW identified a number of codes related to myelography services through the 75% reported together screen. In October 2013, the CPT Editorial Panel established four new bundled Category I codes to report the injection procedure for contrast myelography along with the accompanying radiological S&I. The RUC also reviewed the base CPT code 62284 *Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa)* to ensure relativity across the family.

The specialty societies requested withdrawal of the Myelography family from review at the January 2014 RUC meeting. At the time of survey, the reference service list in the myelography survey instrument mistakenly included a CPT code that was pending CMS review, and may undergo refinement in 2014. As a result, the survey instrument was unintentionally misleading. Since the code in question was chosen as the key reference code for four of the five surveyed myelography codes, the RUC determined that the data was invalid. These codes, along with 72240, 72255, 72265 and 72270, were instead reviewed at the April 2014 RUC meeting.

62302 ***Myelography via lumbar injection, including radiological supervision and interpretation; cervical***
The RUC reviewed the survey results from 37 radiologists and neuroradiologists and agreed with the specialty societies that the following physician time components are accurate for 62302: pre-service time of 24 minutes, intra-service time of 26 minutes and immediate post-service time of 10 minutes. The RUC agreed that four additional minutes should be added to the positioning time above standard pre-time package 1A to place the patient in the prone position.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey's 25th percentile work RVU of 2.29 is appropriate for this service. To justify a work RVU of 2.29, the RUC compared the surveyed code to CPT code 72156 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical* (work RVU= 2.29, intra time= 25 minutes) and agreed that since both services have comparable physician work and identical intra-service time, they should be valued similarly. The RUC also reviewed key reference code 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 noted that while the reference code has less intra-service time, 15 minutes compared to 26 minutes, the reference service is more intense compared to 62302. The additional time in the surveyed code revolves around the work of the cervical myelogram and the radiological supervision and interpretation. **The RUC recommends a work RVU of 2.29 for CPT code 62302.**

62303 ***Myelography via lumbar injection, including radiological supervision and interpretation; thoracic***
The RUC reviewed the survey results from 37 radiologists and neuroradiologists and agreed with the specialty societies that the following physician time components are accurate for 62303: pre-service time of 24 minutes, intra-service time of 25 minutes and immediate post-service time of 10 minutes. The RUC agreed that four additional minutes should be added to the positioning time above the standard pre-time package 1A to place the patient in the prone position.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey's 25th percentile work RVU of 2.29 is appropriate for this service. To justify a work RVU of 2.29, the RUC compared the surveyed code to CPT code 72157 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic* (work RVU= 2.29) and agreed that since both services have comparable physician work and identical intra-service time, they should be valued similarly. The RUC also compared this service to the cervical myelography with radiological S&I, 62302, and determined that, with essentially the same time components and physician work, the two codes should be valued the same. **The RUC recommends a work RVU of 2.29 for CPT code 62303.**

62304 ***Myelography via lumbar injection, including radiological supervision and interpretation; lumbosacral***
The RUC reviewed the survey results from 37 radiologists and neuroradiologists and agreed with the specialty societies that the following physician time components are accurate for 62304: pre-service time of 24 minutes, intra-service time of 25 minutes and immediate post-service time of 10 minutes. The RUC agreed that four additional minutes should be added to the positioning time above the standard pre-time package 1A to place the patient in the prone position.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey's 25th percentile work RVU of 2.25 is appropriate for this service. To justify a work RVU of 2.25, the RUC compared the surveyed code to CPT code 72158 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar* (work RVU= 2.29) and agreed that since both services have comparable physician work and identical

intra-service time they should be valued similarly. In addition, the RUC reviewed 64517 *Injection, anesthetic agent; superior hypogastric plexus* (work RVU= 2.20) and agreed that, with identical intra-service time and comparable physician work, this reference code and 62304 should be valued similarly. **The RUC recommends a work RVU of 2.25 for CPT code 62304.**

62305 ***Myelography via lumbar injection, including radiological supervision and interpretation; 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical)***
The RUC reviewed the survey results from 37 radiologists and neuroradiologists and agreed with the specialty societies that the following physician time components are accurate for 62305: pre-service time of 25 minutes, intra-service time of 30 minutes and immediate post-service time of 10 minutes. The RUC agreed that five additional minutes should be added to the positioning time above the standard pre-time package to place the patient in the prone position and also to match the median survey positioning time of 6 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey's 25th percentile work RVU of 2.35 is appropriate for this service. To justify a work RVU of 2.35, the RUC compared the surveyed code to key reference service 62267 *Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes* (work RVU= 3.00) and agreed that while both services have identical intra-service time of 30 minutes, the reference code has more total time and is thus accurately valued higher than 62305. The RUC also reviewed CPT code 52005 *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service* (work RVU= 2.37, intra time= 30 minutes) and agreed that, with identical intra-service time and comparable physician work, this reference code and 62305 should be valued similarly. **The RUC recommends a work RVU of 2.35 for CPT code 62305.**

62284 ***Injection procedure for myelography and/or computed tomography, lumbar (other than C1-C2 and posterior fossa)***
The RUC reviewed the survey results from 37 radiologists and neuroradiologists and agreed with the specialty societies that the following physician time components are accurate for 62284: pre-service time of 24 minutes, intra-service time of 15 minutes and immediate post-service time of 10 minutes. The RUC agreed that four additional minutes should be added to the positioning time above the standard pre time package to place the patient in the prone position. The RUC also agreed with the specialty societies that the current intra-service time of 15 minutes, lower than the survey median time of 20 minutes, is more appropriate for this service as the current time was just surveyed in October 2010.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the current work RVU of 1.54, lower than the survey's 25th percentile, is appropriate for this service. To justify a work value of 1.54, the RUC compared the surveyed code to the key reference service 64493 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level* (work RVU= 1.52) and noted that both codes have identical intra-service time and comparable physician work. Therefore, both codes should be valued similarly. The RUC also 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, intra time= 15 minutes) and noted that while this service has identical intra-service time to 62284, the reference code has more total time and is accurately valued higher than the surveyed code. **The RUC recommends a work RVU of 1.54 for CPT code 62284.**

72240 ***Myelography, cervical, radiological supervision and interpretation***
The RUC reviewed the survey results from 37 radiologists and neuroradiologists and agreed with the specialty societies that the following physician time components are accurate for 72240: pre-service time of 5 minutes, intra-service time of 16 minutes and immediate post-service time of 5 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the current work RVU of 0.91, lower than the survey's 25th percentile, is appropriate for this service. To justify a work value of 0.91, the RUC compared the surveyed code to MPC code 76805 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation* (work RVU= 0.99) and noted that since both services have identical intra-service time, 15 minutes, and comparable physician work, the recommended value for 72240 is appropriate relative to this similar reference code. The RUC also reviewed CPT code 78227 *Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed* (work RVU= 0.90, intra time= 15 minutes) and agreed that this service is analogous to the surveyed code and should be valued similarly. **The RUC recommends a work RVU of 0.91 for CPT code 72240.**

72255 ***Myelography, thoracic, radiological supervision and interpretation***
The RUC reviewed the survey results from 37 radiologists and neuroradiologists and agreed with the specialty societies that the following physician time components are accurate for 72255: pre-service time of 5 minutes, intra-service time of 15 minutes and immediate post-service time of 5 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the current work RVU of 0.91, lower than the survey's 25th percentile, is appropriate for this service. To justify a work value of 0.91, the RUC compared the surveyed code to CPT codes 76511 *Ophthalmic ultrasound, diagnostic; quantitative A-scan only* (work RVU= 0.94) and 78278 *Acute gastrointestinal blood loss imaging* (work RVU= 0.99) and agreed that both these services, with identical time compared to 72240, accurately place the recommended value relative to similar services across the RBRVS. The RUC also compared 72255 to 72240 and noted that both services are nearly identical in physician work and time and should thus be valued identically. **The RUC recommends a work RVU of 0.91 for CPT code 72255.**

72265 ***Myelography, lumbosacral, radiological supervision and interpretation***
The RUC reviewed the survey results from 37 radiologists and neuroradiologists and agreed with the specialty societies that the following physician time components are accurate for 72265: pre-service time of 5 minutes, intra-service time of 15 minutes and immediate post-service time of 5 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the current work RVU of 0.83, lower than the survey's 25th percentile, is appropriate for this service. To justify a work value of 0.83, the RUC compared the surveyed code to

CPT codes 95867 *Needle electromyography; cranial nerve supplied muscle(s), unilateral* (work RVU= 0.79) and 76816 *Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus* (work RVU= 0.85) and noted that both these services have identical intra time compared to 72265 and provide accurate relativity above and below the recommended value. The RUC also noted that this recommended value maintains the appropriate intensity/complexity to the cervical and thoracic codes. **The RUC recommends a work RVU of 0.83 for CPT code 72265.**

72270 ***Myelography, 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical), radiological supervision and interpretation***
The RUC reviewed the survey results from 37 radiologists and neuroradiologists and agreed with the specialty societies that the following physician time components are accurate for 72270: pre-service time of 5 minutes, intra-service time of 20 minutes and immediate post-service time of 5 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the current work RVU of 1.33, lower than the survey's 25th percentile, is appropriate for this service. To justify a work value of 1.33, the RUC compared the surveyed code to MPC code 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU= 1.40, intra time= 18 minutes) and agreed that with nearly identical physician time components both services should be valued similarly. In addition, the RUC reviewed MPC code 73721 *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (work RVU= 1.35) and noted that since this code has identical physician time and comparable physician work to 72270, the current value for this surveyed code is appropriate. **The RUC recommends a work RVU of 1.33 for CPT code 72270.**

Practice Expense
The RUC reviewed the direct PE inputs and noted that for the existing codes (62284, 72240, 42255, 72265 and 72270) there are decreases across the current clinical labor time, with supplies and equipment mostly crosswalked as well. For the new codes (62302-4) the inputs are largely consistent with the combined component injection and myelography codes, with reductions in the clinical labor time to reflect efficiencies gained now that the codes are bundled. The RUC approved the direct practice expense with minor modifications as 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.

<u>Transversus Abdominis Plane (TAP) Anesthetic Block (Tab 18)</u>
Marc Leib, MD, JD (ASA); Richard Rosenquist, MD (ASA)
Facilitation Committee #2

In February 2014, the CPT Editorial Panel created four new codes to describe transversus abdominis plan block or rectus sheath block single and continuous for the administration of local anesthetic for post-operative pain control and abdominal wall analgesia.

64486 ***Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance when performed)***
The RUC reviewed the survey results from 57 anesthesiologists for CPT code 64486 and determined that the survey 25th percentile work RVU of 1.50 was too high. Therefore, the RUC recommends a direct crosswalk to CPT code 67505 *Retrobulbar injection; alcohol* (work RVU = 1.27 and 10 minutes intra-service time). The RUC determined that the pre-service evaluation time should be decreased by 5 minutes to account for possible duplicative work when the same anesthesiologist who performed the general anesthesia for surgery is now performing this post-surgical service. In addition, the pre-service positioning time was increased by 4 minutes over the pre-time package to allow the anesthesiologist extra time to work around the site on which the surgeon just worked. The RUC recommends 5 minutes evaluation, 5 minutes positioning and 5 minutes scrub, dress and wait pre-time, 10 minutes intra-service time and 10 minutes immediate post service time. For additional support the RUC referenced CPT codes: 32562 *Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day* (work RVU = 1.24 and 10 minutes intra-service time) and 45305 *Proctosigmoidoscopy, rigid; with biopsy, single or multiple* (work RVU = 1.25 and 10 minutes intra-service time). **The RUC recommends a work RVU of 1.27 for CPT code 64486.**

64487 ***Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by continuous infusion(s) (includes imaging guidance when performed)***
The RUC reviewed the survey results from 34 anesthesiologists for CPT code 64487 and determined that the survey 25th percentile work RVU of 1.65 was too high. Therefore, the RUC recommends a direct crosswalk to CPT code 64445 *Injection, anesthetic agent; sciatic nerve, single* (work RVU = 1.48 and 15 minutes intra-service time). The RUC noted the incremental difference of 0.13 between single injection infusion code 64447 *Injection, anesthetic agent; femoral nerve, single* (work RVU = 1.50) and continuous injection infusion code 64448 *Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)* (work RVU = 1.63), as well as the incremental difference of 0.33 between single injection infusion code 62311 *Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)* (work RVU = 1.17) and continuous injection infusion code 62319 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)* (work RVU = 1.50). Based on this, the RUC considered an increment of 0.21 as appropriately bracketed by the incremental value increases between other single and continuous infusion codes. The RUC determined that the pre-service evaluation time should be decreased by 5 minutes to account for possible duplicative work when the same anesthesiologist who performed the general anesthesia for surgery is now performing this post-surgical service. In addition, the pre-service positioning time was increased by 4 minutes over the pre-time package to allow the anesthesiologist extra time to work around the area in which the surgeon just worked. The RUC recommends 5 minutes evaluation, 5 minutes positioning and 5 minutes scrub, dress and wait pre-time, 15 minutes intra-service time and 10 minutes immediate post service time. **The RUC recommends a work RVU of 1.48 for CPT code 64487.**

64488 ***Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance when performed)***
The RUC reviewed the survey results from 37 anesthesiologists for CPT code 64488 and determined that the survey 25th percentile work RVU of 1.60 appropriately accounts for the work required to perform this service. The RUC determined that the pre-service evaluation time should be decreased by 5 minutes to account for possible duplicative work when the same anesthesiologist who performed the general anesthesia for surgery is now performing this post-surgical service. In addition, the pre-service positioning time was increased by 4 minutes over the pre-time package to allow the anesthesiologist extra time to work around the site on which the surgeon just worked. The RUC recommends 5 minutes evaluation, 5 minutes positioning, 5 minutes scrub, dress and wait pre-time, 15 minutes intra-service time and 10 minutes immediate post service time. The RUC noted that although the intra-service time is 15 minutes for both 64487 and 64488, this service is more intense because there are two injection sites for this code. For additional support the RUC referenced CPT codes 64448 *Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)* (work RVU= 1.63 and 15 minutes intra-service time) and CPT code 19285 *Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance* (work RVU = 1.70 and 15 minutes intra-service time). **The RUC recommends a work RVU of 1.60 for CPT code 64488.**

64489 ***Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by continuous infusions (includes imaging guidance when performed***
The RUC reviewed the survey results from 34 anesthesiologists for CPT code 64489 and determined that the survey 25th percentile work RVU of 1.80 appropriately accounts for the work required to perform this service. The RUC determined that the pre-service evaluation time should be decreased by 5 minutes to account for possible duplicative work when the same anesthesiologist who performed the general anesthesia for surgery is now performing this post-surgical service. In addition, the pre-service positioning time was increased by 4 minutes over the pre-time package to allow the anesthesiologist extra time to work around the site on which the surgeon just worked. The RUC recommends 5 minutes evaluation, 5 minutes positioning and 5 minutes scrub, dress and wait pre-time, 20 minutes intra-service time and 10 minutes immediate post service time. The incremental increase in value compared to 64488 also fits well into the range of added value for placement of continuous infusion catheter versus single injection services. For additional support the RUC referenced CPT codes 64646 *Chemodenervation of trunk muscle(s); 1-5 muscle(s)* (work RVU = 1.80 and 20 minutes intra-service time) and 45315 *Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique* (work RVU = 1.80 and 20 minutes intra-service time). **The RUC recommends a work RVU of 1.80 for CPT code 64489.**

Practice Expense
The Practice Expense Subcommittee modified the equipment minutes accounting for time clinical labor staff spends monitoring the patient while he/she is on the stretcher. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Breast Tomosynthesis (Tab 19)
Zeke Silva, MD, (ACR); Kurt Schoppe, MD, (ACR); Mark Alson, MD (ACR); Dana Smetherman, MD (ACR)

In February 2014, the CPT Editorial Panel created three new codes to describe breast tomosynthesis. Breast tomosynthesis is a digital tomographic technique performed using multiple low-dose x-ray exposures that are obtained as the X-ray tube swings in an arc around the compressed breast. The resulting image data is reconstructed using standard computer algorithms to produce a series of sequential stacked slices through the breast. This type of tomographic imaging allows the physician to view the breast as thin discrete image slices on a computer workstation.

77061 ***Digital breast tomosynthesis; unilateral***
The RUC reviewed the survey results from 32 radiologists and determined that the survey 25th percentile work RVU of 0.70 for CPT code 77061 appropriately accounts for the work required to perform this service. The RUC recommends 3 minutes of pre-service, 7 minutes of intra-service and 4 minutes of post-service time. The RUC compared this to the key reference service 77055 *Mammography; unilateral* (work RVU = 0.70) and noted that both services require the same intra-service time to complete and should be valued the same. For additional support the RUC also referenced MPC code 76817 *Ultrasound, pregnant uterus, real time with image documentation, transvaginal* (work RVU = 0.75) and similar service 76830 *Ultrasound, transvaginal* (work RVU = 0.69). **The RUC recommends a work RVU of 0.70 for CPT code 77061.**

77062 ***Digital breast tomosynthesis; bilateral***
The RUC reviewed the survey results from 32 radiologists and determined that the survey 25th percentile work RVU of 0.90 for CPT code 77062 appropriately accounts for the work required to perform this service. The RUC recommends 3 minutes of pre-service, 10 minutes of intra-service and 4 minutes of post-service time. The RUC compared this to the key reference service 77056 *Mammography; bilateral* (work RVU = 0.87) and noted that both services require similar physician work and time. For additional support, the RUC also referenced MPC code 76805 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation* (work RVU = 0.99) and similar service 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86). **The RUC recommends a work RVU of 0.90 for CPT code 77062.**

77063 ***Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 32 radiologists and determined that the survey 25th percentile work RVU of 0.60 for CPT code 77063 appropriately accounts for the work required to perform this service. The RUC recommends 8 minutes of intra-service time. The RUC compared this to the key reference service 76810 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)* (work RVU = 0.98) and noted that the key reference service requires more than double the time to perform than CPT code 77063 and is appropriately valued higher. For additional support the RUC also referenced MPC codes 51797 *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)* (work RVU = 0.80) and 64484 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with*

imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure) (work RVU = 1.00), which has a higher RVU but a comparable time of 10 minutes. Lastly the RUC referenced similar service 78020 *Thyroid carcinoma metastases uptake (List separately in addition to code for primary procedure)* (work RVU = 0.60). **The RUC recommends a work RVU of 0.60 for CPT code 77063.**

77055, 77056, 77057, G0202, G0204 and G0206
The RUC noted that screening mammography and diagnostic mammography CPT and G-codes appeared on the LOI for the specialty society to survey and questioned why these services were not surveyed together. The specialty indicated that they did not survey these services for the April 2014 RUC meeting because they believed it important to have the screening and diagnostic mammography CPT codes on the reference service list for the new breast tomosynthesis codes. Additionally, the specialty society indicated that they wanted to wait until the Proposed Rule for MFS for 2015 is published, to see what CMS proposes for these services. It is possible that the G codes, which describe full field digital mammography (diagnostic and screening), will be impacted by the RUC recommended changes to convert the direct practice expense items for film to digital for the existing analog screening and diagnostic mammography codes (77055, 77056 and 77057) and both these CPT codes and the G codes may describe the same services and direct practice expense inputs. **The RUC requests the specialty society submit an action plan for the September 2014 Relativity Assessment meeting to address what CMS indicates in the CY2015 Proposed Rule regarding these services.**

New Technology
The RUC recommends that codes 77061, 77062 and 77063 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

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

<u>Isodose Calculation with Isodose Planning Bundle (Tab 20)</u>
Michael Kuettel, MD, PhD (ASTRO); Brian Kavanagh, MD, MPH (ASTRO); Gerald White, MD (ASTRO); James Goodwin, MD (ASTRO)

At the February 2014 CPT Editorial Panel meeting, the Panel approved the deletion of six CPT Category I codes (77305, 77310, 77315, 77326-77328) and created five new CPT Category I codes to bundle basic dosimetry calculation(s) with teletherapy and brachytherapy isodose planning.

77300 ***Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician***
The RUC reviewed the survey results from 83 radiation oncologists and medical physicists and agreed with the specialty on the following physician time components: pre-service time of 0 minutes, intra-service time of 15 minutes and post-time of 0 minutes. The RUC determined that the current value of 0.62, lower than the survey 25th

percentile, is appropriate for this service. The RUC compared the surveyed code to MPC code 88112 *Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal* (work RVU= 0.56, intra-service time of 15 minutes) and noted that both services have the same intra-service time and total time. The surveyed code is a slightly more intense service, justifying a slightly higher work value.

The RUC also compared the surveyed code to CPT code 93970 *Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study* (work RVU= 0.70, intra-service time of 15 minutes) and noted that both services have the same intra-service time, however the surveyed code has a lower total time (15 minutes versus 23 minutes), which supports a slightly lower work value for the surveyed code. **The RUC recommends a work RVU of 0.62 for CPT code 77300.**

77306 ***Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)***
The RUC reviewed the survey results from 77 radiation oncologists and medical physicists and agreed with the specialty on the following physician time components: pre-service time of 3 minutes, intra-service time of 40 minutes and post-time of 3 minutes. The specialty society noted that they received permission from the Research Subcommittee to ask survey respondents the typical number of dose calculation they perform for this procedure. The median survey response was two dose calculations for this service. The RUC noted that a volume-weighted analysis of the *Medicare Carrier 5% standard analytic file* confirmed two units of basic dosimetry for this service (same patient, same day, same provider), assuming that the volume of the deleted code 77310 is shared 50/50 between 77306 and 77307. The specialty indicated that they could not foresee additional basic dosimetry calculations on a separate day of service for teletherapy isodose planning codes.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty that the survey 25th percentile work RVU of 1.40 is appropriate. The RUC compared the surveyed code to MPC code 88321 *Consultation and report on referred slides prepared elsewhere* (work RVU= 1.63, intra-service time of 50 minutes) and noted that the reference code has a higher intra-service time (50 minutes versus 40 minutes), supporting a lower work RVU of 1.40 for the surveyed code. The RUC also compared the surveyed code to CPT code 78709 *Kidney imaging morphology; with vascular flow and function, multiple studies, with and without pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)* (work RVU= 1.41, intra-service time of 40 minutes) and noted that since both codes have identical intra-service time and total time, the work RVU recommendation of 1.40 is further supported by the additional reference code. **The RUC recommends a work RVU of 1.40 for CPT code 77306.**

77307 ***Teletherapy isodose plan; complex (Multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)***
The RUC reviewed the survey results from 78 radiation oncologists and medical physicists and agreed with the specialty on the following physician time components: pre-service time of 3 minutes, intra-service time of 80 minutes and post-time of 3 minutes. The specialty society noted that they received permission from the Research Subcommittee to ask survey respondents the typical number of dose calculation they perform for this procedure. The median survey response was four dose calculations for

this service. The RUC noted that a volume-weighted analysis of the *Medicare Carrier 5% standard analytic file* indicated 2.4 units of basic dosimetry for this service (same patient, same day, same provider), assuming that the volume of the deleted code 77310 will be split 50/50 between 77306 and 77307. The specialty indicated that they could not foresee additional basic dosimetry calculations on a separate day of service for teletherapy isodose planning codes.

The RUC reviewed the survey respondents' estimated physician work values, while also accounting for the data from the Medicare Carrier 5% standard analytic file, and agreed with the specialty that the survey 25th percentile work RVU of 2.90 is appropriate. The RUC compared the surveyed code to CPT code 77263 *Therapeutic radiology treatment planning; complex* (work RVU= 3.14, intra-service time of 75 minutes) and agreed that since the surveyed code has a higher intra-service time (80 minutes versus 75 minutes) and a similar work intensity, a work RVU of 2.90 is justified. The RUC also compared the surveyed code to MPC code 95810 *Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU= 2.50, pre-time of 15 minutes, intra-service time of 36.5 minutes, post-time of 15 minutes) and noted that since the surveyed code has a much higher intra-service time (80 versus 36.5 minutes) and a higher total time (86 minutes versus 66.5 minutes), the recommended work value is correctly valued relative to services across the RBRVS. **The RUC recommends a work RVU of 2.90 for CPT code 77307.**

77316 ***Brachytherapy isodose plan; simple (calculation(s) made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)***
The RUC reviewed the survey results from 70 radiation oncologists and medical physicists and agreed with the specialty on the following physician time components: pre-service time of 3 minutes, intra-service time of 40 minutes and post-time of 3 minutes. The specialty society noted that they received permission from the Research Subcommittee to ask survey respondents the typical number of dose calculation they perform for this procedure. The median survey response was one dose calculation for this service. The RUC noted that a volume-weighted analysis of the Medicare Carrier 5% standard analytic file confirmed one unit of basic dosimetry for this service (same patient, same day, same provider).

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty that the survey 25th percentile work RVU of 1.50 is appropriate. The RUC also agreed that the brachytherapy isodose planning is a more intense service relative to teletherapy isodose planning. The RUC compared the surveyed code to MPC code 88321 *Consultation and report on referred slides prepared elsewhere* (work RVU= 1.63, intra-service time of 50 minutes) and noted that the reference code has a higher intra-service time (50 minutes versus 40 minutes), supporting a lower work RVU of 1.50 for the surveyed code. The RUC also compared the surveyed code to CPT code 88380 *Microdissection (ie, sample preparation of microscopically identified target); laser capture* (work RVU= 1.56, intra-service time of 45 minutes) and noted that with similar total time (46 minutes versus 45 minutes) and similar work intensities, the RUC recommended work value is appropriate for 77316. **The RUC recommends a work RVU of 1.50 for CPT code 77316.**

77317 ***Brachytherapy isodose plan; intermediate (calculation(s) made from 5 to 10 sources or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)***
The RUC reviewed the survey results from 70 radiation oncologists and medical physicists and agreed with the specialty on the following physician time components: pre-service time of 3 minutes, intra-service time of 50 minutes and post-time of 3 minutes. The specialty society noted that they received permission from the Research Subcommittee to ask survey respondents the typical number of dose calculation they perform for this procedure. The median survey response was one dose calculation for this service. The RUC noted that a volume-weighted analysis of the *Medicare Carrier 5% standard analytic file* confirmed one unit of basic dosimetry for this service (same patient, same day, same provider).

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty that the respondents overestimated the physician work required to perform this service. The RUC compared the surveyed code to CPT code 88323 *Consultation and report on referred material requiring preparation of slides* (work RVU= 1.83 and intra-service time of 56 minutes) and agreed that since both services have similar intensities and identical total time, they should be valued the same. Therefore, the RUC recommends a direct crosswalk to 88323.

To further justify a work RVU of 1.83 for 77317, the RUC reviewed CPT code 95863 *Needle electromyography; 3 extremities with or without related paraspinal area* (work RVU= 1.87, pre-time of 10 minutes, intra-service time of 40 minutes, post-time of 11 minutes) and noted that the surveyed code has a higher total time (50 minutes versus 40 minutes), although a lower total time (56 minutes versus 61 minutes), validating that a similar work RVU is appropriate. **The RUC recommends a work RVU of 1.83 for CPT code 77317.**

77318 ***Brachytherapy isodose plan; complex (calculation(s) made from over 10 sources or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)***
The RUC reviewed the survey results from 72 radiation oncologists and medical physicists and agreed with the specialty on the following physician time components: pre-service time of 3 minutes, intra-service time of 80 minutes and post-time of 3 minutes. The specialty society noted that they received permission from the Research Subcommittee to ask survey respondents the typical number of dose calculation they perform for this procedure. The median survey response was two dose calculations for this service. The RUC noted that a volume-weighted analysis of the *Medicare Carrier 5% standard analytic file* indicated one unit of basic dosimetry for this service (same patient, same day, same provider).

The RUC agreed with the specialty that the *Medicare Carrier 5% standard analytic file* does not capture a second instance of basic dosimetry for 77318, since the second independent dose calculation is typically billed on a separate day from the brachytherapy isodose planning. Unlike the simple and intermediate brachytherapy isodose planning codes, 77318 is used for a prostate seed implant (vignette found to be 100 percent typical). Typically, the treatment planning for a prostate seed implant is initiated well before the date of the actual implant, since the radioactive seeds need to be custom ordered (typically 80 seeds). The seeds are received a number of days before the implant on a separate day, and then a separate independent dose calculation is performed to take

into account the decay factor and verify the plan prior to the implant. The separate dose calculation is based on the activity of those seeds and re-entered into the actual plan.

The RUC reviewed the survey 25th percentile work RVU of 3.30 and determined that the respondents overestimated the physician work required to perform this service. Given the lack of an appropriate crosswalk to an existing code, the RUC agreed the the physician work and time required to perform 77318 is the same as 77307 (RUC recommended work RVU = 2.90), the other complex code in this family. Therefore, the RUC recommends a work RVU of 2.90 for CPT code 77318. . The RUC compared the surveyed code to CPT code 77263 *Therapeutic radiology treatment planning; complex* (work RVU= 3.14, intra-service time of 75 minutes) and agreed that since the surveyed code has a higher intra-service time (80 minutes versus 75 minutes) and a similar work intensity, a work RVU of 2.90 is justified. The RUC also compared the surveyed code to MPC code 95810 *Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU= 2.50, pre-time of 15 minutes, intra-service time of 36.5 minutes, post-time of 15 minutes) and noted that since the surveyed code has a much higher intra-service time (80 versus 36.5 minutes), as well as a higher total time (86 minutes versus 66.5 minutes), the recommended work value is correctly valued relative to services across the RBRVS. **The RUC recommends a work RVU of 2.90 for CPT code 77318.**

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

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with minor modifications as approved by the Practice Expense Subcommittee. The RUC noted that the clinical labor time for the dose calculations *Medical Dosimetrist/Medical Physicist* (L107A) corresponds with the median survey response to the survey question "*What is the typical number of dose calculations you currently perform for this procedure (typical patient)?*"

Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) (Tab 21)
Jonathan Myles, MD (CAP) and Roger Klein, MD, JD (CAP)

The RUC reviewed two separate pathology issues: Immunohistochemistry codes 88342, 88341 and 88344; and In situ hybridization codes 88365, 88364, 88366 and morphometric analysis in situ hybridization codes 88367, 88373, 88374, 88368, 88369 and 88377. Both issues have been intertwined in the last two years over the revision and creation of new codes to describe these services.

In the Proposed Rule for the 2012 MPFS, CMS received comments specifying that unlike the new FISH codes for urinary tract specimens, 88120 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual* and 88121 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology*, the existing codes 88365 *In situ hybridization (eg, FISH), each probe,* 88367 *Morphometric analysis, in situ hybridization (quantitative or semi-quantitative) each probe; using computer-assisted technology* and 88368 *Morphometric analysis, in situ hybridization (quantitative or semi-*

quantitative) each probe; manual 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 costs associated with 88120 and 88121 and agreed that they were accurate. In January 2012, the RUC recommended that it re-review codes 88365, 88367 and 88368 at the April 2013 meeting. At the April 2013 meeting, upon careful review of the code descriptors and other vignettes, it was determined that the entire family of services should be referred to the CPT Editorial Panel to accurately describe typical services. In May 2013, the CPT Editorial Panel revised the in situ hybridization codes 88365, 88367 and 88368 to specify "each separately identifiable probe per block" and created three new add-on codes "to specify each additional separately identifiable probe per slide". In addition, the panel revised and added relevant parenthetical notes to instruct on the proper use of these codes.

In October 2013, the RUC reviewed the revised and new codes and developed recommendations for in situ hybridization. However, in November 2013, in the Final Rule for the 2014 MPFS, CMS made the following ruling on the immunohistochemistry codes:

> The CPT Editorial Panel revised the existing immunohistochemistry code, CPT code 88342 and created a new add-on code 88343 for CY 2014. Current coding requirements only allow CPT code 88342 to be billed once per specimen for each antibody, but the revised CPT codes and descriptors would allow the reporting of multiple units for each slide and each block per antibody (88342 for the first antibody and 88343 for subsequent antibodies). We believe that this coding would encourage overutilization by allowing multiple blocks and slides to be billed. To avoid this incentive, we are creating G0461 *Immunohistochemistry or immunocytochemistry, per specimen; first single or multiplex antibody stain* (work RVU = 0.60) and G0462 *Immunohistochemistry or immunocytochemistry, per specimen; each additional single or multiplex antibody stain (List separately inaddition to code for primary procedure)* (work RVU = 0.24) to ensure that the services are only reported once for each antibody per specimen.

The specialty societies noted that it was confusing and burdensome for physicians to report CPT codes for private payor payment and report G codes for Medicare payment for immunohistochemistry services. Additionally, the specialty societies noted that the practice expense would be overestimated if codes would be reported per antibody instead of per specimen. Therefore, the specialties sent in a coding proposal to again clarify the descriptors for the immunohistochemistry services as well as the in situ hybridization services. In February 2014, the CPT Editorial Panel deleted one code, created eight new codes and revised six codes to describe immunohistochemistry, in situ hybridization and morphometric analysis in situ hybridization for gene rearrangement(s).

Immunohistochemistry

88342 ***Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure***

The RUC reviewed the survey results from 206 pathologists for CPT code 88342 and determined that the survey 25th percentile work RVU of 0.70 appropriately accounts for

the work required to perform this service. The RUC recommends 25 minutes intra-service time. The RUC compared 88342 to key reference service 88305 *Level IV - Surgical pathology, gross and microscopic examination…* (work RVU = 0.75) and noted that both services require 25 minutes intra-service time, however survey respondents indicated that 88342 is more intense and complex for all measures examined (mental effort and judgment, technical and physical effort and psychological stress). The survey median work RVU for 88342 indicated the overall work of 88305 was less than 88342. However, the specialty societies indicated and the RUC agreed that the 25th percentile work RVU is more appropriate. For additional support the RUC referenced CPT code 88172 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site* (work RVU = 0.69), which requires slightly less physician work and time to complete. **The RUC recommends a work RVU of 0.70 for CPT code 88342.**

88341 ***Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 206 pathologists for CPT code 88341 and determined that the survey 25th percentile work RVU of 0.65 appropriately accounts for the work required to perform this service. The RUC recommends 25 minutes intra-service time. The RUC noted that although this add-on service requires the same time as the base code 88342, the work is slightly less for each additional single antibody. The RUC compared 88341 to key reference service 88305 *Level IV - Surgical pathology, gross and microscopic examination…* (work RVU = 0.75) and noted that both services require 25 minutes intra-service time, however survey respondents indicated that 88341 is more intense and complex for all measures examined (mental effort and judgment, technical and physical effort and psychological stress). The survey median work RVU for 88341 indicated the overall work of 88305 was less than 88341. However, the specialty societies indicated and the RUC agreed that the 25th percentile work RVU is more appropriate. For additional support the RUC referenced CPT code 88387 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)* (work RVU = 0.62), which requires slightly less physician work and time to complete. **The RUC recommends a work RVU of 0.65 for CPT code 88341.**

88344 ***Immunohistochemistry or immunocytochemistry, per specimen each multiplex antibody stain procedure***
The RUC reviewed the survey results from 63 pathologists for CPT code 88344 and determined that the survey 25th percentile work RVU of 0.77 appropriately accounts for the work required to perform this service. The RUC recommends 35 minutes intra-service time. The RUC compared 88344 to key reference service 88360 *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual* (work RVU = 1.10) and noted that both services require 35 minutes intra-service time, however survey respondents indicated that 88344 is more intense and complex for all measures examined (mental effort and judgment, technical and physical effort and psychological stress). The specialty societies indicated and the RUC agreed that the 25th percentile work RVU is appropriate. For additional support the RUC referenced CPT code 88182 *Flow cytometry, cell cycle or DNA analysis* (work RVU = 0.77). **The RUC recommends a work RVU of 0.77 for CPT code 88344.**

In Situ Hybridization

88365 ***In situ hybridization (eg, FISH), per specimen; initial single probe stain procedure***
The RUC reviewed the survey results from 56 pathologists for CPT code 88365 and determined that a work RVU of 0.88, the same as the recommended work RVU for CPT code 88368, appropriately accounts for the work required to perform this service. The RUC noted that the recommended work RVU is just slightly lower than the survey 25th percentile work RVU of 0.90. The RUC recommends 30 minutes intra-service time. The RUC compared 88365 to key reference service 88346 *Immunofluorescent study, each antibody; direct method* (work RVU = 0.86) and determined that 88365 requires more physician work and time to perform and therefore is valued appropriately. For additional support the RUC referenced MPC code 51705 *Change of cystostomy tube; simple* (work RVU = 0.90 and total time 32 minutes) and similar services 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (work RVU = 0.94) and 88358 *Morphometric analysis; tumor (eg, DNA ploidy)* (work RVU = 0.95). **The RUC recommends a work RVU of 0.88 for CPT code 88365.**

88364 ***In situ hybridization (eg, FISH), per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results for CPT code 88365 and determined that a work RVU of 0.88, the same as the recommended work RVU for CPT code 88365 and 88368, appropriately accounts for the work required to perform this service. The RUC noted that the recommended work RVU is lower than the survey 25th percentile work RVU of 0.95. The RUC recommends 30 minutes intra-service time. The RUC determined that since 88365 and the add-on code 88364 require identical time and intensity, these two services should be valued the same. The RUC noted that the pathologist is looking at a second probe with an entirely different color signal than the base code 88365. The RUC compared 88364 to key reference service 88346 *Immunofluorescent study, each antibody; direct method* (work RVU = 0.86) and determined 88365 requires more physician work and time to perform and therefore is valued appropriately. For additional support the RUC referenced MPC code 51705 *Change of cystostomy tube; simple* (work RVU = 0.90 and total time 32 minutes) and similar services 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (work RVU = 0.94) and 88358 *Morphometric analysis; tumor (eg, DNA ploidy)* (work RVU = 0.95). **The RUC recommends a work RVU of 0.88 for CPT code 88364.**

88366 ***In situ hybridization (eg, FISH), per specimen; each multiplex probe stain procedure***
The RUC reviewed the survey results for CPT code 88366 and determined the survey 25th percentile work RVU of 1.24 appropriately accounts for the work required to perform this service. The specialty society provided a breakdown of the random survey respondents who indicated 50 minutes intra-service time and targeted survey respondents who indicated 40 minutes intra-service time. The specialty society recommended an intra-service time of 40 minutes to maintain rank order and the RUC agreed. The RUC compared code 88366 to 88377 and noted that both are manual multiplex in situ hybridization services, but 88377 includes morphometric analysis while the X6 does not. CPT code 88377 provides a number in the report in addition to reporting the result as positive or negative or equivocal. ASCO and CAP have recently updated Her2 practice

guidelines that necessitate that a number is included in the in situ hybridization report. For example, typically in the HER-2report, a Her2: Chromosome 17 ratio is reported as well as the average number of Her2 signals per cell. The normal number of Her2 signals per cells is two, therefore if you get a number above 2 you have an abnormal result and the physician must assess this information in the context of the number of chromosome 17's that are present per cell. The RUC noted that the recommended physician time and work RVUs for CPT code 88366 in relation to 88377 maintain the proper rank order. The RUC compared 88366 to key reference service 88120 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual* (work RVU = 1.20) and determined 88366 requires more physician work and time to perform and therefore is valued appropriately. For additional support the RUC referenced MPC code 94003 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day* (work RVU = 1.37 and 40 minutes total time) and similar service 88187 *Flow cytometry, interpretation; 2 to 8 markers* (work RVU = 1.36 and 38 minutes total time). **The RUC recommends a work RVU of 1.24 for CPT code 88366.**

88367 ***Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; initial single probe stain procedure***
The RUC reviewed the survey results for CPT code 88367 and determined the survey 25th percentile work RVU of 0.86 appropriately accounts for the work required to perform this service. The RUC recommends 25 minutes of intra-service time. The specialty society noted and the RUC agreed that "using computer-assisted technology" for 88367, as included in the descriptor, does not replace the physician work. Computer-assisted technology refers to the computer selecting the images for the pathologist to review. The computer does not adequately distinguish between cancer and non-cancer cells. In addition, the American Society of Clinical Oncology (ASCO) guidelines indicate that a minimum of 40 neoplastic cells need to be examined for signal intensity. The RUC compared 88367 to 88368 and noted that CPT code 88368 is manual and requires slightly more physician work and time because the physician is moving the fluoroscopic microscope around to find the cells of interest that will be counted. In code 88367, the images that the physician evaluates are selected by the computer. CPT code 88367 still requires the physician to analyze and make decisions. The RUC also noted that 88367 requires less Lab Tech/Histotechnician time in the practice expense because the computer is selecting the images instead. The RUC compared 88367 to key reference service 88346 *Immunofluorescent study, each antibody; direct method* (work RVU= 0.86) and agreed that since these service require the same physician work to perform, a work RVU of 0.86 is appropriate. For additional support the RUC referenced MPC code 51705 *Change of cystostomy tube; simple* (work RVU = 0.90) and CPT code 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86). **The RUC recommends an interim work RVU of 0.86 for CPT code 88367.** The RUC noted that CPT code 88367 did not meet the RUC established survey response criteria of 50 responses for codes with Medicare Claims between 100,000-1 million. The specialty societies will bring back this code with 50 or more responses for the RUC to review in September 2014.

88373 ***Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results for CPT code 88373 and determined that a work RVU of 0.86, the same as the recommended work RVU for CPT code 88367,

appropriately accounts for the work required to perform this service. The RUC noted that the recommended work RVU is lower than the survey 25th percentile work RVU of 0.90. The RUC recommends 25 minutes of intra-service time. The specialty society noted and the RUC agreed that "using computer-assisted technology" for 88373, as included in the descriptor, does not replace the physician work. Computer-assisted technology refers to the computer selecting the images for the pathologist to review. The computer does not adequately distinguish between cancer and non-cancer cells. In addition, the American Society of Clinical Oncology (ASCO) guidelines indicate that a minimum of 40 neoplastic cells need to be examined for signal intensity. The RUC compared 88373 to 88369 and noted that CPT code 88369 is manual and requires slightly more physician work and time because the physician is moving the fluoroscopic microscope around to find the cells of interest that will be counted. In code 88373, the images that the physician evaluates are selected by the computer. CPT code 88373 still requires the physician to analyze and make decisions. The RUC also noted that 88373 requires less Lab Tech/Histotechnician time in the practice expense because the computer is selecting the images instead. The RUC compared 88373 to key reference service 88346 *Immunofluorescent study, each antibody; direct method* (work RVU = 0.86) and agreed that since these service require the same physician work to perform, a work RVU of 0.86 is appropriate. For additional support the RUC referenced MPC code 51705 *Change of cystostomy tube; simple* (work RVU = 0.90) and CPT code 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86). **The RUC recommends a work RVU of 0.86 for CPT code 88373.**

88374 ***Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; each multiplex probe stain procedure***

The RUC reviewed the survey results for CPT code 88374 and determined the survey 25th percentile work RVU of 1.04 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes of intra-service time. The specialty society noted and the RUC agreed that "using computer-assisted technology" for 88374, as included in the descriptor, does not replace the physician work. Computer-assisted technology refers to the computer selecting the images for the pathologist to review. The computer does not adequately distinguish between cancer and non-cancer cells. In addition, the American Society of Clinical Oncology (ASCO) guidelines indicate that a minimum of 40 neoplastic cells need to be examined for signal intensity. The RUC compared 88374 to 88377 and noted that CPT code 88377 is manual and requires slightly more physician work and time because the physician is moving the fluoroscopic microscope around to find the cells of interest that will be counted. In code 88374, the images that the physician evaluates are selected by the computer. CPT code 883613 still requires the physician to analyze and make decisions. The RUC also noted that 88374 requires less Lab Tech/Histotechnician time in the practice expense because the computer is selecting the images instead. The RUC compared 88374 to key reference service 88121 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology* (work RVU = 1.00 and 25 minutes) and determined that since 88374 requires slightly more physician work and time to perform, it is value appropriately. For additional support the RUC referenced MPC code 88361 *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; using computer-assisted technology* (work RVU = 1.18 and 40 minutes) and similar service 88331 *Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen* (work RVU =

1.19 and 25 minutes). **The RUC recommends a work RVU of 1.04 for CPT code 88374.**

88368 ***Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; initial single probe stain procedure***
The RUC reviewed the survey results for CPT code 88368 and determined that the survey 25th percentile work RVU of 0.88 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes intra-service time. The RUC compared 88367 to 88368 and noted that CPT code 88368 is manual and requires slightly more physician work and time because the physician is moving the fluoroscopic microscope around to find the cells of interest that will be counted. The RUC compared 88368 to key reference service 88120 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual* (work RVU = 1.20) and determined that although 88368 requires the same physician time to perform, 30 minutes, it requires less overall work, as it accounts for the use of a single probe. For additional support the RUC referenced MPC code 51705 *Change of cystostomy tube; simple* (work RVU = 0.90 and total time 32 minutes) and similar services 88346 *Immunofluorescent study, each antibody; direct method* (work RVU = 0.86), 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (work RVU = 0.94) and 88358 *Morphometric analysis; tumor (eg, DNA ploidy)* (work RVU = 0.95). The RUC noted that CPT code 88368 did not meet the RUC established survey response criteria of 50 responses for codes with Medicare Claims between 100,000-1 million. The specialty societies will bring back this code with 50 or more responses for the RUC to review in September 2014. **The RUC recommends an interim work RVU of 0.88 for CPT code 88368.**

88369 ***Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results for CPT code 88369 and determined that a work RVU of 0.88, the same as the recommended work RVU for CPT code 88365 and 88368, appropriately accounts for the work required to perform this service. The RUC noted that the recommended work RVU is slightly lower than the survey 25th percentile work RVU of 0.89. The RUC recommends 30 minutes intra-service time. The RUC compared 88373 to 88369 and noted that CPT code 88369 is manual and requires slightly more physician work and time because the physician is moving the fluoroscopic microscope around to find the cells of interest that will be counted. The RUC compared 88369 to key reference service 88121 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology* (work RVU = 1.00) and determined that since 88369 requires less physician work but is more intense to perform, it is valued appropriately. For additional support the RUC referenced MPC code 51705 *Change of cystostomy tube; simple* (work RVU = 0.90 and total time 32 minutes) and similar services 88346 *Immunofluorescent study, each antibody; direct method* (work RVU = 0.86), 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (work RVU = 0.94) and 88358 *Morphometric analysis; tumor (eg, DNA ploidy)* (work RVU = 0.95). **The RUC recommends a work RVU of 0.88 for CPT code 88369.**

88377 ***Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; each multiplex probe stain procedure***
The RUC reviewed the survey results from 32 pathologists for CPT code 88377 and determined the survey 25th percentile work RVU of 1.40 appropriately accounts for the work required to perform this service. The RUC recommends 45 minutes intra-service time. The RUC compared 88374 to 88377 and noted that CPT code 88377 is manual and requires more physician work and time because the physician is moving the fluoroscopic microscope around to find the cells of interest that will be counted. The RUC compared code 88366 to 88377 and noted that both are manual multiplex in situ hybridization services, but 88377 includes morphometric analysis while the 88366 does not. CPT code 88377 provides a number in the report in addition to reporting the result as positive or negative or equivocal. ASCO and CAP have recently updated Her2 practice guidelines that necessitate that a number is included in the in situ hybridization report. For example, typically in the HER-2report, a Her2: Chromosome 17 ratio is reported as well as the average number of Her2 signals per cell. The normal number of Her2 signals per cells is two, therefore if you get a number above 2 you have an abnormal result and the physician must assess this information in the context of the number of chromosome 17's that are present per cell. The RUC noted that the recommended physician time and work RVUs for CPT code 88366 in relation to 88377 maintain the proper rank order. The RUC compared 88377 to key reference service 88188 *Flow cytometry, interpretation; 9 to 15 markers* (work RVU = 1.69) and determined 88377 requires less physician work to perform and therefore is valued appropriately. For additional support the RUC referenced MPC codes 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.40 and 28 minutes total time) and 94003 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day* (work RVU = 1.37 and 40 minutes total time) and similar service 88187 *Flow cytometry, interpretation; 2 to 8 markers* (work RVU = 1.36 and 38 minutes total time). **The RUC recommends a work RVU of 1.40 for CPT code 88377.**

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 accepts the direct practice expense inputs as modified by the Practice Expense Subcommittee.

<u>Transient Elastography of Liver (Tab 22)</u>
R. Bruce Cameron, MD (ACG); Joel Brill, MD (AGA); Shivan Mehta, MD (AGA); Seth Gross, MD (ASGE)

At the February 2014 CPT Editorial Panel meeting, the Panel created one new CPT Category I code to describe transient elastography of the liver.

91200 ***Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report***
The RUC agreed that the survey results for physician work and time where invalid due to the specialty's use of an incorrect survey instrument (000 Day Global Period, instead of XXX Global Period), in addition to the survey not meeting the minimum threshold for respondents. Therefore, the RUC recommendations for physician work and time are

interim. The RUC requested that the specialty re-survey with the appropriate survey instrument for the September 2014 RUC meeting.

To determine an appropriate work value, the RUC compared the surveyed code to CPT code 95981 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming* (work RVU= 0.30, pre-time= 2 minutes, intra-time= 10 minutes, post-time= 5 minutes) and noted that since both services have similar intensity and analogous physician work, they should be valued similarly. Therefore, the RUC recommends a direct work RVU and physician time crosswalk from code 95981 to code 91200.

To further justify an interim work RVU of 0.30 for 91200, the RUC reviewed CPT code 93982 *Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report* (work RVU = 0.30, intra-time= 10 minutes) and agreed that the reference code also had similar intensity and analogous physician work to the surveyed code. **The RUC recommends an interim work RVU of 0.30 for CPT code 55840.**

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with minor modifications as approved by the Practice Expense Subcommittee. The RUC noted that the clinical labor time for staff type *diagnostic medical sonographer* (L050B), is disparate from the physician time for 91200.

Corneal Hysteresis Determination (Tab 23)
Stephen A. Kamenetzky, MD (AAO) and Charles Fitzpatrick, OD (AOA)

A new code describing corneal hysteresis determination was developed by the CPT Editorial Panel at the February 2014 meeting. This technique is used by ophthalmologists to measure corneal hysteresis (resiliency) in response to an externally applied force to predict risk of progression of glaucoma.

92145 *Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report*
The RUC reviewed the survey results from 30 ophthalmologists for code 92145 and determined a work RVU 0.17 appropriately accounts for the work required to review this service. The specialty society compared the surveyed service to the key reference service CPT code 76514 *Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)* (work RVU = 0.17, 5 minutes pre-time, 5 minutes intra-time, 5 minutes post-time) and noted that the work is almost identical. Both services generate a value that is coupled with additional data, which is used to influence the treatment of patients with glaucoma. The interpretation of the hysteresis data into the treatment plan of patients with glaucoma is slightly more complex than the review a single value for cornea thickness measurement obtained with pachymetry. However, the work for 92145 and 76514 is very similar and the specialty societies indicated and the RUC agreed these services should be valued the same. . For additional support the RUC referenced MPC code 51741 *Complex uroflowmetry (eg, calibrated electronic equipment)*

(work RVU = 0.17) which requires the same physician work as the surveyed code 92145. **The RUC recommended a work RVU of 0.17 for code 92145.**

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

Practice Expense
The RUC reviewed and approved the direct practice expense inputs as approved by the Practice Expense Subcommittee. Paid invoices are attached for the *Ocular Response Analyzer*. Although the invoices are labelled sales quotes, the attached invoices are in fact what the manufacturer provides as the paid invoice. The purchasing clinical practice has indicated on the invoices that the order has been paid.

EOG VNG (Tab 24)
Paul Pessis, AuD (AAA); Leisha Eiten, AuD, CCC-A (AAA); Alan Desmond, AuD (AAA); John Lanza, MD (AAO-HNS) and Marianna Spanaki, MD, PhD (AAN)
Facilitation Committee #3

In February 2008, the CPT/RUC Joint Workgroup referred 92541, 92542, 92544, and 92545 to the CPT Editorial Panel for development of coding change proposals to condense the group of procedures into a single code and create new coding structures. In February 2009, the CPT Editorial Panel added new code 92540 to combine the four existing services as they are reported together more than 95% of the time. In April 2009, the RUC recommended maintaining the existing work RVUs for CPT codes 92541, 92542, 92544, and 92545. In October 2013 the RUC identified CPT code 92543 through the CMS-Other Source – Utilization over 250,000 screen and referred this issue the CPT Editorial Panel to revise the parentheticals prior to surveying the family (CPT codes 92541-92545). In February 2014, the CPT Editorial Panel added and revised the parenthetical notes for CPT code 92270*Electro-oculography with interpretation and report* and vestibular function tests to ensure appropriate reporting of these services. The RUC agreed that the vestibular function tests (92541-92545) be reviewed following the CPT modification to the parenthetical notes.

The specialty societies indicated that CPT codes 92541-92545 are all Harvard or CMS/Other valued services. The specialty societies indicated that there is compelling evidence that this family of services are potentially misvalued because these services had never been RUC surveyed and audiologists' had not been included in the original Harvard study/CMS valuations. Additionally, prior to 2009, the work of an audiologist was captured in the practice expense clinical labor inputs. However in 2009, when the work of these services was bundled and captured in CPT code 92540, the work RVUs were maintained but the audiologists time in the practice expense inputs were deleted. Therefore, the work of the audiologist is not currently captured in these services. The RUC agreed that there is compelling evidence that these services may be misvalued.

92541 ***Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording***
The RUC reviewed the survey results from 150 audiologists, otolaryngologists and neurologists for CPT code 92541 and recommends maintaining the current work RVU of 0.40. The RUC agreed with the specialty societies to reduce the pre-service and post-service time. Typically this service is performed with two other services in this family.

Therefore, the recommended reductions of 1/3 of the median surveyed pre and post-service times are appropriate. The RUC recommends 3 minutes pre-service, 10 minutes intra-service and 3 minutes immediate post-service time. The RUC determined that the survey median and 25th percentile work RVUs were too high and low respectively and did not appropriately value this service relative to the vestibular function testing family of services. Therefore, the RUC recommends maintaining the current work RVU of 0.40 for CPT code 92541. The RUC compared 92541 to the key reference service 92587 *Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report* (work RVU = 0.35) and noted that although 92541 requires 2 minutes less total time, it is more intense and complex on all measures as indicated by the survey respondents. For additional support the RUC referenced MPC code 92082 *Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)* (work RVU = 0.40) which requires the same physician work to perform. **The RUC recommends a work RVU of 0.40 for CPT code 92541.**

92542 ***Positional nystagmus test, minimum of 4 positions, with recording***
The RUC reviewed the survey results from 133 audiologists, otolaryngologists and neurologists for CPT code 92542 and determined that the survey 25th percentile work RVU of 0.48 appropriately accounts for the work required to perform this service. The RUC agreed with the specialty societies to reduce the pre-service and post-service time. Typically this service is performed with two other services in this family. Therefore, the recommended reductions of 1/3 of the pre and post-service times are appropriate. The RUC recommends 3 minutes pre-service, 10 minutes intra-service and 3 minutes immediate post-service time. The RUC determined that although 92542 requires the same physician time as 92541, 92542 is a more intense service which requires re-positioning the patient multiple times while evaluating the patient throughout the procedure. The RUC compared 92542 to the key reference service 95992 *Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day* (work RVU = 0.75) and noted that 92542 requires almost half the time and is less intense and complex, therefore should be valued lower. For additional support the RUC referenced MPC code 92082 *Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)* (work RVU = 0.40), which requires slightly less work to perform. **The RUC recommends a work RVU of 0.48 for CPT code 92542.**

92543 ***Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording***
The RUC discussed the confusion that survey respondents experienced valuing this service. Although the description states per irrigation, most respondents completed the survey taking into account the entire service of four irrigations. **The RUC recommends referring CPT code 92543 to the CPT Editorial Panel to better define this service, such as having one code to describe the initial irrigation and an add-on code to describe each additional irrigation.**

The RUC recognized that it needed to establish an interim value for 92543 until this service could be redefined by CPT. The RUC recommends directly crosswalking 92543 to similar service, CPT code 92550 *Tympanometry and reflex threshold measurements* (work RVU =0.35 and 3 minutes pre-service, 10 minutes intra-service and 3 minutes immediate post-service time). For additional support the RUC compared 92543 to 94621 *Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)* (work RVU = 1.42), which is comparable when equating the total service and total number of irrigations performed (0.35 x 4 irrigations = 1.40 work RVUs). **The RUC recommends an interim work RVU of 0.35, 3 minutes pre-time 10 minutes intra-time and 3 minutes immediate post-service time for CPT code 92543 and referral to the CPT Editorial Panel.**

92544 ***Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording***
The RUC reviewed the survey results from 118 audiologists, otolaryngologists and neurologists for CPT code 92544 and determined that the survey 25th percentile work RVU of 0.27 appropriately accounts for the work required to perform this service. The RUC agreed with the specialty societies to reduce the pre-service and post-service time. Typically this service is performed with two other services in this family. The RUC recommends 3 minutes pre-service, 5 minutes intra-service and 3 minutes immediate post-service time. The RUC compared 92544 to the key reference service 92567 *Tympanometry (impedance testing)* (work RVU = 0.20) and determined that 92544 requires more physician time and work, therefore it is appropriately valued higher. **The RUC recommends a work RVU of 0.27 for CPT code 92544.**

92545 ***Oscillating tracking test, with recording***
The RUC reviewed the survey results from 123 audiologists, otolaryngologists and neurologists for CPT code 92545 and determined that the survey 25th percentile work RVU of 0.25 appropriately accounts for the work required to perform this service. The RUC agreed with the specialty societies to reduce the pre-service and post-service time. Typically this service is performed with two other services in this family. The RUC recommends 3 minutes pre-service, 5 minutes intra-service and 3 minutes immediate post-service time. The RUC compared 92545 to the key reference service 92567 *Tympanometry (impedance testing)* (work RVU = 0.20) and determined that 92545 requires more physician time and work, therefore it is appropriately valued higher. **The RUC recommends a work RVU of 0.25 for CPT code 92545.**

Practice Expense
The Practice Expense Subcommittee had one minor modification, removing a "syringe 20 ml" from the direct practice expense inputs for CPT code 92543. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

<u>Interventional Transesophageal Echocardiography (TEE) (Tab 25)</u>
Richard Wright, MD (ACC); Michael Main, MD (ACC); Mark Leib, MD (ASA); Richard Rosenquist, MD (ASA) and Christopher Troianos, MD (ASA)
Facilitation Committee #2

In February 2014, the CPT Editorial Panel created CPT code 93355 to address the added physician work, time and practice expense required to perform transesophageal echocardiography during interventional cardiac procedures. CPT codes 93312-93318 were added for review to ensure intra-family relativity.

Prior to making recommendations for this set of services, the specialty societies presented compelling evidence that these codes are potentially misvalued. There are three primary compelling evidence arguments:

1. Change in technique: When these procedures were last reviewed in 1996, the Intersocietal Accreditation Commission (IAC) had not issued standards for adult transesophageal echocardiography testing. These did not arrive until 1997. Last updated in 2013, these standards are extensive. Furthermore, the Society of Cardiovascular Anesthesiologists recently issued (in 2013) a document titled "Guidelines for Performing a Comprehensive Transesophageal Echocardiographic Examination," which also lays out extensive standards. As a result of these robust standards, the typical physician time to perform this service has increased. The IAC Standards and Guidelines for Adult Echocardiography Accreditation note that the total procedure time is estimated to be between 45 and 60 minutes for the typical patient scenario. This exceeds the current physician time of 43 minutes for CPT code 93312. Therefore, the lack of any standard examination at the time of the initial RUC valuation, and the presence of these current very rigorous criteria, clearly demonstrates a significant change in required technique.
2. Change in technology: Transesophageal echocardiography achieved widespread clinical adoption in the 1980s. Originally, only single plane (and then subsequently biplane) transducers were available. Using these early transducers (available at the time of the original RUC valuation in 1994), only limited views were available, and examination length was significantly truncated. At present, all TEE imaging is performed with multiplane transducers which allows much more detailed, definitive, and time consuming examinations (multiplane transducers are mandated by current IAC and professional society standards). During the period of the initial RUC review, multiplane transesophageal echocardiography was new technology, and not yet routinely available for clinical practice.
3. Change in knowledge: Prior to the original RUC review and valuation in 1994, there were few published studies which evaluated TEE safety. The IAC standards now allow that "TEE is an invasive examination," and recent published reports estimate the risk of death secondary to TEE complications at 1:10,000, with the risk of major complications estimated at 0.2% to 0.5%. Careful attention to the patient's medical history and deferral of TEE in patients with a history of dysphasia, or other known upper gastrointestinal tract pathology is mandatory. Review of the medical history and medical decision making related to proceeding with or deferring the examination adds significantly to the pre-procedural time and intensity, and physician psychological stress during the whole of the procedure.

   Given these arguments, the RUC accepted compelling evidence that the current value for these TEE codes may be potentially misvalued.

93312 ***Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report***

The RUC reviewed the survey results from 131 cardiologists and anesthesiologists and agreed with the specialty societies that the following physician time components are appropriate: pre-service time of 15 minutes, intra-service time of 30 minutes and immediate post-service time of 15 minutes.

The RUC reviewed the survey respondents' estimated work values and agreed that while the median work RVU of 3.40 was slightly high, the 25th percentile work RVU of 2.25 was too low. Therefore, in order to value this service the RUC reviewed CPT code 43247 *Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body* (work RVU=3.18, 30 minutes intra-service time) and noted that both services have identical intra-service time and comparable total time. The RUC agreed to directly crosswalk the work RVUs of 43247 to the surveyed code 93312. To justify a work value of 3.18, the RUC reviewed CPT code 32557 *Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance* (work RVU=3.12, intra-service time= 30 minutes) and agreed that since both codes have identical intra-service time and comparable physician work, the recommended value is appropriately valued relative to other services across the RBRVS. **The RUC recommends a work RVU of 3.18 for CPT code 93312.**

93313 ***Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only***
The RUC reviewed the survey results from 38 cardiologists and anesthesiologists and agreed with the specialty societies that the following physician time components are appropriate: pre-service time of 5 minutes and intra-service time of 10 minutes. The RUC agreed to lower the pre-service time from the median survey time of 12 minutes because the physician is waiting for the second operator to place the probe.

The RUC reviewed the survey respondents' estimated work values and agreed that the median work RVU of 1.00 is an accurate value for this service. To justify this value, the RUC compared the surveyed code to CPT code 78472 *Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing* (work RVU= 0.98) and agreed that since both codes have the same time components, they should both be valued similarly. In addition, the RUC reviewed CPT code 72192 *Computed tomography, pelvis; without contrast material* (work RVU= 1.09) and MPC code 23350 *Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography* (work RVU= 1.00) and agreed that both these services provide justification for the RUC recommended value for 93313. **The RUC recommends a work RVU of 1.00 for CPT code 93313.**

93314 ***Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only***
The RUC reviewed the survey results from 54 cardiologists and anesthesiologists and agreed with the specialty societies that the following physician time components are appropriate: pre-service time of 15 minutes, intra-service time of 30 minutes and immediate post-service time of 15 minutes.

The RUC reviewed the survey respondents' estimated work values and agreed that the median work RVU of 2.80 is an accurate value for this service. To justify this value, the RUC compared the surveyed code to CPT code 75573 *Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)* (work RVU= 2.55) and agreed that while both services have identical intra-service time, 30 minutes, 93314 is a more intense procedure and is accurately valued higher than this

reference code. In addition, the RUC reviewed CPT code 10030 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous* (work RVU= 3.00) and noted that both services have identical intra-service time, but the reference code has more total time and should thus be valued slightly higher than 93314. **The RUC recommends a work RVU of 2.80 for CPT code 93314.**

93315 ***Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report***
The RUC reviewed the survey results from 42 cardiologists and anesthesiologists and agreed with the specialty societies that the following physician time components are appropriate: pre-service time of 15 minutes, intra-service time of 40 minutes and immediate post-service time of 15 minutes.

The RUC reviewed the survey respondents' estimated work values and agreed that the median work RVU of 3.29 is an accruate value for this service. To justify this value, the RUC compared the surveyed code to CPT code 36147 *Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report* (work RVU= 3.72) and agreed that since the reference code has more total time compared to 93315, 80 minutes and 70 minutes, respectively, 36147 should be valued higher than the surveyed code. The RUC also reviewed CPT code 95953 *Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended* (work RVU= 3.08) and agreed while both services have identical total times, this reference code is slightly less intense than the surveyed code and is correctly valued less. Finally, the RUC compared 93315 to 93312 and noted that this service is more complex because this service is performed on pediatric patients with complex anatomy and should be valued slightly higher than the adult service. **The RUC recommends a work RVU of 3.29 for CPT code 93315.**

93316 ***Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only***
The RUC reviewed the survey results for CPT code 93316 and agreed with the specialty societies that the following physician time components are appropriate: pre-service time of 5 minutes and intra-service time of 20 minutes. The RUC agreed to lower the pre-service time from the median survey time of 15 minutes because the physician is waiting for the second operator to place the probe.

The RUC reviewed the survey respondents' estimated work values and agreed that the median work RVU of 1.50 is an accruate value for this service. To justify this value, the RUC compared the surveyed code to CPT codes 72148 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material* (work RVU= 1.48, intra-service time= 20 minutes) and 93350 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report* (work RVU= 1.46, intra-service time= 20 minutes) and noted that both reference codes have identical intra-service and comparable physician work relative to 93316. Furthermore, the RUC noted that this value fits into appropriate rank order compared to 93313 as it is a more intense

and longer procedure. **The RUC recommends a work RVU of 1.50 for CPT code 93316.**

93317 ***Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only***
The RUC reviewed the survey results for CPT code 93316 and agreed with the specialty societies that the following physician time components are appropriate: pre-service time of 15 minutes, intra-service time of 30 minutes and immediate post-service time of 15 minutes.

The RUC reviewed the survey respondents' estimated work values and agreed that the median work RVU of 3.00 is an accruate value for this service. To justify this value, the RUC compared the surveyed code to CPT code 10030 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous* (work RVU= 3.00) and noted that both services have identical intra-service time, 30 minutes, and should thus be valued the same. The RUC also compared this service to the comparable 93314 service and agreed that while both codes have the same time components, the increased intensity for 93317 justifies a slightly higher work value. **The RUC recommends a work RVU of 3.00 for CPT code 93317.**

93318 ***Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis***
The RUC reviewed the survey results from 55 cardiologists and anesthesiologists and agreed with the specialty societies that the following physician time components are appropriate: pre-service time of 15 minutes, intra-service time of 60 minutes and immediate post-service time of 15 minutes.

The RUC reviewed the survey respondents' estimated work values and agreed that the 25th percentile work RVU of 2.40 is an accruate value for this service. To justify this value, the RUC compared the surveyed code to CPT code 75563 *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging* (work RVU= 3.00) and noted that while both services have identical intra-service time, 60 minutes, the reference code is a more intense procedure and is thus accurately valued higher than 93318. The RUC also reviewed CPT code 38241 *Hematopoietic progenitor cell (HPC); autologous transplantation* (work RVU= 3.00, intra time= 60 minutes) and agreed that since the reference code has more total time than the surveyed code, 108 minutes and 90 minutes, respectively, it should be valued higher. **The RUC recommends a work RVU of 2.40 for CPT code 93318.**

93355 ***Echocardiography, transesophageal (TEE) for guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (e.g., TAVR, transcatheter pulmonary valve replacement, mitral valve repair, paravalvular regurgitation repair, left atrial appendage occlusion/closure, ventricular septal defect closure) (peri- and intra-procedural), real time image acquisition and documentation, guidance with quantitative measurements, probe manipulation, interpretation and report, including diagnostic transesophageal echocardiography, and, when performed, administration of ultrasound contrast, Doppler, color flow, and 3D***

The RUC reviewed the survey results from 57 cardiologists and anesthesiologists and agreed with the specialty societies that the following physician time components are appropriate: pre-service time of 20 minutes, intra-service time of 120 minutes and immediate post-service time of 20 minutes. The RUC discussed the large time variations between this interventional guidance TEE procedure and the traditional diagnostic procedure, and agreed that the variance is appropriate. This new service includes seamless performance of pre-, intra-, and post-interventional procedure TEE imaging in the hybrid/operating room. The TEE physician is present during this entire procedure, providing ongoing real-time guidance which enables proper device selection, positioning, and deployment, including diagnosis/exclusion of procedure-related complications.

The RUC reviewed the survey respondents' estimated work values and agreed that the median work RVU of 4.66 is an accruate value for this service. To justify this value, the RUC compared the surveyed code to CPT code 77338 *Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan* (work RVU= 4.29) and noted that the reference code has slightly less intra-service time, 115 minutes compared to 120 minutes, and less total time. Therefore, the recommended value of 4.66 for 93355 accurately places it relative to this comparable service. The RUC also compared the surveyed code to the other codes in the family and noted that with longer times and high complexity, 93355 is correctly valued as the highest procedure. **The RUC recommends a work RVU of 4.66 for CPT code 93355.**

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

Carotid Intima-Media Thickness Ultrasound (Tab 26)
Richard Wright, MD (ACC); Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); Gregory Nicola, MD (ASNR); Joshua Hirsch, MD (ASNR)

In February 2014, the CPT Editorial Panel created a new code to describe the work of using carotid ultrasound to measure atherosclerosis and quantify the intima-media thickness.

93895 ***Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral***
The RUC reviewed survey results from 47 cardiologists, neuroradiologists and radiologists. The RUC determined that the survey median of work RVU 0.55 appropriately accounts for the work required to perform this service. The RUC determined that the following physician time components of 5 minutes of pre-service, 10 minutes of intra-service and 5 minutes of post-service compare well with the key reference service CPT code 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), which is also on the MPC list. For additional support, the RUC referenced MPC code 93224 *External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional* (work RVU = 0.52; 2 minutes pre-service, 15 minutes intra-service, and 7 minutes post-service). As this service becomes more widespread, the RUC questioned what type of physicians would be providing this service, primary care or specialists, such as radiologists and cardiologists. The RUC

determined that primary care physicians will be the primary providers of this service and requested that this service be re-reviewed in April 2015 with primary care societies also participating in the survey process and presentation. No primary care specialty declared a level of interest in the current survey. **The RUC recommends a work RVU of 0.55 as an interim value until April 2015 when this code will be reviewed with the participation of primary care physicians as primary providers of the service.**

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

Practice Expense
The RUC recommends the direct practice expense inputs with minor modifications as accepted by the Practice Expense Subcommittee.

Brief Behavioral Assessment-PE Only (Tab 27)
Steve Krug, MD, FAAP (AAP); Randy Phelps, PhD (APA)

In October 2013, the CPT Editorial Panel created a new code to describe brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/ hyperactivity disorder (ADHD) scale), with scoring and documentation. At the January 2014 RUC meeting, the Practice Expense Subcommittee requested clarification on the type of individual who was providing the scoring of a standardized pediatric inventory. The specialty societies decided to postpone the issue and seek clarification regarding who performs the service; a non-physician qualified healthcare professional, clinical staff or administrative staff and the issue was postponed to the April 2014 RUC meeting. At the February 2014 CPT Panel meeting, the Panel removed language from the description of service that referred to a non-physician qualified healthcare professional as providing the service in order to clarify that it is clinical staff that provide and score the instrument.

The RUC reviewed and approved the direct practice expense inputs with no modifications as recommended by the Practice Expense Subcommittee.

Chronic Care Management (Tab 28)
John Agens, MD (AGS); Thomas Weida, MD (AAFP); Marianna Spinaki, MD, PhD (AAN); Mary Newman, MD (ACP); Joseph Schlecht, DO (AOA); Robert DeMarco, MD (ACCP); Katina Nicolacakis, MD (ATS); Michael Lill, MD (ASBMT); Phillip Rodgers, MD (AAHPM); Charles Crecelius, MD (AMDA)

In May 2012, the CPT Editorial Panel created three new codes to describe complex chronic care management services that are patient-centered management and support services. These CPT codes were designed to describe a complex patient who requires changes in the care plan and significant clinical staff resources (i.e., typically 60 minutes of nurse care coordination in a calendar month). In the MPFS Final Rule for 2014, CMS broadened the proposal to capture all patients receiving 20 minutes or more of clinical staff management time to address two or more chronic conditions, expected to last at least 12 months or until the death of the patient, that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline.

A number of specialty societies submitted a coding change proposal to the CPT Editorial Panel to establish one new CPT code for chronic care management (CCM). The proposed

code for CCM has the same descriptor as the G code proposed by CMS. In February 2014, the CPT Editorial Panel created a new code to describe chronic care management and new introductory language. CPT decided to retain CPT codes 99487 and 99489 and to delete CPT code 99488, *Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month* (the complex chronic care management (CCCM) code that included a face-to-face visit). The CPT coding structure starting in January 2015 will be as follows: 99487 and 99489 will exist as a family of two codes that, when appropriate, will be used together to describe *complex* chronic care management per calendar month for 60 minutes of clinical staff time and add-on for 30 minutes of clinical staff time; 99490 will exist as a separate stand-alone code to describe chronic care management per calendar month with at least 20 minutes of clinical staff time.

The RUC noted it was important that 99490 be surveyed on its own, with only the new CPT instructions for 99490 available to respondents. The specialty societies indicated that codes 99487 and 99489 were not included on the reference service list, so the respondents would not confuse the new code with CPT codes 99487 and 99489. The specialty societies noted that the clinical staff time for the other non-face-to-face chronic care management code, 99487, was not surveyed back in 2012 because the descriptor specified "60 minutes" of clinical staff time was required to report 99487. However, the descriptor for 99490 says "*at least 20 minutes of clinical staff time.*" Therefore, the actual staff time is not specified, so the specialty societies determined it was important to survey for "typical" clinical staff time in order to make sure the code was accurately valued. Two questions regarding the amount of clinical staff time were added to the survey: one for the amount of time spent by clinical staff performing clinical staff activities and a second question asking how much physician time was spent performing clinical staff activities. It is important to note that the standard questions for physician work and physician time spent on supervision were also asked. Therefore, the survey asked three questions regarding time in this survey: (2a) asked about physician time spent supervising, (2b) asked about clinical staff activities performed by clinical staff and (2c) asked about clinical staff activities performed by the physician. *Please see the attached document and spreadsheet providing this additional information on clinical staff time further breakdown.*

99490 ***Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:***

- ***multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,***
- ***chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,***
- ***comprehensive care plan established, implemented, revised, or monitored***

(Chronic care management services of less than 20 minutes duration, in a calendar month, are not reported separately)

The RUC reviewed the survey results from 338 physicians for CPT code 99490 and determined that the survey 25th percentile work RVU of 1.00 and 30 minutes intra-service time appropriately accounted for the work required to perform this service. The specialty societies indicated and the RUC agreed that the physician work of supervising chronic care management required for 99490 is the same as 99487 *Complex chronic care management* (RUC recommended work RVU = 1.00), which also includes 60 minutes of

clinical staff time. The RUC noted that the survey median work RVU of 1.50 would cause a rank order anomaly. The RUC also compared 99490 to the key reference service 99214 and determined that the work and physician time required to perform 99490 is less, therefore is appropriately valued lower. The RUC confirmed the proper rank order with the following Evaluation and Management services: 99367 *Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician* (work RVU = 1.10), 99339 *Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities…15-29 minutes* (work RVU = 1.25), 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 1.42) and 99340 *Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities…30 minutes or more* (work RVU = 1.80). For additional support the RUC referenced MPC code 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report* (work RVU = 0.85). **The RUC recommends a work RVU of 1.00 for CPT code 99490.**

New Technology/New Services List:
The specialty societies requested and the RUC agrees that CPT code 99490 be added to the new technology/new services list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

Practice Expense
The Practice Expense Subcommittee noted that typical clinical staff type providing the service is an RN (L051A) not an RN/LPN/MTA (L037D) blend for 60 minutes of clinical staff time. The PE Subcommittee recognized that, under certain circumstances, other individuals with less than an RN degree may be performing components of these services up to the extent allowable by their states' scope of practice. However, the PE Subcommittee valued this service as the typical scenario as an RN performing this service. The RN is assessing a patient with multiple chronic conditions and of all the physicians queried in providing these services over the last decade, all indicated they have worked only with an RN. **The RUC recommends 60 minutes of clinical labor time performed by an RN (L051A) as recommended by the Practice Expense Subcommittee.**

Application of Topical Fluoride Varnish (Tab 29)
William Frese, MD, FAAP (AAP); Steve Krug, MD, FAAP (AAP)

CPT Code 99188 was developed as a new code during the February 2014 CPT Editorial Panel meeting. This code describes the application of topical fluoride varnish to the teeth of young children by pediatricians or other qualified health care professionals.

99188 ***Application of topical fluoride varnish by a physician or other qualified health care professional***
The RUC reviewed the survey results from 145 pediatricians and recommends the median work RVU of 0.20 for CPT code 99188. The RUC recommends 2 minutes of pre-service time, 5 minutes intra-service and 2 minutes post-service time. The RUC determined that this code compared well with the key reference service CPT code 92567 *Tympanometry (impedance testing)* (work RVU = 0.20, 1 minute pre-time, 4 minutes

intra-service time, 1 minute post-service) The RUC noted that code 99188 requires one additional minute of pre, intra and post-service time compared to this key reference service. The RUC also compared code 99188 to CPT code 99211 *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services* (work RVU = 0.18, 5 minutes intra-service time) which has similar time and intensity measures. The RUC determined that for this comparison, recommending a higher work value is warranted because 99188 describes a slightly more intense service. It was noted that a child may not be cooperative during this procedure, reflecting an appropriate time and intensity for the application by the physician. **The RUC recommends a work RVU of 0.20 for code 99188.**

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

XI. CMS Request/Relativity Assessment Identified Codes

Laparoscopic Hysterectomy (Tab 30)
George A. Hill, MD (ACOG)
Facilitation Committee #1

These services were identified through the New Technology/New Services List in April 2007. In October 2013, the Relativity Assessment Workgroup noted there may have been diffusion in technology for this service and requests that the specialty society's survey physician work and review practice expense at the January 2014 meeting. In January 2014, the specialty societies requested and the RUC agreed that these services be postponed to April 2014 RUC meeting. The specialty societies determined that the vignettes to be included in the survey were not typical. The RUC recommended that these services be postponed and surveyed, with revised vignettes, for physician work and develop direct practice expense inputs for the April 2014 RUC meeting.

The RUC had a robust discussion reviewing this family of services and used magnitude estimation to develop its recommendations. The RUC is recommending direct crosswalks for all eight laparoscopic hysterectomy codes. The specialty society concurred with this approach. The recommended work RVUs are all below the survey 25th percentile results. Additionally, the specialty society reduced all the full-day 99238 visits to a half-day 99238.

These recommendations result in appropriate rank order and consistent differentials related to uterine size and procedural differences (total hysterectomy versus cervical sparing hysterectomy and whether or not bilateral salpingo-oophorectomy is performed). These differentials were used to confirm the selected crosswalks, but not to determine the values recommended.

58541 ***Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;***
The RUC reviewed the survey results for CPT code 58541and noted that there has been diffusion in the technology for this service since its previous valuation. The specialty society noted that an additional 5 minutes of pre-positioning time to pre-time package 3 is necessary to place the patient in the dorsal lithotomy position. The RUC agreed with the

following physician times: 56 minutes pre-time, 75 minutes intra-service time 30 minutes immediate post-service time a half-day 99238 and two 99213 office visits. The physician work and time required to perform this service has decreased, however the survey 25th percentile work RVU is higher than the current work RVU of 14.70. Therefore, the RUC recommends a direct crosswalk to 59150 *Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy* (work RVU = 12.29 and 70 minutes intra-service time). For additional support the RUC referenced MPC codes 57288 *Sling operation for stress incontinence (eg, fascia or synthetic)* (work RVU = 12.13) and 58720 *Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)* (work RVU = 12.16). **The RUC recommends a work RVU of 12.29 for CPT code 58541.**

58542 ***Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)***
The RUC reviewed the survey results for CPT code 58542 and noted that there has been diffusion in the technology for this service since its previous valuation. The specialty society noted that an additional 5 minutes of pre-positioning time to pre-time package 3 is necessary to place the patient in the dorsal lithotomy position. The RUC agreed with the following physician times: 56 minutes pre-time, 88 minutes intra-service time 30 minutes immediate post-service time a half-day 99238 and two 99213 office visits. The physician work and time required to perform this service has decreased, however the survey 25th percentile work RVU is higher than the current work RVU of 16.56. Therefore, the RUC recommends a direct crosswalk to 27416 *Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])* (work RVU = 14.16 and 90 minutes intra-service time). For additional support the RUC referenced MPC codes 53445 *Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff* (work RVU = 13.00) and 52649 *Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* (work RVU = 14.56). **The RUC recommends a work RVU of 14.16 for CPT code 58542.**

58543 ***Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;***
The RUC reviewed the survey results for CPT code 58543 and noted that there has been diffusion in the technology for this service since its previous valuation. The specialty society noted that an additional 5 minutes of pre-positioning time to pre-time package 3 is necessary to place the patient in the dorsal lithotomy position. The RUC agreed with the following physician times: 56 minutes pre-time, 110 minutes intra-service time 30 minutes immediate post-service time a half-day 99238 and two 99213 office visits. The physician work and time required to perform this service has decreased, however the survey 25th percentile work RVU is higher than the current work RVU of 16.87. Therefore, the RUC recommends a direct crosswalk to 64911 *Nerve repair; with autogenous vein graft (includes harvest of vein graft), each nerve* (work RVU = 14.39 and 120 minutes intra-service time). For additional support the RUC referenced MPC codes 52649 *Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* (work RVU = 14.56) and 52601 *Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal*

urethrotomy are included) (work RVU = 15.26). **The RUC recommends a work RVU of 14.39 for CPT code 58543.**

58544 ***Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)***
The RUC reviewed the survey results for CPT code 58544and noted that there has been diffusion in the technology for this service since its previous valuation. The specialty society noted that an additional 5 minutes of pre-positioning time to pre-time package 3 is necessary to place the patient in the dorsal lithotomy position. The RUC agreed with the following physician times: 56 minutes pre-time, 120 minutes intra-service time 30 minutes immediate post-service time a half-day 99238 and two 99213 office visits. The physician work and time required to perform this service has decreased, however the survey 25th percentile work RVU is higher than the current work RVU of 18.37. Therefore, the RUC recommends a direct crosswalk to 60500 *Parathyroidectomy or exploration of parathyroid(s);* (work RVU = 15.60 and 120 minutes intra-service time). For additional support the RUC referenced MPC codes 52649 *Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* (work RVU = 14.56) and 52601 *Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)* (work RVU = 15.26). **The RUC recommends a work RVU of 15.60 for CPT code 58544.**

58570 ***Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;***
The RUC reviewed the survey results for CPT code 58570 and noted that there has been diffusion in the technology for this service since its previous valuation. The physician work and time required to perform this service has decreased, however the survey 25th percentile work RVU is higher than the current work RVU of 15.88. Therefore, the RUC recommends a direct crosswalk to 53440 *Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)* (work RVU = 13.36 and 90 minutes intra-service time). For additional support the RUC referenced MPC codes 53445 *Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff* (work RVU = 13.00) and 52649 *Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* (work RVU = 14.56). **The RUC recommends a work RVU of 13.36 for CPT code 58570.**

58571 Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
The RUC reviewed the survey results for CPT code 58571 and noted that there has been diffusion in the technology for this service since its previous valuation. The specialty society noted that an additional 5 minutes of pre-positioning time to pre-time package 3 is necessary to place the patient in the dorsal lithotomy position. The RUC agreed with the following physician times: 56 minutes pre-time, 90 minutes intra-service time 30 minutes immediate post-service time a half-day 99238 and two 99213 office visits. The physician work and time required to perform this service has decreased, however the survey 25th percentile work RVU is higher than the current work RVU of 17.69. Therefore, the RUC recommends a direct crosswalk to 29915 *Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)*(work RVU = 15.00 and 90 minutes intra-service time).

For additional support the RUC referenced MPC codes 52649 *Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* (work RVU = 14.56) and 52601 *Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)* (work RVU = 15.26). **The RUC recommends a work RVU of 15.00 for CPT code 58571.**

58572 Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g;
The RUC reviewed the survey results for CPT code 58572 and noted that there has been diffusion in the technology for this service since its previous valuation. The specialty society noted that an additional 5 minutes of pre-positioning time to pre-time package 3 is necessary to place the patient in the dorsal lithotomy position. The RUC agreed with the following physician times: 56 minutes pre-time, 120 minutes intra-service time 30 minutes immediate post-service time a half-day 99238 and two 99213 office visits. The physician work and time required to perform this service has decreased, however the survey 25th percentile work RVU is higher than the current work RVU of 20.09. Therefore, the RUC recommends a direct crosswalk to 28446 *Open osteochondral autograft, talus (includes obtaining graft[s]) (*work RVU = 17.71 and 120 minutes intra-service time). For additional support the RUC referenced MPC codes 58150 *Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);* (work RVU = 17.31) and 50220 *Nephrectomy, including partial ureterectomy, any open approach including rib resection;* (work RVU = 18.68). **The RUC recommends a work RVU of 17.71 for CPT code 58572.**

58573 Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
The RUC reviewed the survey results for CPT code 58573 and noted that there has been diffusion in the technology for this service since its pervious valuation. The specialty society noted that an additional 5 minutes of pre-positioning time to pre-time package 3 is necessary to place the patient in the dorsal lithotomy position. The RUC agreed with the following physician times: 56 minutes pre-time, 130 minutes intra-service time 30 minutes immediate post-service time a half-day 99238 and two 99213 office visits. The physician work and time required to perform this service has decreased, however the survey 25th percentile work RVU is higher than the current work RVU of 23.11. Therefore, the RUC recommends a direct crosswalk to 43771 *Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only (*work RVU = 20.79 and 120 minutes intra-service time). For additional support the RUC referenced MPC codes 50546 *Laparoscopy, surgical; nephrectomy, including partial ureterectomy* (work RVU = 21.87) and 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection* (work RVU = 19.68). **The RUC recommends a work RVU of 20.79 for CPT code 58573.**

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 recommends the standard 090-day global direct practice expense inputs as approved by the Practice Expense Subcommittee.

Prostatectomy (Tab 31)
Norm Smith, MD (AUA); Tom Turk, MD (AUA); Martin Dineen, MD (AUA); Phil Wise, MD (AUA)

In October 2013, the RUC recommended that the specialty survey Harvard-valued CPT codes 55840, 55842 and 55845 for the April 2014 RUC meeting. The RUC also recommended maintaining CPT code 55866, since it was recently reviewed in October 2009, and there is no evidence of a change in technology to perform this service. In the Proposed Rule for 2014, CMS requested that CPT codes 55845 and 55866 be reviewed through the potentially misvalued services process. The specialty society submitted action plans in October 2013. The RUC requested that CPT codes 55840, 55842 and 55845 be surveyed for the April 2014 RUC meeting. Subsequently, CMS added 55866 to be reviewed as part of the family.

55840 ***Prostatectomy, retropubic radical, with or without nerve sparing;***
The RUC reviewed the survey results from 38 urologists and agreed with the specialty on the following physician time components: pre-service time of 51 minutes (the standard pre-time package of 3 *Straightforward Patient/Difficult Procedure in a facility*), intra-service time of 180 minutes and immediate post-service time of 33 minutes (the standard post-time package 9B). The RUC agreed with the specialty that two hospital visits were appropriate with the first visit on the day of surgery (99231) and the other on the first post-operative day (99232), where the patient is assessed for pain, hemodynamics and bladder spasms. The RUC also agreed that a full discharge day (99238), which typically occurs on the second post-operative day, is appropriate for this inpatient procedure. Finally, the RUC agreed that the following office visits during the 90-day global period were justified: one 99214 office visit which includes decatheterization, the teaching of Kegel exercises and review of the final pathology report, one 99213 office visit which includes checking on continence and the discussion of penile rehabilitation for return of erectile function and one 99213 office visit which includes reviewing the PSA test and following up on continence and sexual function.

The RUC reviewed the survey respondents' estimated physician work values and agreed that they were overvalued, with a 25th percentile work RVU of 24.13. To determine an appropriate work value, the RUC compared the surveyed code to CPT code 50542 *Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed* (work RVU= 21.36) and agreed that since both services have identical intra-service time of 180 minutes and a nearly identical total time (448 minutes versus 449 minutes), they should be valued the same. Therefore, the RUC recommends a direct work RVU crosswalk from code 50542 to code 55840. To further justify a work RVU of 21.36 for 55840, the RUC reviewed CPT code 50220 *Nephrectomy, including partial ureterectomy, any open approach including rib resection;* (work RVU= 18.68, intra-time of 120 minutes) and noted that the surveyed code has a much higher intra-service time, as well as a slightly higher total time (448 minutes versus 432 minutes), and is therefore, correctly valued higher than 50220. **The RUC recommends a work RVU of 21.36 for CPT code 55840.**

55842 ***Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)***
The RUC reviewed the survey results from 36 urologists and agreed with the specialty on the following physician time components: pre-service time of 51 minutes (the standard pre-time package of 3 *Straightforward Patient/Difficult Procedure in a facility*), intra-service time of 180 minutes and immediate post-service time of 33 minutes (the standard post-time package 9B). The RUC agreed with the specialty that two hospital visits were appropriate with the first visit on the day of surgery (99231) and the other on the first post-operative day (99232), where the patient is assessed for pain, hemodynamics and bladder spasms. The RUC also agreed that a full discharge day (99238), which typically occurs on the second post-operative day, is appropriate for this inpatient procedure. Finally, the RUC agreed that the following office visits during the 90-day global period were justified: one 99214 office visit which includes decatheterization, the teaching of Kegel exercises and review of the final pathology report, one 99213 office visit which includes checking on continence and the discussion of penile rehabilitation for return of erectile function and one 99213 office visit which includes reviewing the PSA test and following up on continence and sexual function.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey 25th percentile work RVU of 24.16 is appropriate. The RUC compared the surveyed code to the key reference service 50240 *Nephrectomy, partial* (work RVU= 24.21) and noted that since both services have identical intra-service time of 180 minutes, as well as similar intensity as reported by survey respondents, the work value of 24.16 is appropriate. To further justify a work RVU of 24.16, the RUC reviewed CPT code 38724 *Cervical lymphadenectomy (modified radical neck dissection)* (work RVU= 23.95) and noted that both services have identical intra-service time of 180 minutes and similar intensities. **The RUC recommends a work RVU of 24.16 for CPT code 55842.**

55845 ***Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes***
The RUC reviewed the survey results from 32 urologists and agreed with the specialty on the following physician time components: pre-service time of 51 minutes (the standard pre-time package of 3 *Straightforward Patient/Difficult Procedure in a facility*), intra-service time of 198 minutes and immediate post-service time of 33 minutes (the standard post-time package 9B). The RUC agreed with the specialty that two hospital visits were appropriate with the first visit on the day of surgery (99231) and the other on the first post-operative day (99232), where the patient is assessed for pain, hemodynamics and bladder spasms. The RUC also agreed that a full discharge day (99238), which typically occurs on the second post-operative day, is appropriate for this inpatient procedure. Finally, the RUC agreed that the following office visits during the 90-day global period were justified: one 99214 office visit which includes decatheterization, the teaching of Kegel exercises and review of the final pathology report, one 99213 office visit which includes checking on continence and the discussion of penile rehabilitation for return of erectile function and one 99213 office visit which includes reviewing the PSA test and following up on continence and sexual function.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey median work RVU of 29.07 is appropriate. To justify a work RVU of 29.07, the RUC compared the surveyed code to CPT code 43282 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh* (work RVU= 30.10) and noted that the surveyed code has a slightly lower intra-service

time (198 minutes versus 210 minutes), though a slightly higher total time (454 minutes versus 466 minutes), which supports a similar work value between the two services. The RUC also compared the surveyed code to CPT code 32670 *Thoracoscopy, surgical; with removal of two lobes (bilobectomy)* (work RVU= 28.52) and noted that the surveyed code has a higher intra-service time (198 minutes versus 180 minutes), which confirms that the RUC recommended work value is appropriate. **The RUC recommends a work RVU of 29.07 for CPT code 55845.**

55866 ***Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed***
Code 55866 was identified as a CMS Fastest Growing service in 2007. In February 2008 the Relativity Assessment Workgroup (RAW) recommended that the specialty society develop a coding proposal to separate code 55866 into two codes to distinguish between robotic and non-robotic laparoscopic prostatectomy. The CPT Editorial Panel determined that the code should describe the typical method and not be separated into two codes. The Relativity Assessment Workgroup recommended that 55866 be reviewed at the October 2009 RUC meeting. At the October 2009 RUC meeting, the RUC determined the survey 25th percentile work RVU of 32.06 was appropriate and the parenthetical (including robotic when performed) should be added to the descriptor. Code 55866 was added to the new technology list for review at the September 2014 RAW meeting.

In the Final Rule for 2014, CMS requested review of CPT codes 55845 and 55866 as potentially misvalued because the work RVUs for the laparoscopic procedure are higher than for the open procedure and, in general, a laparoscopic procedure would not require greater resources than the open procedure. CMS noted that most of the commenters indicated that it was appropriate that the work RVUs be higher for CPT code 55866 than for CPT code 55845. CMS believes that there are enough questions about how these codes should be valued that they finalized the proposal to review these codes as potentially misvalued codes. **The RUC recommends that the specialty societies submit an action plan for the September 2014 RAW meeting.**

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

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

<u>Laminectomy (Tab 32)</u>

In 2011, CMS identified CPT code 63047 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar* as potentially misvalued through the CMS High Expenditure Procedural Codes screen. The specialty societies added CPT code 63048 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)* to be reviewed as part of this family of services. The RUC submitted recommendations for codes 63047 and 63048 for CY 2014. In the Final Rule for 2014,

CMS requested that CPT codes 63045 and 63046 be reviewed in concert with 63047 and 63048 and valued these services as interim until 63045 and 63046 are reviewed.

No specialty societies indicated an interest to survey these services. The specialty societies who typically perform these services and the RUC commented that CMS should have requested that these services be reviewed when the Agency initially identified CPT code 63047. Nevertheless, the specialty societies indicated that these two sets of services are not the same family. The specialty societies noted that 63045 and 63046 represent very different physician work; the spinal cord is present at these levels, and the techniques for bone removal as well as physician stress and risk of complications are very different as a result. In addition, 63045 and 63046 represent a small proportion (<15%) of the aggregate volume of what CMS has now declared to be the "family" of codes.

The RUC agreed that it would have been less burdensome on the specialty societies if all of these services were identified and surveyed at the same time. However, the RUC noted CPT codes 63045 and 63046 are Harvard valued, the Medicare utilization is slowly increasing and these services should be surveyed. **The RUC recommends that CPT codes 63045 and 63046 be surveyed for September 2014.**

Duplex Scans (Tab 33)
Matthew Sideman, MD (SVS); Robert Zwolak, MD (SVS); Michael Sutherland, MD (SVS); David Han, MD (SVS); Gary Seabrook, MD (SVS); Zeke Silva, MD (ACR) Kurt Schoppe, MD (ACR) and Richard Wright, MD (ACC)

In 2011, CMS identified CPT code 93880 as potentially misvalued through the CMS High Expenditure Procedural Codes screen. The specialty societies added CPT code 93882 to be reviewed as part of this family of services. The RUC submitted recommendations for codes 93880 and 93882 for CY 2014. In the 2013 PFS Final Rule with comment period, CMS reviewed 93925 and 93926, which were identified through the CMS-Other - Utilization over 500,000 screen. CMS disagreed with the respective AMA RUC recommended work RVUs of 0.90 and 0.70 and established interim final values of 0.80 and 0.50 instead. CMS believes the AMA RUC recommended values for these two sets of codes do not maintain the appropriate relative values within the family of duplex scans. In addition to these four codes, there are several other duplex scan codes that may fit within this family, including CPT codes: 93930, 93970, 93971, 93975, 93976 and 93979. CMS is concerned that the AMA RUC recommended values for 93880 and 93882, as well as the interim final values for 93925 and 93926, do not maintain the appropriate relativity within this family and CMS requested that the AMA RUC assess relativity among the entire family of codes and then recommend appropriate work RVUs. CMS also requests that the AMA RUC consider CPT codes 93886 and 93888 in conjunction with the duplex scan codes in order to assess the relativity between and among these codes. Therefore, CMS will maintain the CY 2013 RVUs for CPT codes 93880 and 93882 on an interim final basis until they receive further recommendations from the AMA RUC.

DUPLEX SCANS

Compelling Evidence
The specialty societies presented compelling evidence that these codes are currently misvalued. First, there has been a change in the physician work, technique and provider since the last valuation as part of the First Five-Year Review in 1995. There are much

more complex, detailed practice guidelines established for these procedures that were not in existence when the first Medicare Physician Payment Schedule was created in 1992 or during the first Five-Year Review. The Intersocietal Commission for Accreditation of Vascular Laboratories (ICAVL) has published an extensive list of B-mode, color Doppler and Doppler waveform analysis and the exams must evaluate sites of endovascular interventions that were essentially never performed in any significant volume 25 years ago, but are common now. In addition, previously colorflow technology did not have wide commercial availability, and ultrasound technology had insufficient sensitivity to evaluate arterial wall characteristics and plaque morphology. Compared to review of static images printed on x-ray film, new video archiving technology provides for the interpretation of more images, more sophisticated velocity waveforms, and more post-processing of the acquired data. Finally, the dominant specialty has changed. In 1995, Radiology presented this code to the RUC. At that time the dominant provider was radiology, accounting for 40% of the total Medicare claims for this service (global + -26), and neither Cardiology nor Vascular Surgery were involved in presenting this code during the first Five-Year Review. In 2013, Cardiology and Vascular Surgery are the dominant providers of these services, with Radiology representing a substantially smaller percentage of the claims.

Additionally, there are rank order anomalies within the family of vascular duplex codes. Surveying all codes together has highlighted several anomalies within the current database. Specifically, 93970 *Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study* is currently ranked incorrectly above complete arterial studies of the extracranial carotid arteries (93880), bilateral lower extremity arteries (93925), bilateral upper extremity arteries (93930), and complete studies of the abdominal vessels (93978). CPT 93971 *Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study* is currently ranked incorrectly above unilateral or limited studies of the extracranial carotid arteries (93882), upper extremity arteries (93931), the abdominal vessels (93979), and the combined arterial and venous evaluation of the hemodialysis access (93990). **The RUC agreed that there is compelling evidence that codes 93880, 93882, 93925, 93926, 93930, 93931, 93978 and 93979 are potentially misvalued.**

93880 ***Duplex scan of extracranial arteries; complete bilateral study***
The RUC reviewed the survey results from79 radiologists, cardiologists and vascular surgeons and agreed that the survey 25th percentile work RVU of 0.80 for CPT code 93880 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time: 5 minutes of pre-service time, 15 minutes of intra-service time and 5 minutes of post-service time. The RUC noted that the intra-service time was slightly higher than the 2012 survey. The specialties noted that the current survey is from a larger sample and the 15 minutes of intra-service time is consistent and appropriate in relation to the family of services. The RUC compared 93880 to the key reference service 93970 *Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study* (work RVU= 0.70) and agreed that both services are vascular lab codes, however, there is a difference in the body area and type of blood vessels imaged. CPT code 93880 is an arterial examination which is more intense and complex than a venous examination. Additionally, 93880 is a study of a complete carotid duplex which is more intense, there are more images to review and interpret and complications are more severe than a study of the extremities as in 93970, therefore 93880 is appropriately valued higher than 93970. The RUC compared the surveyed code to MPC code 99231 *Subsequent hospital care, per*

day, for the evaluation and management of a patient, (work RVU= 0.76) and noted that 93880 requires more physician work and time and should be valued slightly higher. The RUC also compared the surveyed code to MPC code76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU= 0.81) and agreed that both services require similar physician work and time and should thus be valued similarly. The RUC also noted that this service requires the same time as 93925 and 93930 (total time of 25 minutes) and therefore the RUC is recommending the same work RVU for these three services. **The RUC recommends a work RVU of 0.80 for CPT code 93880.**

93882 ***Duplex scan of extracranial arteries; unilateral or limited study***
The RUC reviewed the survey results from 56 radiologists, cardiologists and vascular surgeons and agreed that the survey 25th percentile work RVU of 0.50 for CPT code 93882 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time: 5 minutes of pre-service time, 10 minutes of intra-service time and 5 minutes of post-service time. The RUC reviewed the key reference service CPT code 93971 *Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study* (work RVU= 0.45) and agreed that both codes have identical intra-service time of 10 minutes, with analogous physician work. Therefore, the recommended work value of 0.50 accurately values 93882 in comparison to this reference code. Additionally, the RUC compared the surveyed code to MPC code 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU= 0.56) and agreed that both services have identical intra-service time of 10 minutes and should be valued similarly. Finally, the RUC reviewed MPC code 99212 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 0.48) and noted that this reference code should be valued slightly lower than 93882 because it requires slightly less physician work and time, 16 versus 20 minutes total time, to perform. **The RUC recommends a work RVU of 0.50 for CPT code 93882.**

93925 ***Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study***
The RUC reviewed the survey results from 57 radiologists, cardiologists and vascular surgeons and determined that the survey 25th percentile work RVU of 0.80 for CPT code 93925 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time: 5 minutes of pre-service time, 15 minutes of intra-service time and 5 minutes of post-service time. The RUC compared 93925 to the key reference service 93970 *Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study* (work RVU= 0.70) and agreed that both services are vascular lab studies performed on lower extremities, however, there is a difference in the body area and type of blood vessels imaged. CPT code 93925 is an arterial examination which is more intense and complex than a venous examination and therefore is appropriately valued higher than 93970. The RUC compared the surveyed code to MPC code 99231 *Subsequent hospital care, per day, for the evaluation and management of a patient* (work RVU= 0.76) and noted that 93925 requires more physician work and physician time and should be valued slightly higher. The RUC also compared the surveyed code to MPC code 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU= 0.81) and agreed that both services require similar physician work and time and should thus be valued similarly. The RUC also noted that this service requires the same time as 93880 and 93930 (total time of 25 minutes) and therefore the RUC is recommending the same work RVU for these three services. **The RUC recommends a work RVU of 0.80 for CPT code 93925.**

93926 ***Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study***
The RUC reviewed the survey results from 57 radiologists, cardiologists and vascular surgeons and agreed that the survey 25th percentile work RVU of 0.60 for CPT code 93926 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time: 5 minutes of pre-service time, 10 minutes of intra-service time and 5 minutes of post-service time. The RUC reviewed the key reference service CPT code 93971 *Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study* (work RVU= 0.45) and agreed that both codes have identical intra-service time, 10 minutes, however 93926 is an arterial examination which is more intense and complex than a venous examination. Therefore, the recommended work value of 0.60 accurately values 93926 in comparison to this reference code. Additionally, the RUC compared the surveyed code to MPC codes 99212 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 0.48) and noted that this reference code should be valued slightly lower than 93926 because it requires slightly less physician work and time, 16 versus 20 minutes total time, to perform and 76817 *Ultrasound, pregnant uterus, real time with image documentation, transvaginal* (work RVU = 0.75) and noted that 76817 requires more physician work and time to perform and is appropriately valued higher. The RUC noted that this service is appropriately valued higher than the extracranial and upper extremity arteries duplex scans services and it requires more work to perform on a larger and more complex area. **The RUC recommends a work RVU of 0.60 for CPT code 93926.**

93930 ***Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study***
The RUC reviewed the survey results from 56 radiologists, cardiologists and vascular surgeons and determined that the survey median work RVU of 0.80 for CPT code 93930 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time: 5 minutes of pre-service time, 15 minutes of intra-service time and 5 minutes of post-service time. The RUC compared 93930 to the key reference service 93970 *Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study* (work RVU= 0.70) and agreed that both services are vascular lab studies performed on lower extremities. However, there is a difference in the body area and type of blood vessels imaged. CPT code 93930 is an arterial examination which is more intense and complex than a venous examination and therefore is appropriately valued higher than 93970. The RUC compared the surveyed code to MPC code 99231 *Subsequent hospital care, per day, for the evaluation and management of a patient,* (work RVU= 0.76) and noted that 93880 requires more physician work and more physician time have similar and should be valued slightly higher. The RUC also compared the surveyed code to MPC code 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU= 0.81) and agreed that both codes have similar physician work and time and should thus be valued similarly. The RUC also noted that this service requires the same time as 93880 and 93925 (total time of 25 minutes) and therefore the RUC is recommending the same work RVU for these three services. **The RUC recommends a work RVU of 0.80 for CPT code 93930.**

93931 ***Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study***
The RUC reviewed the survey results from 56 radiologists, cardiologists and vascular surgeons and agreed that the survey 25th percentile work RVU of 0.50 for CPT code 93931 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time: 5 minutes of pre-service time, 10 minutes of intra-service time and 5 minutes of post-service time. The RUC reviewed the key reference service CPT code 93971 *Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study* (work RVU= 0.45) and agreed that both codes have identical intra-service time, 10 minutes, with analogous physician work. However, 93931 is a limited scan on the upper extremities and the key reference service is a venous study. Therefore, the recommended work value of 0.50 accurately values 93931 in comparison to this reference code. Additionally, the RUC compared the surveyed code to MPC code 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU= 0.56) and agreed that both services have identical intra-service time of 10 minutes and should be valued similarly. Finally, the RUC reviewed MPC codes 99212 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 0.48) and noted that this reference code should be valued slightly lower than 93931 because it requires slightly less physician work and time, 16 versus 20 minutes total time, to perform. **The RUC recommends a work RVU of 0.50 for CPT code 93931.**

93970 ***Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study***
The specialty societies did not survey CPT code 93970, as it was recently surveyed, reviewed by the RUC and a recommendation was submitted and accepted by CMS for CPT 2013. The physician work has remained the same for the last 20 years for this service. Therefore, the specialty societies determined it did not warrant another survey and would serve appropriately as anchor references for this family of services. The RUC agreed that reaffirming the current work value from CPT 2013 is appropriate. **The RUC recommends maintaining the work RVU of 0.70 for CPT code 93970.**

93971 ***Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study***
The specialty societies did not resurvey CPT code 93971, as it was recently surveyed, reviewed by the RUC and a recommendation was submitted and accepted by CMS for CPT 2012. The physician work has remained the same for the last 20 years for this service. Therefore, the specialty societies determined it did not warrant another survey and would serve appropriately as anchor references for this family of services. The RUC agreed that reaffirming the current work value from CPT 2013 is appropriate. **The RUC recommends maintaining the work RVU of 0.45 for CPT code 93971.**

93975 ***Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study***
The RUC reviewed the survey results from 54 radiologists, cardiologists and vascular surgeons and determined that the survey median work RVU of 1.30 for CPT code 93975, a decrease from the current value, appropriately accounts for the work required to perform this service. The RUC recommends the following physician time: 5 minutes of pre-service time, 20 minutes of intra-service time and 5 minutes of post-service time. The RUC compared 93975 to the key reference service 93306 *Echocardiography,*

transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography (work RVU= 1.30) and agreed that both services have analogous physician work and time and should be valued the same. The RUC also referenced MPC codes 99238 *Hospital discharge day management; 30 minutes or less* (work RVU= 1.28) and 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU= 1.40) and determined that the recommended work RVU of 1.30 places this service relative to other similar services. **The RUC recommends a work RVU of 1.30 for CPT code 93975.**

93976 ***Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study***
The RUC reviewed the survey results from 53 radiologists, cardiologists and vascular surgeons and determined that the survey median work RVU of 1.00 for CPT code 93976, a decrease from the current value, appropriately accounts for the work required to perform this service. The RUC recommends the following physician time: 5 minutes of pre-service time, 15 minutes of intra-service time and 5 minutes of post-service time. The RUC compared 93976 to the key reference service 93970 *Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study* (work RVU= 0.70) and agreed that both services are vascular lab studies. However, there is a difference in the body area and type of blood vessels imaged. CPT code 93976 is a limited study that involves both arterial inflow and venous outflow examination of an organ and is therefore more intense. Likewise, 93976 is more intense than 93880, 93925 and 93930 because it includes both a study of arterial inflow and venous outflow of organ systems and is appropriately valued higher. CPT code 93976 relies more on the interpretation of Doppler wave forms which are non-numerical and use deep Doppler which is more complex; therefore there is an increased complexity to interpret the Doppler spectrum. The RUC also referenced MPC codes 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 0.97) and 95805 *Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness* (work RVU= 1.20) and determined that the recommended work RVU of 1.00 places this service relative to other similar services. **The RUC recommends a work RVU of 1.00 for CPT code 93976.**

93978 ***Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study***
The RUC reviewed the survey results from 56 radiologists, cardiologists and vascular surgeons and determined that the survey median work RVU of 0.97 for CPT code 93978 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time: 5 minutes of pre-service time, 15 minutes of intra-service time and 5 minutes of post-service time. The RUC compared 93978 to the key reference service 93970 *Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study* (work RVU= 0.70) and agreed that both services are vascular lab studies, however, there is a difference in the body area and type of blood vessels imaged. CPT code 93978 is an abdominal duplex evaluation that is complicated by visual obstruction from overlying bowel and adipose tissue making imaging more difficult, intense and complex to perform compared to the key reference service. The RUC also referenced MPC codes 78306 *Bone and/or joint imaging; whole body* (work RVU= 0.86) and 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 0.97) and

determined that the recommended work RVU of 0.97 places this service relative to other similar services. **The RUC recommends a work RVU of 0.97 for CPT code 93978.**

93979 ***Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study***
The RUC reviewed the survey results from 56 radiologists, cardiologists and vascular surgeons and determined that the survey 25th percentile work RVU of 0.70 for CPT code 93979 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time: 5 minutes of pre-service time, 10 minutes of intra-service time and 5 minutes of post-service time. The RUC noted that 93979 requires slightly less work than the complete studies (93880, 93925 and 93930) and is appropriately valued lower. The RUC compared 93979 to the key reference service 93970 *Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study* (work RVU= 0.70) and agreed that both services are analogous and should be valued the same. The RUC also referenced MPC codes 99212 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 0.48) and 78306 *Bone and/or joint imaging; whole body* (work RVU= 0.86) and determined that the recommended work RVU of 0.70 places this service relative to other similar services. **The RUC recommends a work RVU of 0.70 for CPT code 93979.**

TRANSCRANIAL DOPPLER STUDIES

The specialty societies indicated that the valuation source for these services is CMS/Other and these services were never previously surveyed, therefore it is not apparent how a valuation was developed. Additionally, the dominant providers are neurology and radiology, different than the duplex scan codes. However, CMS requested that these services be surveyed and reviewed with the duplex scan codes. The RUC agreed that there is compelling evidence that codes 93886 and 93888 are potentially misvalued.

93886 ***Transcranial Doppler study of the intracranial arteries; complete study***
The RUC reviewed the survey results from 44 neurologists and radiologists and determined that the survey median work RVU of 1.00 for CPT code 93886 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time: 5 minutes of pre-service time, 17 minutes of intra-service time and 5 minutes of post-service time. The RUC compared 93886 to the key reference service 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU= 1.08) and agreed that both services are analogous and should be valued similarly. The RUC also referenced MPC codes 94004 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; nursing facility, per day* (work RVU= 1.00) and 95805 *Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness* (work RVU= 1.20) and determined that the recommended work RVU of 1.00 places this service relative to other similar services. Lastly, the RUC noted that this service is appropriately valued higher than the duplex scan codes, as the typical patient is critically ill, possibly in a coma, therefore it is more challenging to identify the arteries and more difficult to complete the measurements. **The RUC recommends a work RVU of 1.00 for CPT code 93886.**

93888 ***Transcranial Doppler study of the intracranial arteries; limited study***
The RUC reviewed the survey results from 32 neurologists and radiologists and determined that the survey median work RVU of 0.70 for CPT code 93888 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time: 5 minutes of pre-service time, 10 minutes of intra-service time and 5 minutes of post-service time. The RUC compared 93888 to the key reference service 76821 *Doppler velocimetry, fetal; middle cerebral artery* (work RVU= 0.70) and agreed that both services require the same physician work and time should be valued the same. The RUC also referenced MPC codes76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU= 0.56) and 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 0.97) and determined that the recommended work RVU of 0.70 places this service relative to other similar services. Lastly, the RUC noted that this service is appropriately valued higher than the duplex scan codes, as the typical patient is critically ill, possibly in a coma, therefore it is more challenging to identify the arteries and more difficult to complete the measurements. **The RUC recommends a work RVU of 0.70 for CPT code 93888.**

Practice Expense
The Practice Expense Subcommittee made minor modifications to the direct practice expense inputs. The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.

Ultrasound Guidance (Tab 34)
Richard Wright, MD (ACC)

In the NPRM for 2014, CMS noted that in relation to CPT code 76942, the discrepancy in clinical staff intra-service times and the resulting potentially inaccurate payment raises a fundamental concern regarding the incentive to furnish ultrasound guidance. However, CMS noted that this concern spans more than just an individual code for ultrasound guidance. Accordingly, CMS proposed additional ultrasound guidance codes (76930, 76932, 76940, 76942, 76948, 76950, and 76965) as potentially misvalued.

76930 ***Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation***
The RUC reviewed the survey results from practicing cardiologists and agreed with the specialty society that the following physician time components are accurate for 76930: pre-service time of 7 minutes, intra-service time of 30 minutes and immediate post-service time of 5 minutes. The pre and post times were reduced from the survey median in order to render them compatible with other recently reviewed XXX global image guidance codes 77002 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device* and 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 survey respondents' estimated physician work values and agreed with the specialty society that the values overestimate the work involved in 76930. Therefore, the RUC agreed that the current work RVU of 0.67, lower than the survey's 25th percentile, is appropriate. To justify this value, the RUC compared the surveyed code to CPT code 72275 *Epidurography, radiological supervision and interpretation* (work RVU= 0.76, intra-service time= 30 minutes) and noted that both services have identical

intra-service times and should be valued similarly. The RUC also reviewed CPT code 77280 *Therapeutic radiology simulation-aided field setting; simple* (work RVU= 0.70, intra-service time= 25 minutes) and agreed that this comparable service confirms that the recommended value for 76930 is appropriate relative to other similar services. **The RUC recommends a work RVU of 0.67 for CPT code 76930.**

76932 ***Ultrasonic guidance for endomyocardial biopsy, imaging supervision and interpretation***
The RUC reviewed the survey results from practicing cardiologists and agreed with the specialty society that the following physician time components are accurate for 76932: pre-service time of 7 minutes, intra-service time of 32 minutes and immediate post-service time of 5 minutes. The pre and post times were reduced from the survey median in order to render them compatible with other recently reviewed XXX global image guidance codes 77002 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device* and 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 survey respondents' estimated physician work values and agreed with the specialty society that the values overestimate the work involved in 76932. Therefore, the RUC agreed that the current work RVU of 0.67, lower than the survey's 25th percentile, is appropriate. To justify this value, the RUC compared the surveyed code to CPT code 74251 *Radiologic examination, small intestine, includes multiple serial films; via enteroclysis tube* (work RVU= 0.69, intra-service time= 32 minutes) and noted that since both codes have identical intra-service time, they should both be valued similarly. The RUC also compared 76932 to the pericardiocentesis guidance code, 76930, and agreed that since both code have almost identical time components and similar physician work, they are correctly valued the same. **The RUC recommends a work RVU of 0.67 for CPT code 76932.**

76940 ***Ultrasound guidance for, and monitoring of, parenchymal tissue ablation***
76948 ***Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation***
76965 ***Ultrasonic guidance for interstitial radioelement application***
The RUC reviewed the prior review history for CPT code 76940. During the time of the original valuation for this service, the original CPT code for ultrasound guidance for parenchymal tissue ablation, 76490, was renumbered by the CPT Editorial Panel to 76940 for CPT 2004. In February 2002, the RUC reviewed the specialty physician work RVU recommendations and determined that a work RVU of 4.00 was appropriate for this service. CMS accepted this value for 2003. However, when the code was renumbered in 2004, the Final Medicare Physician Payment Schedule listed the new code number, 76940, as 2.00 work RVUs. The error went unnoticed until these services were reviewed under the NPRM for the 2014 CMS screen. The RUC discussed that since this service is low volume, conducting a survey may not yield sufficient results to properly value this service. The Committee agreed with the specialty societies that the interested societies should bring forward an action plan for all three codes (76940, 76948 and 76965) to the Relativity Assessment Workgroup (RAW) at the September RUC meeting which provides a more robust analysis of the utilization and physician usage data. **Until this review, the RUC recommends the current work values as interim for the following codes: a work RVU of 2.00 for CPT Code 76940, a work RVU of 0.38 for CPT code 76948 and a work RVU of 1.34 for CPT code 76965.**

Ultrasound Guidance for Needle Placement (Tab 35)
Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); Howard Lando, MD (AACE); Barry Smith, MD (AAPMR); David Lenrow, MD (AAPMR); Fredrica Smith, MD (ACRh); Tim Laing, MD (ACRh); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA); Eric Whitacre, MD, FACS (ASBS); Norm Smith, MD (AUA); Tom Turk, MD (AUA); Jerry Niedzwiecki, MD (SIR); Michael Hall, MD (SIR); Allan Glass, MD (TES)

In April 2011, this service was identified through the CMS/Other codes with Medicare utilization over 500,000 screen. The specialty societies initially recommended a delay in surveying 76942 since 76942 has been recently bundled into a number of services including paracentesis, thoracentesis, chest tube placement, breast biopsy and most recently arthrocentesis. The RUC recommended to review the survey instrument at the Research Subcommittee October 2013 and to survey for work and develop direct practice expense inputs by April 2014.

Prior to valuing this service, the RUC reviewed the specialty societies' compelling evidence that the current value for this procedure may be misvalued. The specialty societies explained that a flawed methodology was used to arrive at the current work value of 0.67. Prior to this survey, 76942 had not been reviewed by the RUC and was originally valued using a CMS/Other crosswalk methodology. Since it is unknown how CMS valued this service originally, the RUC agreed that this represents a flawed methodology. Furthermore, there has been a significant change in the dominant providers of this service since its initial valuation. In 1993, two specialties, urologists and diagnostic radiologists provided the vast majority of services. In 2013, there was a plurality of performing specialties with the dominant providers being orthopedic surgeons and rheumatologists. The RUC agreed that there is compelling evidence that CPT code 76942 may be misvalued.

76942 ***Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation***
The RUC reviewed the survey results from 255 diagnostic and interventional radiologists, endocrinologists, anesthesiologists, rheumatologists, urologists and breast surgeons and agreed with the specialty societies that the following physician time components are accurate for 76942: pre-service time of 7 minutes, intra-service time of 15 minutes and immediate post-service time of 5 minutes. The pre-service and post-service times were reduced from the survey median in order to render them compatible with other recently reviewed XXX global image guidance codes 77002 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device* and 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 survey respondents' estimated physician work values and agreed that while compelling evidence exists that 76942 is potentially misvalued, the survey median work RVU of 0.76 was not appropriate. Therefore, the RUC agreed that the current work RVU of 0.67 accurately values this procedure. To justify a value of 0.67, the RUC compared the surveyed code to key reference code 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU= 0.56) and noted that since 76536 has less intra-service time than the surveyed code, 10 minutes compared to 15 minutes, the reference code is appropriately valued less than 76942. The RUC also reviewed CPT codes 76881

Ultrasound, extremity, nonvascular, real-time with image documentation; complete (work RVU= 0.63, intra time= 15 minutes) and MPC code 76816 *Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus* (work RVU= 0.85, intra time= 15 minutes) and agreed that both reference codes, with identical intra-service time compared to the surveyed code, provide appropriate brackets below and above the recommended value for 76942, respectively. Finally, the RUC compared 76942 to other image guidance for needle placement codes and agreed that a recommended work value of 0.67 accurately places this service in the mid-range of guidance codes, slightly above the less intense and complex CPT code 77003 *Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)* (work RVU= 0.60, intra time= 15 minutes). **The RUC recommends a work RVU of 0.67 for CPT code 76942.**

Practice Expense
The RUC reviewed the direct PE inputs and noted a slight increase in clinical labor time for 76942 due to the increase of 5 minutes of intra-service time from the survey. The RUC approved the direct practice expense with no modifications as approved by the Practice Expense Subcommittee.

Medicare Utilization
The RUC noted that CMS identified 76942 as being potentially misvalued in the 2014 NPRM because of the high frequency that it is billed with CPT code 20610 *Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa),* which has a shorter clinical staff intra-service time than the ultrasound guidance procedure. In response, the specialty societies created a bundled code for arthrocentesis performed with ultrasound guidance which will be a new service in CY2015. As the expected billing pattern for 76942 as a stand-alone service is unknown, the RUC agreed to monitor the future utilization of 76942 to ensure that the services commonly billed with it do not include clinical staff times which is non – congruent with the clinical staff times of the ultrasound guidance service.

Anesthetic Injection – Spinal Nerve (Tab 36)

In April 2013, CPT code 64412 *Injection, anesthetic agent; spinal accessory* (work RVU = 1.18) was identified via the High Growth screen. It is primarily performed (58%) by internal medicine, family and general practice physicians. In October 2013, the Relativity Assessment Workgroup reviewed the action plan submitted by the American College of Physicians (ACP), which indicated ACP would survey for presentation at the April 2014 RUC meeting. In February 2014, the level of interest process was conducted and ACP and AAFP indicated no interest in surveying or commenting on CPT code 64412 and ASA, AAPM&R, ISIS all indicated a level 2 interest, comment only.

Since ACP had indicated they would survey this service, the RAW did not have any further discussion regarding why the large growth in Medicare utilization occurred, nor did it discuss any possible misreporting of this service. The Medicare frequency went from 2,763 in 2006 to 10,917 in 2011.

Upon further analysis, it appears that half of the current utilization is now coming from the state of Michigan (*see attached spreadsheet*). The growth is being performed primarily by internal medicine physicians and a re-survey will not address the misreporting of this service. It appears that physicians are reporting 64412 *Injection, anesthetic agent; spinal accessory* (work RVU = 1.18) instead of 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66) or 20553 *Injection(s); single or multiple trigger point(s), 3 or more muscle(s)* (work RVU = 0.75).

AMA staff reached out to ACP, AAFP, ASA, AAPM&R and ISIS and requested action to address the inappropriate reporting of this service, such as the addition of a CPT parenthetical or deletion of the code. ASA, AAPM&R, AAN and ISIS submitted a letter for this April 2014 agenda indicating they will develop a CPT Assistant article to clarify the proper use of 64412 and requested that the RAW review utilization in 3 years. AMA staff questioned why a parenthetical would not be developed to stop this inappropriate reporting immediately for the CPT 2015 cycle. At the April 2014 RUC meeting, the specialty societies requested for CPT code 64412 to be referred to the CPT Editorial Panel to address the inappropriate billing. **The RUC recommends that CPT code 64412 be referred to the CPT Editorial Panel for revision.**

Morphometric Analysis (Tab 37)
Jonathan Myles, MD (CAP); Michael McEachin, MD(CAP) and Gerald Hanson, MD (ASCP)

At the October 2013 RUC meeting, the Relativity Assessment Workgroup identified CPT code 88356 through the High Volume Growth Services screen, where Medicare utilization increased by at least 100% from 2006 to 2011. The RUC recommended that the specialty societies survey the physician work and present to the RUC for the 2015 CPT cycle.

88356 ***Morphometric analysis; nerve***
The RUC reviewed the survey results from 33 neuropathologists and recommends the following physician time components: pre-service time of 0 minutes, intra-service time of 90 minutes, and post-service time of 0 minutes. The RUC reviewed the survey and agreed with the specialty societies that the 25th percentile value of 2.80 is appropriate for this service.

To justify a work RVU of 2.80, the RUC compared the surveyed code to key reference service 88309 *Level VI - Surgical pathology, gross and microscopic examination Bone resection Breast, mastectomy - with regional lymph nodes Colon, segmental resection for tumor Colon, total resection Esophagus, partial/total resection Extremity, disarticulation Fetus, with dissection Larynx, partial/total resection - with regional lymph nodes Lung - total/lobe/segment resection Pancreas, total/subtotal resection Prostate, radical resection Small intestine, resection for tumor Soft tissue tumor, extensive resection Stomach - subtotal/total resection for tumor Testis, tumor Tongue/tonsil -resection for tumor Urinary bladder, partial/total resection Uterus, with or without tubes and ovaries, neoplastic Vulva, total/subtotal resection* (work RVU= 2.80, 90 minutes of intra-time) and noted that both services have identical intra-service time, whereas the survey respondents indicated that 88356 is a slightly more intense service than 88309.

The RUC also compared the surveyed code to CPT code 95872 *Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied* (work RVU=2.88, 15 minutes of pre-time, 60 minutes of intra-time, 20 minutes of post-time) and noted that 95872 requires less intra-service time, 60 minutes versus 90 minutes, but has a higher intensity, which supports a similar work valuation for the surveyed code. The RUC also noted that both services have similar total times of 95 minutes and 90 minutes, respectively. **The RUC recommends a work RVU of 2.80 for CPT code 88356.**

Work Neutrality
The RUC's recommendation for CPT code 88356 will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs for Morphometric Analsyis and agreed with the specialty that several inputs needed to be changed to reflect changes in practice patterns, laboratory standards and techniques since the service was last reviewed in 2004. In general, the total clinical staff times were significantly lowered relative to the current inputs.

The PE Subcommittee agreed that the time for *oven, convection (lab)* (EP029) and the Electron Microscopy Tissue processor are not tied to staff time. There are three new equipment items included for this service: glass knife breaker (invoice #1), block face milling machine (invoice #2) and electron microscopy tissue processor (invoice #3). Appropriate invoices are attached. The RUC approved the revised PE spreadsheet as modified by the PE Subcommittee.

Endovenous Ablation (Tab 38)
Matthew Sideman, MD (SVS); Robert Zwolak, MD (SVS); Michael Sutherland, MD (SVS); David Han, MD (SVS); Gary Seabrook, MD (SVS) Jerry Niedzwiecki, MD (SIR); Michael Hall, MD (SIR); Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); Richard Wright, MD (ACC); Clifford Kavinsky, MD (SCAI); Christopher Senkowski, MD (ACS) and Mark Forrestal, MD (ACPh)

At the October 2013 meeting, the Relativity Assessment Workgroup reviewed High Volume Growth Services where Medicare utilization increased by at least 100% from 2006 to 2011. The RUC requested that these services be surveyed for physician work and develop practice expense inputs.

36475 ***Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated***
The RUC reviewed the survey results from 81 physicians for CPT code 36475 and determined that the survey 25th percentile work RVU of 5.30 appropriately accounts for the work required to perform this service. The RUC recommends the following physician times: 34 minutes pre-time, 45 minutes intra-service time and 15 minutes immediate post-time. The RUC noted that the physician work and time has decreased for these services since it was last surveyed and therefore the recommended decrease is appropriate. However, the intensity for this service has increased and the RUC determined that is appropriate as the site in which this service is typically performed has changed. This service is now typically performed in the office and is more intense since

the physician is on his/her own. Therefore, more mental effort and stress is placed on the physician to perform properly because if a complication occurs the patient must be transferred to the hospital.

The RUC noted that the work for percutaneous radiofrequency and percutaneous laser services, CPT codes 36475 and 36478 is the same. The RUC compared 36475 to the key reference service 35476 *Transluminal balloon angioplasty, percutaneous; venous* (work RVU = 5.10 and intra-service time 35 minutes) and noted both services are endoluminal venous procedures, however, 36475 requires 10 more minutes of intra-service time and is more intense to perform than 35476. Therefore, 36475 is appropriately valued higher than the key reference service. The RUC also referenced MPC codes 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 52235 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)* (work RVU = 5.44). **The RUC recommends a work RVU of 5.30 for CPT code 36475.**

36476 ***Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 73 physicians for CPT 36476 and determined that the work RVU should be 2.65 work RVUs, half that of the base code 36475 (RUC recommended work RVU = 5.30). The RUC also recommended that the pre-service and post-service time as indicated by the survey respondents be deleted as all work should be accounted for in the base code. The RUC recommends 30 minutes of intra-service time. The RUC referenced similar services 15152 *Tissue cultured skin autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 2.50) and 15156 *Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)* (work RVU = 2.75), which demonstrate the relativity of CPT code 36476 among other similar services. Lastly, the RUC referenced MPC code 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)* (work RVU = 2.25). **The RUC recommends a work RVU of 2.65 for CPT code 36476.**

36478 ***Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated***
The RUC reviewed the survey results from 81 physicians for CPT code 36478 and determined that the survey 25th percentile work RVU of 5.30 appropriately accounts for the work required to perform this service. The RUC recommends the following physician times: 34 minutes pre-time, 45 minutes intra-service time and 15 minutes immediate post-service time. The RUC noted that the physician work and time has decreased for these services since it was last surveyed and therefore the recommended decrease is appropriate. However, the intensity for this service has increased and the RUC determined that is appropriate as the site in which this service is typically performed has changed. This service is now typically performed in the office and is more intense, since the physician is on his/her own. Therefore, more mental effort and stress is placed on the

physician to perform properly because, if a complication occurs, the patient must be transferred to the hospital.

The RUC noted that the work for percutaneous radiofrequency and percutaneous laser services, CPT codes 36475 and 36478 is the same .The RUC compared 36478 to the key reference service 35476 *Transluminal balloon angioplasty, percutaneous; venous* (work RVU = 5.10) and noted both services are endoluminal venous procedures, however, 36478 requires 10 more minutes of intra-service time and is more intense to perform than 35476. Therefore, 36478 is appropriately valued higher than the key reference service. The RUC also referenced MPC codes 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 52235 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)* (work RVU = 5.44). **The RUC recommends a work RVU of 5.30 for CPT code 36478.**

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)***
The RUC reviewed the survey results from 75 physicians for CPT 36479 and determined that the work RVU should be 2.65 work RVUs, half that of the base code 36478 (RUC recommended work RVU = 5.30). The RUC also recommended that the pre-service and post-service time as indicated by the survey respondents be deleted as all work should be accounted for in the base code. The RUC recommends 30 minutes of intra-service time. The RUC referenced similar services 15152 *Tissue cultured skin autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU = 2.50) and 15156 *Tissue cultured skin autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure)* (work RVU = 2.75), which demonstrate the relativity of CPT code 36479 among other similar services. Lastly, the RUC referenced MPC code 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)* (work RVU = 2.25). **The RUC recommends a work RVU of 2.65 for CPT code 36479.**

New Technology
CPT codes 36475, 36476, 36478 and 36479 will be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and specifically review utilization trends.

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 Practice Expense Subcommittee deleted sedation for the clinical labor staff on line 35, and eliminated the duplicative tilt table from the equipment. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

CT Angiography – Head & Neck (Tab 39)
Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); Gregory Nicola, MD (ASNR); Joshua Hirsch, MD (ASNR)

At the October 2013 RUC meeting, the Relativity Assessment Workgroup identified CPT code 70496 through the High Volume Growth Services screen, where Medicare utilization increased by at least 100% from 2006 to 2011. The RUC recommended that the specialty societies survey the physician work and present to the RUC for the 2015 CPT cycle. At this time, CPT code 70498 was added to the survey list as it is part of the CT Angiography of the head & neck family of services.

70496 ***Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing***
The RUC reviewed the survey results from 85 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 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 1.85 and agreed with the specialty societies that the current value of 1.75 is appropriate for this service.

The RUC compared the surveyed code to key reference service 70553 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences* (work RVU= 2.29, 5 minutes of pre-time, 25 minutes of intra-time, 7 minutes of post-time) and noted that while the reference code has more intra-service and post-service time, the survey respondents indicated that 70496 is a more intense service than 70553, which supports the recommended work value of 1.75. Furthermore, the reference code is an apt comparator, since both codes require contrast administration, both involve imaging of the brain, and 70496 is more commonly performed in the inpatient setting with more acute symptoms relative to 70553.

The RUC also compared the surveyed code to MPC code 74176 *Computed tomography, abdomen and pelvis; without contrast material* (work RVU= 1.74, 5 minutes pre-time, 22 minutes intra-time, 5 minutes post-time) and noted that the codes have similar intra-service times, whereas the surveyed code is slightly more intense to perform, justifying the similar work value. Additionally, the RUC compared the surveyed code to CPT code 75572 *Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)* (work RVU= 1.75, 10 minutes of pre-time, 20 minutes of intra-time, 10 minutes of post-time) and noted that both services have the same intra-service time of 20 minutes, whereas 75572 has 10 more minutes of total time. The RUC agreed that a similar work value is justified, since the surveyed code has a higher intensity relative to 75572. **The RUC recommends a work RVU of 1.75 for CPT code 70496.**

70498 ***Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing***
The RUC reviewed the survey results from 85 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 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 1.80 and agreed with the specialty societies that the current value of 1.75 is appropriate for this service.

The RUC compared the surveyed code to CPT code 70552 *Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)* (work RVU= 1.78, 5 minutes of pre-time, 20 minutes of intra-time, 7 minutes of post-time) and noted that both services have identical intra-service time of 20 minutes, and similar total times, 32 minutes and 30 minutes, respectively. Furthermore, the RUC noted that both codes require contrast administration and are of similar intensity. Therefore, the RUC agreed that 70498 should be valued similarly to 70552.

The RUC also compared the surveyed code to MPC code 74176 *Computed tomography, abdomen and pelvis; without contrast material* (work RVU= 1.74, 5 minutes pre-time, 22 minutes intra-time, 5 minutes post-time) and noted that the codes have similar intra-service times, whereas the surveyed code is slightly more intense to perform, justifying the slightly higher work value. Additionally, the RUC compared the surveyed code to CPT code 75572 *Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)* (work RVU= 1.75, 10 minutes of pre-time, 20 minutes of intra-time, 10 minutes of post-time) and noted that both services have the same intra-service time of 20 minutes, whereas 75572 has 10 more minutes of total time. The RUC agreed that a similar work value is justified, since the surveyed code has a higher intensity relative to 75572. **The RUC recommends a work RVU of 1.75 for CPT code 70498.**

Practice Expense
The Practice Expense (PE) Subcommittee reviewed the direct practice expense inputs for the CT Angiography Head & Neck services and noted that these services mostly crosswalk to the CT Angiography Abdomen and CT Angiography Chest services approved at the October 2013 and January 2014 RUC meetings, respectively. The RUC approved the revised PE spreadsheet as modified by the PE Subcommittee.

Doppler Flow Testing (Tab 40)
Matthew Sideman, MD (SVS); Robert Zwolak, MD (SVS); Michael Sutherland, MD (SVS); David Han, MD (SVS); Gary Seabrook, MD (SVS); Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR) and Richard Wright, MD (ACC)

At the October 2013, meeting the Relativity Assessment Workgroup reviewed High Volume Growth Services where Medicare utilization increased by at least 100% from 2006 to 2011. The RUC requested that these services be surveyed for physician work and develop practice expense inputs for the January 2014 RUC meeting. The RUC allowed the specialty societies to defer this issue until the April 2014 RUC meeting.

Compelling Evidence
The specialty societies presented compelling evidence that CPT code 93990 is currently misvalued. First, there has been a change in the physician work, technique and provider since it was last valued in 1995. There are much more complex, detailed practice guidelines established for Doppler flow testing that were not in existence when the first Medicare Physician Payment Schedule was created in 1992 or when the value for this

service was last established. The Intersocietal Commission for Accreditation of Vascular Laboratories (ICAVL) has published an extensive list of B-mode, color Doppler and Doppler waveform analysis. The exams must now evaluate sites of endovascular interventions that were essentially never performed in any significant volume 25 years ago, but are common now.

In addition, previously, colorflow technology did not have wide commercial availability, and ultrasound technology had insufficient sensitivity to evaluate arterial wall characteristics and plaque morphology. Compared to review of static images printed on x-ray film, new video archiving technology provides for the interpretation of more images, more sophisticated velocity waveforms, and more post-processing of the acquired data.

The patient population has changed as well as a result of the *CMS Fistula First Breakthrough Initiative,* which places more emphasis on creating and sustaining native autogenous fistulas. Finally, the dominant specialty has changed. In 1995, Radiology presented this code to the RUC. At that time the dominant provider was radiology, accounting for 40% of the total Medicare claims for this service (global + -26), and neither Cardiology nor Vascular Surgery were involved in presenting this code during the original review. In 2013, Vascular Surgery is now the dominant provider, with Radiology representing a substantially smaller percentage of the claims.

Additional compelling evidence is the existence of rank order anomalies within the family of vascular duplex codes. Surveying all codes together has highlighted several anomalies within the current database. Specifically, 93970 *Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study* is currently ranked incorrectly above complete arterial studies of the extracranial carotid arteries (93880), bilateral lower extremity arteries (93925), bilateral upper extremity arteries (93930), and complete studies of the abdominal vessels (93978). CPT 93971 *Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study* is currently ranked incorrectly above unilateral or limited studies of the extracranial carotid arteries (93882), upper extremity arteries (93931), the abdominal vessels (93979), and the combined arterial and venous evaluation of the hemodialysis access (93990). The RUC agreed that there is compelling evidence that CPT code 93990 is potentially misvalued.

93990 ***Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)***
The RUC reviewed survey results from 55 radiologists, cardiologists and vascular surgeons and agreed that the survey 25th percentile work RVU of 0.60 appropriately accounts for the work required to perform this service. The RUC recommends the following physician time: 5 minutes of pre-service time, 11 minutes of intra-service time and 5 minutes of post-service time.

The RUC compared the surveyed code to key reference code 93970 *Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study* (work RVU= 0.70, pre-time of 3 minutes, intra-time of 15 minutes, post-time 5 minutes) and noted that the reference code has slightly higher total time (23 minutes versus 21 minutes), whereas the survey respondents indicated that the surveyed code is a more intense service than the key reference code, supporting the recommended work value of 0.60 for 93990. The RUC also compared the surveyed code to MPC code

76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU= 0.56, pre-time of 4 minutes, intra-time of 10 minutes, post-time of 4 minutes) and noted that the surveyed code has a slightly higher intra-service time (11 minutes versus 10 minutes), as well as a higher total time (21 minutes versus 18 minutes), which further justifies a work RVU of 0.60 for 93990. The RUC noted that a work RVU recommendation of 0.60 places 93990 in appropriate rank order with the duplex scan family of codes, at the higher end of the limited study subset within that family. **The RUC recommends a work RVU of 0.60 for CPT code 93990.**

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

CT – Maxillofacial (Tab 41)
Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); Gregory Nicola, MD (ASNR); Joshua Hirsch, MD (ASNR)

The Relativity Assessment Workgroup identified CPT code 70486 through the CMS/Other Source – Utilization over 250,000 screen. In October 2013, the RUC noted that this code was never RUC reviewed but is frequently reported. The RUC recommended that this service be surveyed for physician work and develop direct practice expense inputs for the January 2014 RUC meeting. The specialty societies expanded the survey to include two other codes in the CT Maxillofacial family: 70487 and 70488. The specialty societies also requested to defer this issue until the April 2014 RUC meeting.

70486 ***Computed tomography, maxillofacial area; without contrast material***
The RUC reviewed the survey results from 62 radiologists and neuroradiologists and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 3 minutes, intra-service time of 10 minutes and immediate post-service time of 3 minutes.

The RUC reviewed the survey respondents' estimated physician work values for CPT code 70486 and determined that the survey 25th percentile work RVU of 1.07 was not appropriate. The RUC noted that the survey respondents indicated that this service is less intense and complex than the CT Angiography – Head and Neck services. The RUC determined that a direct crosswalk to CPT code 70450 *Computed tomography, head or brain; without contrast material* (work RVU=0.85, 10 minutes intra-service) is appropriate for this service. Although the survey respondents selected CPT code 72125 *Computed tomography, cervical spine; without contrast material* (work RVU = 1.07, 15 minutes intra-service time) as the key reference service, the RUC determined that 70450 is a better crosswalk because of the identical intra-service time. For additional support the RUC compared the surveyed code to CPT code 78598 *Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed* (work RVU = 0.85, 10 minutes intra-service).**The RUC recommends a work RVU of 0.85 for CPT code 70486.**

70487 ***Computed tomography, maxillofacial area; with contrast material(s)***
The RUC reviewed the survey results from 62 radiologists and neuroradiologists and agreed with the specialty societies that the following physician time components are

appropriate for this service: pre-service time of 5 minutes, intra-service time of 12 minutes and immediate post-service time of 5 minutes.

The RUC reviewed the survey respondents' estimated physician work values for CPT code 70487 and determined that the survey 25th percentile work RVU of 1.17 is appropriate for this service. The RUC compared the surveyed code to key reference service 70460 *Computed tomography, head or brain; with contrast material(s)* (work RVU = 1.13) and determined that both services require the same physician time and similar intensity and complexity to perform and therefore should be valued similarly. For additional support, the RUC referenced MPC code 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27). **The RUC recommends a work RVU of 1.17 for CPT code 70487.**

70488 ***Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections***
The RUC reviewed the survey results from 62 radiologists and neuroradiologists and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 5 minutes, intra-service time of 15 minutes and immediate post-service time of 5 minutes.

The RUC reviewed the survey respondents' estimated physician work values for CPT code 70488 and determined that the survey 25th percentile work RVU of 1.30 is appropriate for this service. The RUC compared the surveyed code to key reference service 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.40) and noted that 74170 requires slightly more physician time to complete and is appropriately valued higher than 70488. For addtional support, the RUC referenced MPC code 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.27). **The RUC recommends a work RVU of 1.30 for CPT code 70488.**

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

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

X-Ray Exams (Tab 42)
William Creevy, MD (AAOS); Kurt A. Schoppe, MD (ACR); Zeke Silva, MD (ACR); Gregory Nicola, MD (ASNR); Tim Tillo, DPM (APMA)

The Relativity Assessment Workgroup identified these services through the CMS/Other Source – Utilization over 250,000 screen. In October 2013, the RUC noted that these services were never RUC reviewed but are frequently reported. The RUC recommended that these services be surveyed for physician work and develop direct practice expense inputs for the January 2014 RUC meeting. At the January meeting the specialty societies suggested to crosswalk these services. The RUC did not accept the crosswalk methodology and requested action of the specialty societies by the April 2014 RUC meeting, acknowledging that the specialty societies may again pursue an alternative

methodology through the Research Subcommittee. The Research Subcommittee considered the request and determined that these services should be surveyed because they have not been recently reviewed. The RUC recommended that these services be surveyed for physician work and direct practice expense inputs for April 2014. Anticipating the volume of radiology codes that were scheduled to be reviewed at the April 2014 RUC meeting the specialty requested that review of these services be postponed to the September 2014 RUC meeting. **The specialties requested and the RUC agreed that the six radiologic examination codes be surveyed for physician work and develop direct practice expense inputs for the September 2014 RUC.**

Transluminal Balloon Angioplasty (Tab 43)
Adam Weinstein, MD (RPA); Zeke Silva, MD (ACR); Gerald Niedzwiecki, MD (SIR); Matthew Sideman, MD (SVS); Clifford Kavinsky, MD, FSCAI (SCAI)

CPT code 75978 was identified through the CMS High Expenditure Procedural Codes screen. The RUC recommended a survey of physician work and practice expense to be presented at the April 2014 RUC meeting.

75978 ***Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation***
The specialty societies including radiologists and vascular surgeons requested that this code be referred to the CPT Editorial Panel by the RUC to bundle this code with related services. The RUC agreed to this request by the specialties suggesting that the issue be considered at the October 2014 CPT Editorial Panel meeting. **The RUC recommends that CPT code 75978 be referred to CPT Editorial Panel.**

CT Abdomen and Pelvis – PE Only (Tab 44)
Zeke Silva, MD (ACR)

In establishing interim final direct PE inputs for CY2013, CMS reviewed the direct PE inputs for all of the abdomen, pelvis, and abdomen/pelvis combined CT codes. For each set of codes, CMS established a common set of disposable supplies and medical equipment. CMS established clinical labor minutes that reflects the fundamental assumption that the component codes should include a base number of minutes for particular tasks, and that the number of minutes in the combined codes should reflect efficiencies that occur when the regions are examined together. Among other refinements, CMS adjusted the intra-service time for CPT codes 72194, 74160, and 74177 by 2 minutes, 4 minutes, and 6 minutes, respectively.

CMS refined the minutes in the service period such that the aggregate number of clinical labor minutes is consistent within this family of codes. CMS believes that the aggregate clinical labor time in each clinical service period (pre-service period, service period, and post-service period) or aggregate number of minutes for particular equipment items that reflects the total typical resource use is more important than the minutes associated with each clinical labor task, which are used by the AMA RUC to develop their recommendations. CMS hopes that in reviewing future services, commenters consider the aggregate clinical labor time as well, recognizing that it is the aggregate time that ultimately has implications for payment.

The RUC reviewed CMS' CY2013 refinements to the direct PE inputs, specifically reductions to the clinical labor intra-service time and equipment time, of CT abdomen

and pelvis codes 72194 *(CT pelvis without and with contrast)*, 74160 *(CT abdomen with contrast)*, and 74177 *(CT abdomen and pelvis with contrast)*. The RUC agreed that the aggregate number of clinical labor minutes should be consistent within a family of codes and contended that this problem will be alleviated as codes in a family are reviewed together. Although the aggregate minutes should be consistent, the RUC and the specialties agree that it is inappropriate to unilaterally alter individual clinical staff time direct inputs for the sole purpose of equalizing the aggregate minutes. This has the potential to distort relativity across the larger RBRVS, as these codes may serve as crosswalks for new, revalued, or revised codes in the future.

The RUC and the specialties recognize that bundled codes may yield efficiencies for certain staff activities, however these efficiencies are best evaluated using the clinical expertise of the PE subcommittee. The RUC does not support the exclusive use of the aggregate minutes to determine efficiencies because the practice expense bottom up methodology requires review of individual practice expense inputs.

Bilateral Ocular Screening - PE Only (Tab 45)
Stephen A. Kamenetzky, MD (AAO); Steven E. Krug, MD (AAP)

CMS requested a review of the practice expense to correct the direct practice expense inputs for supplies and equipment. The RUC recommended that direct practice expense inputs be developed for the April 2014 RUC meeting.

The specialty societies determined and the RUC agreed that CPT code 99174 *Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral (Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral)* requires a revision of the code descriptor because of changes in the way that the service is performed. The specialty has requested descriptor changes in order to ensure correct practice expenses for existing CPT code 99174 *Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral* (work RVU = 0.00), which is analyzed in the office, as well as a new code for situations when a similar service is performed offsite. The technology for 99174, has changed and the new code, CPT Code 9917X , reflects the use of ocular screening instruments that perform both the screening and the analysis with report as well as the use of instruments that perform only the screening but require the analysis and report be done at a separate remote site after electronic transfer. Codes are needed to describe the two technologies and to allow the accurate capture of the practice expense of each. **The RUC recommends CPT code 99174 be referred to the CPT Editorial Panel for revision at the May 2014 CPT meeting.**

XII. CMS OPPS/ASC CAP Proposal – Codes Identified by Specialty to Review (Practice Expense Only)

Plastic Surgery (Tab 46)
Melissa Crosby, MD (ASPS); Mark Villa, MD (ASPS)

Following publication of the 2014 Final Rule, the RUC solicited feedback from specialty societies regarding CPT codes potentially impacted by the OPPS/ASC payment cap proposal. Specialty societies looked over the list of 211 codes identified by the proposal and indicated which services they have an interest in reviewing. The RUC recommended

developing practice expense (PE) inputs only for the subset of codes identified by specialty societies, grouped by specialty, at the April 2014 RUC meeting.

This review marks a new type of screen for the RUC, whereby specialty societies bring forward codes from a range of services identified by CMS through a policy proposal. The CMS OPPS/ASC cap proposal was to limit the practice expense payment through the physician payment schedule at the lower of two facility payment schedules, either the OPPS or ASC payment schedule. The expectation was to review a subset of services to demonstrate that the associated practice expenses are not overestimates. Upon review it became apparent that for services that have not been reviewed in ten or more years, simply applying modern standards could result in PE RVU increases. When increasing certain sections of the direct PE inputs while decreasing other, it is difficult to estimate if the changes will result in an overall increase or decrease in the PE RVU. The Practice Expense Subcommittee has used their clinical expertise to accurately value these services, as they do with all services that are brought forward for review. Although the CMS OPPS/ASC cap proposal was not implemented in the final rule for 2014, the RUC is forwarding practice expense recommendations to CMS to illustrate that the RUC's review of practice expense is based on clinical necessity of the associated costs and payment should not be arbitrarily limited based on completely separate payment systems.

Resource costs in the Medicare physician payment schedule are developed through an extremely thorough "bottom-up" methodology in which the necessary resource costs are added line by line to achieve the actual costs for the physician to provide the care. In contrast, payment to facilities under the OPPS is calculated on the geometric mean of the costs of services in the same ambulatory payment classification (APC). To equate the rigorously developed line item costs associated with specific services performed in the non-facility setting, with charges that are intended to be an average of "similar" services when performed in the facility is severely flawed because the two systems are making payments under vastly different assumptions. The RUC maintains that resource cost data collected under the RBRVS is actually more reliable for two primary reasons. First, pricing in the RBRVS reflects actual costs, while the OPPS/ASC payment system reflects charges that are mathematically manipulated into costs. Second, in the RBRVS, direct resource costs are calculated on a line item basis. This process is extremely thorough and takes into account the clinical intricacies of each service.

The review of these services generally represents decreased direct practice expense or maintenance of the current inputs, with the exception of the addition of equipment direct PE inputs *mayo stand* (EF015) CPT codes 12041, 12054, 12055 and 12057. Decreases include significant decreases in equipment minutes to conform to current conventions. **The RUC reviewed and approved the direct practice expense inputs with minor modification as approved by the Practice Expense Subcommittee.**

<u>Otolaryngology-PE Only (Tab 47)</u>
John Lanza, MD (AAO-HNS); Wayne Koch, MD (AAO-HNS)

Following publication of the 2014 Final Rule, the RUC solicited feedback from specialty societies regarding CPT codes potentially impacted by the OPPS/ASC payment cap proposal. Specialty societies looked over the list of 211 codes identified by the proposal and indicated which services they have an interest in reviewing. The RUC recommended developing practice expense (PE) inputs only for the subset of codes identified by specialty societies, grouped by specialty, at the April 2014 RUC meeting.

This review marks a new type of screen for the RUC, whereby specialty societies bring forward codes from a range of services identified by CMS through a policy proposal. The CMS OPPS/ASC cap proposal was to limit the practice expense payment through the physician payment schedule at the lower of two facility payment schedules, either the OPPS or ASC payment schedule. The expectation was to review a subset of services to demonstrate that the associated practice expenses are not overestimates. Upon review it became apparent that for services that have not been reviewed in ten or more years, simply applying modern standards could result in PE RVU increases. When increasing certain sections of the direct PE inputs while decreasing other, it is difficult to estimate if the changes will result in an overall increase or decrease in the PE RVU. The Practice Expense Subcommittee has used their clinical expertise to accurately value these services, as they do with all services that are brought forward for review. Although the CMS OPPS/ASC cap proposal was not implemented in the final rule for 2014, the RUC is forwarding practice expense recommendations to CMS to illustrate that the RUC's review of practice expense is based on clinical necessity of the associated costs and payment should not be arbitrarily limited based on completely separate payment systems.

Resource costs in the Medicare physician payment schedule are developed through an extremely thorough "bottom-up" methodology in which the necessary resource costs are added line by line to achieve the actual costs for the physician to provide the care. In contrast, payment to facilities under the OPPS is calculated on the geometric mean of the costs of services in the same ambulatory payment classification (APC). To equate the rigorously developed line item costs associated with specific services performed in the non-facility setting, with charges that are intended to be an average of "similar" services when performed in the facility is severely flawed because the two systems are making payments under vastly different assumptions. The RUC maintains that resource cost data collected under the RBRVS is actually more reliable for two primary reasons. First, pricing in the RBRVS reflects actual costs, while the OPPS/ASC payment system reflects charges that are mathematically manipulated into costs. Second, in the RBRVS, direct resource costs are calculated on a line item basis. This process is extremely thorough and takes into account the clinical intricacies of each service.

Some of the services identified have not been reviewed in many years and were modified to remove and/or add supplies and equipment to reflect changes in the way the service is currently performed. In some cases errors were corrected, such as including cleaning time for instruments. Additionally, practice expense standards that have developed in the years since the services were last reviewed were applied. **The RUC reviewed and approved the direct practice expense inputs with modification as approved by the Practice Expense Subcommittee.**

Pathology-PE Only (Tab 48)
Jonathan Myles, MD (CAP); Swati Mehrotra, MD (ASC)

Following publication of the 2014 Final Rule, the RUC solicited feedback from specialty societies regarding CPT codes potentially impacted by the OPPS/ASC payment cap proposal. Specialty societies looked over the list of 211 codes identified by the proposal and indicated which services they have an interest in reviewing. The RUC recommended developing practice expense (PE) inputs only for the subset of codes identified by specialty societies, grouped by specialty, at the April 2014 RUC meeting.

This review marks a new type of screen for the RUC, whereby specialty societies bring forward codes from a range of services identified by CMS through a policy proposal. The CMS OPPS/ASC cap proposal was to limit the practice expense payment through the physician payment schedule at the lower of two facility payment schedules, either the OPPS or ASC payment schedule. The expectation was to review a subset of services to demonstrate that the associated practice expenses are not overestimates. Upon review it became apparent that for services that have not been reviewed in ten or more years, simply applying modern standards could result in PE RVU increases. When increasing certain sections of the direct PE inputs while decreasing other, it is difficult to estimate if the changes will result in an overall increase or decrease in the PE RVU. The Practice Expense Subcommittee has used their clinical expertise to accurately value these services, as they do with all services that are brought forward for review. Although the CMS OPPS/ASC cap proposal was not implemented in the final rule for 2014, the RUC is forwarding practice expense recommendations to CMS to illustrate that the RUC's review of practice expense is based on clinical necessity of the associated costs and payment should not be arbitrarily limited based on completely separate payment systems.

Resource costs in the Medicare physician payment schedule are developed through an extremely thorough "bottom-up" methodology in which the necessary resource costs are added line by line to achieve the actual costs for the physician to provide the care. In contrast, payment to facilities under the OPPS is calculated on the geometric mean of the costs of services in the same ambulatory payment classification (APC). To equate the rigorously developed line item costs associated with specific services performed in the non-facility setting, with charges that are intended to be an average of "similar" services when performed in the facility is severely flawed because the two systems are making payments under vastly different assumptions. The RUC maintains that resource cost data collected under the RBRVS is actually more reliable for two primary reasons. First, pricing in the RBRVS reflects actual costs, while the OPPS/ASC payment system reflects charges that are mathematically manipulated into costs. Second, in the RBRVS, direct resource costs are calculated on a line item basis. This process is extremely thorough and takes into account the clinical intricacies of each service.

Some of the services identified have not been reviewed in many years and were modified to adjust clinical staff time and remove and/or add supplies and equipment to reflect changes in the way the service is currently performed. **The RUC reviewed and approved the direct practice expense inputs with modification as approved by the Practice Expense Subcommittee.**

<u>Neurology and Neuromuscular Procedures (Tab 49)</u>
David Lenrow, MD (AAPMR); Marc R. Nuwer, MD, PhD (AAN); Marianna V. Spanaki, MD, PhD, MBA (AAN); Benn E. Smith, MD (AANEM)

Following publication of the 2014 Final Rule, the RUC solicited feedback from specialty societies regarding CPT codes potentially impacted by the OPPS/ASC payment cap proposal. Specialty societies looked over the list of 211 codes identified by the proposal and indicated which services they have an interest in reviewing. The RUC recommended developing practice expense (PE) inputs only for the subset of codes identified by specialty societies, grouped by specialty, at the April 2014 RUC meeting.

This review marks a new type of screen for the RUC, whereby specialty societies bring forward codes from a range of services identified by CMS through a policy proposal. The

CMS OPPS/ASC cap proposal was to limit the practice expense payment through the physician payment schedule at the lower of two facility payment schedules, either the OPPS or ASC payment schedule. The expectation was to review a subset of services to demonstrate that the associated practice expenses are not overestimates. Upon review it became apparent that for services that have not been reviewed in ten or more years, simply applying modern standards could result in PE RVU increases. When increasing certain sections of the direct PE inputs while decreasing other, it is difficult to estimate if the changes will result in an overall increase or decrease in the PE RVU. The Practice Expense Subcommittee has used their clinical expertise to accurately value these services, as they do with all services that are brought forward for review. Although the CMS OPPS/ASC cap proposal was not implemented in the final rule for 2014, the RUC is forwarding practice expense recommendations to CMS to illustrate that the RUC's review of practice expense is based on clinical necessity of the associated costs and payment should not be arbitrarily limited based on completely separate payment systems.

Resource costs in the Medicare physician payment schedule are developed through an extremely thorough "bottom-up" methodology in which the necessary resource costs are added line by line to achieve the actual costs for the physician to provide the care. In contrast, payment to facilities under the OPPS is calculated on the geometric mean of the costs of services in the same ambulatory payment classification (APC). To equate the rigorously developed line item costs associated with specific services performed in the non-facility setting, with charges that are intended to be an average of "similar" services when performed in the facility is severely flawed because the two systems are making payments under vastly different assumptions. The RUC maintains that resource cost data collected under the RBRVS is actually more reliable for two primary reasons. First, pricing in the RBRVS reflects actual costs, while the OPPS/ASC payment system reflects charges that are mathematically manipulated into costs. Second, in the RBRVS, direct resource costs are calculated on a line item basis. This process is extremely thorough and takes into account the clinical intricacies of each service.

The review of these services represents decreased direct practice expense or maintenance of the current inputs. Decreases include elimination of electroencephalogram (EEG) scoring by the REEGT (L047B) in CPT codes 95812 and 95813 because of implementation of electronic medical records. **The RUC reviewed and approved the direct practice expense inputs with minor modification as approved by the Practice Expense Subcommittee.**

XIII. HCPAC Review Board (Tab 50)

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

Computer-Assisted Adjustment of External Fixation (Tab 50)
Timothy Tillo, DPM (APMA)

Following publication of the 2014 Final Rule, the RUC solicited feedback from the specialties societies regarding CPT codes potentially impacted by the OPPS/ASC Payment Cap. Specialty societies reviewed the list of 211 identified through the cap and indicated which codes they have an interest in re-reviewing. The RUC recommended

developing practice expense inputs only for the subset of codes identified by specialty societies, grouped by specialty, at the April 2014 RUC meeting.

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with no modification as approved by the Practice Expense Subcommittee.

The RUC filed the HCPAC Review Board Report.

XIV. Practice Expense Subcommittee (Tab 51)

Doctor Manaker, Chair, presented the report of the Practice Expense Subcommittee

- Doctor Manaker thanked the members of the Practice Expense Subcommittee for the 20+ hours over a day and a half that they spent reviewing the practice expense materials for this meeting.
- Although there is no official rule, the PE Subcommittee precedent is that members of the PE Subcommittee cannot present on behalf of their society to the PE Subcommittee. The Subcommittee discussed that there are situations in which a member of the RUC Advisory Committee is also a member of the PE Subcommittee and may be the only Advisor that is able to present to the PE Subcommittee. Some scenarios where this might be necessary include weather, health issues, or lack of resources for smaller specialty societies. The PE Subcommittee recommends maintaining the precedent that PE Subcommittee members do not present to the PE Subcommittee on behalf of their society. In the rare case that a PE Subcommittee member needs to present to the PE Subcommittee on behalf of their society, the specialty society should notify the PE Subcommittee at the time that recommendations are submitted. The Subcommittee will consider the exception and vote on the issue at the beginning of the PE Subcommittee meeting. If the presenter is approved, the issue will be moved to the end of the PE Subcommittee meeting.
- The PE Subcommittee discussed an appeals process for practice expense refinements and outlined the RUC's formal appeal process, recognizing that there is an opportunity to extract and discuss PE issues when the codes in question come before the full RUC for review. PE is part of the overall RUC recommendation and as such, an appeal could be based on reconsideration of practice expense. If the practice expense is passed by the full RUC then the next opportunity for a formal appeal is the RUC appeal process and all appeals of RUC decisions shall be in writing, subsequent to the previous meeting and prior to the next meeting.
- The RUC responded to CMS' proposal to cap practice expense payment at the lower of two payment systems, the outpatient prospective payment system or the ambulatory surgical center payment system, by tasking the PE Subcommittee with reviewing a sample subset of the codes impacted by the cap.
- The PE Subcommittee discussed the possibility of forming a Workgroup to examine clinical staff time standards for quality assurance (QA). Such clinical staff time is allocated only for federally mandated requirements (such as cytopathology, mammography and radiation therapy services) as a direct practice expense for the corresponding CPT codes. Since this is a code by code process and there are various state regulations, the PE Subcommittee determined that a standard for QA is not necessary at this time and that the Subcommittee will continue to determine whether or not it is an appropriate practice expense input on a code by code basis. The Subcommittee then

discussed and left open the possibility of requesting a HCPCS code to account for locally (state) regulated requirements.

- The issue of the rising expense of disposable supplies and equipment was discussed by at this meeting and at the last meeting. The PE Subcommittee had planned to discuss it at this meeting, however, due to the size of this meeting, the importance of the issue and the need for AMA staff to research the issue, it was postponed to the September 2014 PE Subcommittee meeting.

The RUC approved the Practice Expense Subcommittee Report

XV. Relativity Assessment Workgroup (Tab 52)

Doctor Raphaelson provided a summary of the Relativity Assessment Workgroup meeting.

- Review Action Plan (11981)
  At the October 2013 meeting, the Relativity Assessment Workgroup reviewed High Volume Growth Services where Medicare utilization increased by at least 100% from 2006 to 2011. The RUC requested that CPT code 11980 Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin) be surveyed for physician work and develop practice expense inputs for the January 2014 RUC meeting. In January 2014 the RUC questioned whether CPT code 11981 should also be reviewed since it is "CMS/Other" and has not been reviewed. The RUC requested that the specialty societies submit an action plan to the RAW in April to consider whether 11981 is part of this family and should be surveyed. **The Workgroup reviewed codes 11981 and 11980 and determined that these services are not part of a family of services and 11981 does not require further review at this time. Additionally, code 11981 is primarily performed by orthopaedic surgery, whereas, code 11980 is performed primarily by urology and not performed at all by orthopaedic surgeons.**

Doctor Raphaelson indicated that the Workgroup examined three screening criteria.

- **Review Pre-Time Analysis Action Plans**
  In January 2014, the RUC identified codes reviewed prior to April 2008 with pre-time greater than pre-time package 4 Facility - Difficult Patient/Difficult Procedure (63 minutes) for services with 2012 Medicare Utilization over 10,000. The screen identified 19 services with more pre-service time than the longest standardized pre-service package. The RUC reviewed these services and requested action plans from the specialty societies on how to address the pre-service time for these services. **The Relativity Assessment Workgroup reviewed these action plans and agreed with the specialty societies that codes 34802, 34812 and 34825 (and code family) be referred to CPT for revision in the 2017 cycle. The Workgroup agreed that code 39400 and code family be referred to CPT for revision in the 2016 cycle. For the remaining 15 codes identified, the Workgroup requests revised action plans in which the specialty societies provide the following information: current total pre-service time; median times for pre-service components from the most recent survey; specialty recommendation for pre-service package to be applied to the code, with any recommended adjustments to the package; specialty recommendation for a crosswalk code to support the recommended pre-service time changes; and a summary of the RUC rationale for code valuation, to indicate whether the code was valued based on magnitude estimation or other methodology.**

- **Review 010-Day Global Post-Operative Visits Action Plans**
  In January 2014, the RUC reviewed 010-day global services (based on 2012 Medicare utilization data) and identified 18 services with >1.5 office visits and 2012 Medicare utilization > 1,000. The RUC requested action plans from the specialty societies to address/explain the office visits associated with these services for review in April 2014.
  The Workgroup reviewed the action plans and recommend the following:

CPT Code	RAW Rec
10061	Maintain current post-operative visits. Reaffirm the Oct 2010 approved visits.
11750	Survey Sept 2014
11752	Survey Sept 2014
20245	Survey Sept 2014 with code 20240.
28002	Maintain current post-operative visits. Reaffirm the Oct 2010 approved visits.
38570	Survey Sept 2014
38571	Survey Sept 2014
38572	Survey Sept 2014
40800	Maintain. Current post-op visits are appropriate. One visit is needed to assess healing after the procedure, ensure there is no infection, review pathology or microbiology. Typically the area is not healed after one visit so another visit is performed to assess healing and ensure there is no infection. The physician will also assess function, swallow speech and need for therapy during the second post-op visit.
40812	Maintain. Current post-op visits are appropriate. One visit is needed to assess healing after the procedure, ensure there is no infection, review pathology or microbiology. Typically the area is not healed after just one visit, so another visit is performed to assess healing and ensure there is no infection. The physician also needs to inspect suture line in 40812 to ensure good closure with no dehiscence. The physician will also assess function, swallow, speech, and need for therapy during the second post-operative visit.
40820	Maintain. Current post-op visits are appropriate. One visit is needed to assess healing after the procedure, ensure there is no infection. Typically the area is not healed after just one visit, so another visit is performed to assess healing and ensure there is no infection. The physician will also assess function, swallow, speech, and need for therapy during the second post-operative visit.
46500	Survey Sept 2014
55706	Maintain no change. This service is also on the New Technology list scheduled for review by the RAW in Sept 2014.
65855	Survey April 2015
66761	Maintain current post-operative visits. Reaffirm the April approved visits.
68801	Survey
68810	Survey
68815	Survey

- **Review 090-Day Global Post-Operative Visits Action Plans**
  In January 2014, the RUC reviewed 090-day global services (based on 2012 Medicare utilization data) and identified 10 services, reported at least 1,000 times per year that included more than 6 office visits. The Workgroup reviewed the 10 services and requested action plans from the specialty societies to address/explain the office visits associated with these services

for review in April 2014. The Workgroup agreed with the specialty societies that the post-operative visits for two services are appropriate and should be maintained and the remaining eight services should be surveyed. **The Workgroup recommends:**

CPT Code	RAW Recommendation
19357	Maintain. Reaffirmed the Feb 2010 approved visits.
20692	Maintain. Current post-operative visits are appropriate. CPT code 20692 is for the application of a multi-planar external fixator system. Post-discharge, patients with multi-planar external fixators require weekly follow-up in order to assess progress of fracture healing and regularly adjust and replace the struts within the system. If a patient does not receive frequent assessment the fracture(s) may not properly heal, thus it is essential that patients be regularly seen post-operatively in the office. Patients also frequently have pin tract infections that require frequent, in-office monitoring.
26356	Survey Jan 2015 with 26357 & 26358
28293	Survey Jan 2015
31588	Survey Sept 2014 with 31582, 31584 & 31587
47135	47135-Survey Sept 2014; 47136-Refer to CPT for deletion
65780	Survey
66170	Survey
66172	Survey
67113	Survey with 67108. Refer CPT code 67112 to CPT Editorial Panel for deletion at Oct 2014 meeting.

CPT Code 33235
Additionally, AMA staff reviewed 090-day global services that have more than one 99215 office visit. Based on 2012 Medicare utilization data, only one service (code 33235), reported more than 1,000 times per year, included a 99215. However, AMA staff reviewed the archives folder and the recommendation submitted to CMS for the May 1994 recommendation for code 33235 or tracking number AS13 indicated **two 99214** office visits, not two 99215 office visits. This is consistent with CPT code 33234. This was an error in the database/physician time file has been corrected.

Doctor Raphelson also announced the following informational items were included in the Relativity Assessment Workgroup materials:

a. Status of CPT Code 64412 (Tab 36 of April 2014 meeting)
b. Referrals to the CPT Editorial Panel
c. Referrals to the CPT Assistant Editorial Board
d. Potentially Misvalued Services Progress Report
e. Full CMS/Relativity Assessment Status Report

The RUC approved the Relativity Assessment Workgroup Report

XVI. Research Subcommittee (Tab 53)

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

- **The RUC reviewed and accepted the March conference call reports.**

- **Review of Education Material**
  The American Physical Therapy Association (APTA) has developed a podcast that has gone through several revisions and as well as a slightly modified version of the AMA slide deck. Doctor Collins pointed out that receiving requests like this could happen more often in the future with the general shift towards using more electronic media. **The Research Subcommittee found the podcast modifications to be appropriate and recommended approval of the educational tool.**

- **Requirement to Present Summary Data to RUC if Survey is Conducted- Discussion**
  There was an issue raised at the April RUC meeting about whether societies who are scheduled to present survey data may pull their data and not present for an assortment of reasons. The Research Subcommittee had a comprehensive discussion regarding the pros and cons about who can best evaluate that. **The Research Subcommittee deferred this proposal until the September 2014 meeting and requested that AMA staff provide a report listing all of the impacted proposals from the past five years.** This report will help the Research Subcommittee understand the reasons for these delays and determine if requiring the submission of aggregate survey data would be worthwhile.

- **Specialty Society Request for Review of Pre-service and Post-service Intensity**
  The American College of Surgeons (ACS) submitted a very detailed analytic document that examined the history and valuation of pre- and post-service work for surgical procedures. ACS provided an in depth comparison of pre- and post-service components with E/M codes and discovered that certain portions of pre-service surgical time, particularly scrub, dress and wait time, are valued lower than the lowest value office visit, 99211. There was a robust discussion about the significance of the findings from the ACS report. ACS was very clear that they have no interest in trying to revalue surgical services and was providing this analysis purely as information. The Research Subcommittee recommended that the appropriate response to this information is to use it as further evidence that the building block and reverse building block methodologies are inappropriate to use when valuing services in the RBRVS. This information further validates this reasoning, since it confirms that the intensities were originally arbitrarily derived. Since the RUC has always placed an emphasis on magnitude estimation, this data should be used in any arguments to CMS and other stakeholders who may advocate for the use of the building block methodology to value a specific service. It was recommended that every RUC member read the ACS report.

- **Specialty Society Recommendations for RUC Survey**
  A number of specialty societies submitted questions and/or recommended improvements regarding the Qualtrics online RUC survey templates. Some of the specialty society recommendations are either being further reviewed by staff or in process of implementation. The general content-related suggestions, not particular to Qualtrics, were wide-ranging and the Subcommittee felt that there was not sufficient time to cover ever recommendations at the current meeting. The Research Subcommittee requested for AMA Staff to create a more concise, summary of recommendations and deferred the item until either a future conference call or the next Subcommittee meeting. Following a RUC Advisor question regarding when all societies will be required to use Qualtrics, RUC Staff and Doctor Levy clarified that the RUC is in the middle of the transition and there is currently no specific deadline.

- **Review of Specialty Society Requests Pertaining to Issues on April RUC Agenda**
  There were three issues pertaining to surveys for the April 2014 RUC meeting. The first two issues, regarding Sacroiliac Joint Fusion (27279X and 27280) and Endovascular Ablation (36475, 36476, 36478, 36479), involved potentially tainted survey pools due to inappropriate communications. The Research Subcommittee had felt that the societies handled the situation with great aplomb and appropriately. **The Research Subcommittee recommended for the tabs to be presented at the April 2014 meeting without modification.**

  The second issue, regarding Corneal Hysteresis Determination (9214X1), had to do with a society that did not receive Research approval for conducting a targeted survey sample in advance of conducting their survey. The society had done what they would have been instructed to do by the Research Subcommittee anyway, given that they did not have any other option due to a very low utilization of the services. **The Research Subcommittee accepted the usage of a targeted survey sample and recommended for the tab to be presented at the April 2014 meeting without modification.**

  Doctor Collins pointed out that if any society is conducting a survey and they think that they have tainted survey data, they should retain the tainted data and consider presenting that in addition to the untainted summary data. One of the surveys for the April meeting did not reach the minimum number of survey respondents if the potentially tainted data was excluded. If the societies compare the tainted and non-tainted pools and there is no difference, it may be accepted to combine those pools, though the data summary should be presented both separately and in aggregate.

- **Other Business**
  The rough schedule of the transition to the online RUC survey tool was shared as an informational item. The process continues to proceed according to plan. There is no set date for complete transition to the Qualtrics, tool though work continues in that direction.

  The RUC approved the Research Subcommittee Report

XVII. Administrative Subcommittee (Tab 54)

Doctor J. Allan Tucker, MD, Chair, provided a summary of the Administrative Subcommittee report:

- **Review Rotating Seat Policies and Election Rules**
  Doctor Tucker indicated that the Administrative Subcommittee reviewed the rotating seat policies and election rules. The Subcommittee noted that this body reviewed the candidates for the primary care and internal medicine rotating seats (Tab 55) and confirmed that all candidates met the rotating seat criteria and will be placed on the ballot for election at this meeting.

- **Attestation from Vendors Supplying Survey Sample**
  Doctor Tucker indicated that the Administrative Subcommittee considered an item proposed at the January 2014 meeting, when a RUC member proposed that if a targeted survey is utilized using contact information provided from a company/vendor, an attestation should be required stating that the company/vendor provided no further communication regarding valuation or reimbursement. The RUC referred this issue to the

Administrative Subcommittee to determine what action should be taken. The Administrative Subcommittee discussed this issue and recommends:

- The RUC require attestation statements from companies/vendors attesting that they have not and will not contact potential RUC survey respondents.
- The RUC add a question to the survey instrument for respondents to confirm that they have not received correspondence directly from the company/vendor.

AMA staff will work with the AMA Office of General Counsel to draft language for review by the Administrative Subcommittee in September 2014.

- Members of the Administrative Subcommittee expressed concern that the CPT Editorial Panel consider adoption of a code as Category III if it is not a service performed by enough physicians to allow for collection of data. It was noted that most of these new technology coding proposals are supported by the respective specialty society.

- **RUC Advisors serving as temporary RUC Alternate Members**
  Doctor Tucker also indicated the Subcommittee considered an issue proposed by a RUC member that the RUC create a policy that when a Specialty Society RUC Advisor fills in for a RUC member during a RUC meeting he/she should not serve as an Advisor for the remainder of the CPT cycle. The RUC referred the proposal to the Administrative Subcommittee to determine what action should be taken. Currently the RUC Structure and Functions document specifies if a RUC Alternate Member serves as a RUC Advisor, he/she may not serve as a RUC Alternate Member the remainder of the meeting.
  - *III.B.3.Organization and Structure Advisory Committee Designation.* This proposal is suggesting expanding the time period for an entire cycle as well as establishing a rule if a RUC Advisor serves as a RUC Alternate.

  The Administrative Subcommittee discussed this issue and determined that further extending what capacity RUC participants serve as for an entire cycle would place too many restrictions on the physicians who volunteer and the specialty societies involved, specifically smaller specialty societies. The Subcommittee determined that RUC Members and Alternates appropriately serve as an expert when serving in that capacity and only RUC Advisors advocate for their associated specialty society. **The Administrative Subcommittee reaffirmed the current policy that any RUC Advisors who temporarily fill in for a RUC Alternate at a meeting (or RUC Alternate as a RUC Advisor) must continue to serve the remainder of that meeting in that capacity.**

  The RUC approved the Administrative Subcommittee Report

XVIII. Rotating Seat Elections

- Joseph R. Schlect, DO, American Osteopathic Association, was elected to the RUC's Primary Care Rotating seat.
- Robert J. Kossman, MD, President of the Renal Physicians Association was elected for nephrology to the Internal Medicine rotating seat. Doctor Kossman was uncontested.

XIX. Other Business (Tab 56)

- A RUC alternate proposed that the Administrative Subcommittee review possible conflict of interests resulting from participation in clinical trials. The RUC refers this issue to the Administrative Subcommittee to determine what action should be taken.

- ASCRS and ACS submitted a letter to the RUC requesting reconsideration of a recently adopted standard for dorsal lithotomy positioning time (ie, 5 minutes). The societies disagree that this standard positioning time requested for urological procedures should have been applied to rectal procedures and prefer to present positioning time on a code by code basis. This will be clarified to be for urology only. Other specialties ASCRS and ACS will bring up other standards as they bring relevant codes.
- A RUC member proposed that the RUC provide a written description of magnitude estimation.
    - Staff Note - CMS is responsible for the definition of magnitude estimation. CMS obtained the analysis and definition from the Hsaio Harvard studies. In the June 1991 Proposed Rule, CMS provides this definition of magnitude estimation, "Magnitude estimation is a technique that rates each dimension in relation to a reference service using a ratio scale."[1]
    - The Hsiao study includes the following description of magnitude estimation: After consulting with measurement psychologists, statisticians, economists, and sociologists, we selected magnitude estimation as the best method to obtain subjective assessments of work, mental effort and judgment, technical skill and physical effort, and stress. (In an experiment with an alternative method, we tried to assess physicians' indifference curves by asking them to trade one procedure for another. "In terms of work and effort," we asked, "how many N procedures would you be willing to perform for every M procedure?" This trade-off method proved unworkable because the physicians often replied, "Since I am paid $400 for procedure M, and $50 for procedure N, I am willing to trade eight for one." Thus, they were not rating work but merely reiterating what we already knew about the relative charges.)

      Magnitude estimation is a method of measuring subjective perceptions and judgments to yield reproducible and valid results.942 For example, magnitude estimation yields close correspondences between physical measures of sensation and the subjective ratings of perceptions, such as between the intensity of light and subjective rating of brightness. Moreover, it can reliably replicate results across many groups of people.

      In this method the respondent is asked to rate a service in relation to a reference service, using a ratio scale rather than a cardinal or ordinal scale. Respondents can rate a service as high or low as they believe necessary to reflect reality. In general surgery, for example, we selected uncomplicated inguinal hernia repair as the reference service and gave its work a value of 100. A surgeon who judged the work of a lower anterior resection for rectal carcinoma to be 4 1/2 times that of an uncomplicated inguinal hernia repair responded with a rating of 450.[2]
- A RUC member commented that it is not clear what a family of codes is. The Chair clarified that we have to depend on the specialty societies to determine this since they are the experts in the services they perform.
- A RUC member brought up the issue of increasing influence of outside bodies. The RUC determined that the Administrative Subcommittee sufficiently addresses conflict of interest issues.

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[1] **"Medicare Program; Fee Schedule for Physicians' Services; Proposed Rule," 56 Federal Register 108 (5 June 1991), pp. 25802.**

[2] **Hsiao et al (1988). Measurement and Analysis of Intraservice Work. JAMA, Vol 260 (No. 16), pp. 2363.**

- A RUC member proposed that with increased survey thresholds the RUC may need to take some action to help specialty societies increase their survey numbers. The Chair determined that the RUC should not take any action at this time and determine after a couple meetings with the new thresholds if any action is needed.
- The RUC expressed their gratitude to the Chair for getting the RUC through this high volume meeting very efficiently.

Doctor Levy adjourned the meeting at 4:45pm on Saturday, April 26, 2014.

AMA/Specialty Society RVS Update Committee **Tab 50**
Health Care Professionals Advisory Committee Review Board
April 24, 2014

Members: William Mangold, MD (Chair), Anthony Hamm, DC (Co-Chair), Jane White, PhD, RD, FADA (Alt. Co-Chair), Carmen Vega- Barochowitz, MS, CCC-SLP, Scott Collins, MD, Leisha Eiten, AuD, CCC-A, Charles Fitzpatrick, OD, Mary Foto, OTR, James Georgoulakis, PhD, Emily Hill, PA-C, Stephen Levine, PT, DPT, MSHA, Eileen Moynihan, MD, W Bryan Sims, DNP, APRN-BC, FNP, Timothy Tillo, DPM and Doris Tomer, LCSW

I. Introduction and CMS Update

Doctor Edith Hambrick from CMS attended the HCPAC meeting. Doctor Hambrick updated the group on the recent resignations of HHS Secretary Kathleen Sebelius and CMS Deputy Administrator Jonathan Blum. She stated that President Obama will nominate Sylvia Matthews-Burwell currently at OMB as Secretary Sebelius' replacement. Sean Cavanaugh who is currently the Director of CMMI will replace Jonathan Blum.

II. CMS OPPS/ASC CAP Proposal – Codes Identified by Specialty to Review (Practice Expense Only)

Computer-Assisted Adjustment of External Fixation (CPT Code 20697)
American Podiatric Medical Association

Tony Hamm, DC, HCPAC Co-Chair asked the specialty society to come forward and discuss this issue. Tim Tillo, DPM, representing the APMA, stated that this code was on the list of codes identified by specialties as being potentially impacted by the OPPS/ASC Payment CAP. Specifically, the RUC recommended developing practice expense inputs for a subset of codes including CPT Code 20697. Tim Tillo reported that the APMA developed PE inputs which were presented and passed without change by the PE Subcommittee during this meeting.

The HCPAC accepted the direct practice expense inputs as approved by the PE Subcommittee.

III. Other Business

Susan Clark mentioned to the HCPAC that it would be considered acceptable to replace "physician" with "qualified health care professional" in survey process education as well as the survey instrument.

Jane White discussed the team based care chronic care transitional management plan. She believes that it may be a good idea for the HCPAC to reach out and work with appropriate AMA staff on this issue.

AMA/Specialty Society RVS Update Committee **Tab 51**
Practice Expense Subcommittee
April 23-24, 2014

Members Present: Scott Manaker, MD, PhD, FCCP (Chair), Guy Orangio, MD (Vice Chair), Albert Bothe, MD (CPT), James Blankenship, MD, Joel Brill, MD, Neal Cohen, MD, Thomas Cooper, MD, David Han, MD, Timothy Laing, MD, Howard Lando, MD, Alan Lazaroff, MD, Geraldine B. McGinty, MD, Eileen M. Moynihan, MD, Margaret Neal, MD, Chad Rubin, MD, W Bryan Sims, DNP, APRN-BC, FNP, Robert Stomel, DO, Thomas J. Weida, MD

I. Direct Practice Expense Inputs Refinement

At the January 2014 RUC meeting a Practice Expense (PE) Subcommittee member expressed interest in developing a formal appeals process for CMS refinements to practice expense. Currently the RUC solicits comments from the specialty societies for each refinement, collates the information, and submits the information to CMS. CMS assured the PE Subcommittee that these comments are taken seriously and are considered in their rulemaking. Apart from the RUC process, specialty societies often appeal directly to CMS when they do not agree with practice expense refinements.

The PE Subcommittee discussed an appeals process for practice expense refinements and considered developing a refinement panel parallel to the panel convened for refinements to RUC recommendations on physician work. CMS reminded the PE Subcommittee that the refinement panel is limited to appeals based on new information and that a practice expense appeals process might need to be similarly limited. Following a robust discussion the PE Subcommittee did not pursue creation of a separate practice expense refinement panel at this time.

The PE Subcommittee also discussed situations when specialty societies disagree with the practice expense recommendation approved by the RUC. RUC staff reminded the Subcommittee that there is an appeals process for reconsideration of RUC recommendations. The appeals process is outlined below:

A. Requests for reconsideration at a RUC meeting will follow the standard Sturgis, Standard Code of Parliamentary Procedures.
B. If a specialty requests an appeal of a RUC recommendation made at the previous RUC meeting, the Chair will appoint an Ad Hoc Committee as in Section I.F.3., with the exception of I.F.3.d. If time permits, the RUC will hold the relevant portion of the final recommendation of the RUC while the reconsideration process continues.
C. All appeals of RUC decisions shall be in writing, subsequent to the previous meeting and prior to the next meeting.
D. The Ad Hoc Committee shall meet in person or by telephone conference within two weeks, when possible, of receipt of a written request for an appeal.
E. The Ad Hoc Committee shall invite appellants to meet with the Ad Hoc Committee in person or by telephone to discuss the rationale for RUC decisions or to provide written comments.
F. The Ad Hoc Committee will notify individuals or specialty societies who previously provided written comments on an issue under appeal and elicit further comments.
G. The Ad Hoc Committee shall vote to recommend to the RUC whether the RUC should reconsider its previous recommendation and, if so, shall develop a new

recommendation for consideration by the RUC. If the Ad Hoc Committee determines not to reconsider a RUC recommendation, no further RUC action is taken.

H. The Ad Hoc Committee shall provide its recommendation for reconsideration to the AMA for distribution to the RUC at least two weeks prior to the next meeting of the RUC and shall communicate to all relevant parties in a timely manner. A recommendation not to reconsider can be submitted any time prior to the RUC meeting.

I. An appeal request of a RUC recommendation submitted less than two weeks prior to an upcoming RUC meeting will be deferred to the subsequent RUC meeting to permit at least two weeks notice to all parties.

J. In the event the RUC reconsiders an action by this appeal process, the RUC decision will be final.

K. Approval of reconsideration of a RUC recommendation, which required a two-thirds majority, shall itself require a two-thirds approval.

PE is part of the overall RUC recommendation and as such an appeal could be based on reconsideration of practice expense.

II. Clarification of Advisory Committee Member participation on PE Subcommittee

The PE Subcommittee discussed the existing operating policy regarding Practice Expense Subcommittee members' role in presenting work recommendations to the RUC. Currently RUC Advisory Committee members participate on Subcommittees and Workgroups of the RUC and this activity does not preclude them from presenting work recommendations to the RUC on behalf of their specialty societies. Advisory Committee members are included on the Subcommittees and Workgroups to provider greater input to these discussions and recommendations, which ultimately require approval of the full RUC.

Although there is no official rule, the PE Subcommittee precedent is that members of the PE Subcommittee cannot present on behalf of their society to the PE Subcommittee. The Subcommittee discussed that there are situations in which a member of the RUC Advisory Committee is also a member of the PE Subcommittee and may be the only Advisor that is able to present to the PE Subcommittee. Some scenarios where this might be necessary include weather, health issues, or lack of resources for smaller specialty societies. **The PE Subcommittee recommends maintaining the precedent that PE Subcommittee members do not present to the PE Subcommittee on behalf of their society. In the rare case that a PE Subcommittee member needs to present to the PE Subcommittee on behalf of their society, the specialty society should notify the PE Subcommittee at the time that recommendations are submitted. The Subcommittee will consider the exception and vote on the issue at the beginning of the PE Subcommittee meeting. If the presenter is approved the issue will be moved to the end of the PE Subcommittee meeting.**

III. Outpatient Prospective Payment System and Ambulatory Surgical Center Cap

Following publication of the 2014 Final Rule, the RUC solicited feedback from the specialties societies regarding CPT codes potentially impacted by the OPPS/ASC Payment Cap. Specialty societies indicated an interested in re-reviewing or validating a recent RUC review, for 59 of the 211 codes identified through the cap. **The PE Subcommittee reviewed the codes identified by specialty societies, grouped by families and will provide CMS with the recommendations as a sample subset of the codes impacted by the cap. Other services from the list of 211 that have been recently reviewed will also be identified to CMS.**

IV. Clinical Staff Time Standards for QA

The RUC discussed the possibility of creating a standard for clinical staff time devoted to QA. Such clinical staff time is allocated only for federally mandated requirements (such as cytopathology, mammography and radiation therapy services) as a direct practice expense for the corresponding CPT codes. In the last CPT cycle a CPT Workgroup was created to consider creating a code for mandated activities. Ultimately the group determined that it was not necessary to create this type of code. The PE Subcommittee determined that a standard for QA is not necessary at this time and that the Subcommittee will continue to determine whether or not it is an appropriate practice expense input on a code by code basis. The Subcommittee then discussed and left open the possibility of requesting a HCPCS code to account for locally (state) regulated requirements.

V. Rising Expense of Disposable Supplies and Equipment

The PE Subcommittee discussed the issue of rising expenses for new technology and changes in practice standards. As part of the misvalued code initiative the practice expense is reviewed in addition to the work. Some of these codes are captured in the high volume or high expense screens because of very expensive equipment and disposable supplies. An unintended consequence of this review is that the cost of already high cost equipment and disposable supplies continues to escalate in the interim and is reflected in the direct practice expense inputs recommendations. Examples from the January 2014 meeting include: the linac accelerator in the radiation treatment codes and the list of supplies and equipment in the GI codes. The equipment cost is increasing must faster than the physician fee schedule at a 0.5% a year. An unintended consequence of this review is that the cost of already high cost equipment and disposable supplies continues to escalate in the interim and is reflected in the direct practice expense inputs recommendations. This pulls PE RVUs from other codes in the fee schedule because as the total cost all of the disposable supplies and equipment remains fixed, they are not rebased. There are a number of solutions, some of which CMS has proposed in the past and not moved forward with:

- Pricing from other sources such as the VA or the GAO acquisition cost list
- Propriety hospital acquisition cost list (unusable)
- Both inpatient and outpatient hospital cost report
- ASP/AWP pricing akin to what CMS has done for chemotherapy
- CMS or contractor re-pricing

If we fail to come up with some reasonable suggestions for rebasing these expensive devices and expensive supplies, they will continue to pull PE RVUs into these new codes and create distortions compared to old codes based on how recently a code is reviewed. Although purchasing power is variable, a rebasing of all supplies and equipment would maintain relativity. **The PE Subcommittee recommends that staff research this issue and provide data to the PE Subcommittee prior to the October 2014 RUC meeting. The PE Subcommittee will discuss the issue at the October 2014 RUC meeting and develop recommendations to provide to the RUC and CMS.**

VI. Practice Expense Recommendations for CPT 2015

Tab	Title	PE Input Changes (Yes or No)
4	Cryoablation Treatment of the Bone Tumors	Yes Minor Modifications

Tab	Title	PE Input Changes (Yes or No)
5	Internal Fixation of Rib Fracture	No Standard 090 Day Global
6	Percutaneous Vertebroplasty and Augmentation	Yes Minor Modifications
7	Total Disc Arthroplasty Additional Cervical Level Add-On Code	Yes Minor Modifications
8	Sacroiliac Joint Fusion	Yes Minor Modifications
9	Subcutaneous Implantable Defibrillator Procedures	Yes Minor Modifications
10	Transcatheter Mitral Valve Repair	Yes Minor Modifications
11	ECMO-ECLS	No
12	Transcatheter Placement of Carotid Stents	No Standard 090 Day Global
13	Flexible Sigmoidoscopy	Yes Minor Modifications
14	High Resolution Anoscopy	Yes Minor Modifications
15	Cryoablation of Liver Tumor	Yes Minor Modifications
16	Cystourethroscopy Insertion Transprostatic Implant	Yes Minor Modifications
17	Myelography	Yes Minor Modifications
18	Transversus Abdominis Plane (TAP) Anesthetic Block	Yes Minor Modifications
19	Breast Tomosynthesis	No
20	Isodose Calculation with Isodose Planning Bundle	Yes Minor Modifications

Tab	Title	PE Input Changes (Yes or No)
21	Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s)	Yes Minor Modifications
22	Transient Elastography of Liver	Yes Modifications
23	Corneal Hysteresis Determination	No
24	EOG VNG	Yes Minor Modifications
25	Interventional Transesophageal Echocardiography (TEE)	Yes Minor Modifications
26	Carotid Intima-Media Thickness Ultrasound	Yes Minor Modifications
27	Brief Behavioral Assessment	No
28	Chronic Care Management	No
29	Application of Topical Fluoride Varnish	Yes Minor Modifications
30	Laparoscopic Hysterectomy	No Standard 090 Day Global
31	Prostatectomy	Yes Minor Modifications
32	Laminectomy	No PE Recommendation
33	Duplex Scans	Yes Minor Modifications
34	Ultrasound Guidance	No PE Recommendation
35	Ultrasound Guidance for Needle Placement	No
36	Anesthetic Injection Spinal Nerve	No PE Recommendation Refer to CPT

Tab	Title	PE Input Changes (Yes or No)
37	Morphometric Analysis	Yes Minor Modifications
38	Endovenous Ablation	Yes Minor Modifications
39	Ultrasound Guidance for Needle Placement	Yes Minor Modifications
40	Doppler Flow Testing	Yes Minor Modifications
41	CT Maxillofacial	Yes Minor Modifications
42	X-Ray Exams	No PE Recommendation Postponed
43	Transluminal Balloon Angioplasty	No PE Recommendation Refer to CPT
44	CT Abdomen and Pelvis	No PE Recommendation
45	Bilateral Ocular Screening	No PE Recommendation Refer to CPT
46	CMS OPPS ASC CAP Proposal – Plastic Surgery-PE Only	Yes Minor Modifications
47	CMS OPPS ASC CAP Proposal – Otolaryngology-PE Only	Yes Modifications (due to volume will be distributed electronically only)
48	CMS OPPS ASC CAP Proposal – Pathology-PE Only	Yes Modifications (due to volume will be distributed electronically only)
49	CMS OPPS ASC CAP Proposal – Neurology-PE Only	Yes Minor Modifications
50	Computer-Assisted Adjustment of External Fixation	Yes Modifications

AMA/Specialty Society RVS Update Committee **Tab 52**
Relativity Assessment Workgroup
April 24, 2014

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

I. Review Action Plan (11981)

At the October 2013 meeting, the Relativity Assessment Workgroup reviewed High Volume Growth Services where Medicare utilization increased by at least 100% from 2006 to 2011. The RUC requested that CPT code 11980 *Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)* be surveyed for physician work and develop practice expense inputs for the January 2014 RUC meeting. In January 2014 the RUC questioned whether CPT code 11981 should also be reviewed since it is "CMS/Other" and has not been reviewed. The RUC requested that the specialty societies submit an action plan to the RAW in April to consider whether 11981 is part of this family and should be surveyed. **The Workgroup reviewed codes 11981 and 11980 and determined that these services are not part of a family of services and 11981 does not require further review at this time. Additionally, code 11981 is primarily performed by orthopaedic surgery, whereas, code 11980 is performed primarily by urology and not performed at all by orthopaedic surgeons.**

II. Review Pre-Time Analysis Action Plans

In January 2014, the RUC identified codes reviewed prior to April 2008 with pre-time greater than pre-time package 4 *Facility - Difficult Patient/Difficult Procedure* (63 minutes) for services with 2012 Medicare Utilization over 10,000. The screen identified 19 services with more pre-service time than the longest standardized pre-service package. The RUC reviewed these services and requested action plans from the specialty societies on how to address the pre-service time for these services. **The Relativity Assessment Workgroup reviewed these action plans and agreed with the specialty societies that codes 34802, 34812 and 34825 (and code family) be referred to CPT for revision in the 2017 cycle. The Workgroup agreed that code 39400 and code family be referred to CPT for revision in the 2016 cycle. For the remaining 15 codes identified the Workgroup requests revised action plans in which the specialty societies provide the following information: current total preservice time; median times for preservice components from the most recent survey; specialty recommendation for preservice package to be applied to the code, with any recommended adjustments to the package; specialty recommendation for a crosswalk code to support the recommended pre-service time changes; and a summary of the RUC rationale for code valuation, to indicate whether the code was valued based on magnitude estimation or other methodology.**

III. Review 010-Day Global Post-Operative Visits Action Plans

In January 2014, the RUC reviewed 010-day global services (based on 2012 Medicare utilization data) and identified 18 services with >1.5 office visits and 2012 Medicare utilization > 1,000. The RUC requested action plans from the specialty societies to address/explain the office visits associated with these services for review in April 2014. **The Workgroup reviewed the action plans and recommend the following:**

CPT Code	RAW Rec
10061	Maintain current post-operative visits. Reaffirm the Oct 2010 approved visits.
11750	Survey Sept 2014
11752	Survey Sept 2014
20245	Survey Sept 2014 with code 20240.
28002	Maintain current post-operative visits. Reaffirm the Oct 2010 approved visits.

Approved by the RUC – April 26, 2014

38570	Survey Sept 2014
38571	Survey Sept 2014
38572	Survey Sept 2014
40800	Maintain. Current post-op visits are appropriate. One visit is needed to assess healing after the procedure, ensure there is no infection, review pathology or microbiology. Typically the area is not healed after one visit so another visit is performed to assess healing and ensure there is no infection. The physician will also assess function, swallow speech and need for therapy during the second post-op visit.
40812	Maintain. Current post-op visits are appropriate. One visit is needed to assess healing after the procedure, ensure there is no infection, review pathology or microbiology. Typically the area is not healed after just one visit, so another visit is performed to assess healing and ensure there is no infection. The physician also needs to inspect suture line in 40812 to ensure good closure with no dehiscence. The physician will also assess function, swallow, speech, and need for therapy during the second post-operative visit.
40820	Maintain. Current post-op visits are appropriate. One visit is needed to assess healing after the procedure, ensure there is no infection. Typically the area is not healed after just one visit, so another visit is performed to assess healing and ensure there is no infection. The physician will also assess function, swallow, speech, and need for therapy during the second post-operative visit.
46500	Survey Sept 2014
55706	Maintain no change. This service is also on the New Technology list scheduled for review by the RAW in Sept 2014.
65855	Survey April 2015
66761	Maintain current post-operative visits. Reaffirm the April approved visits.
68801	Survey
68810	Survey
68815	Survey

IV. Review 090-Day Global Post-Operative Visits Action Plans

In January 2014, the RUC reviewed 090-day global services (based on 2012 Medicare utilization data) and identified 10 services, reported at least 1,000 times per year that included more than 6 office visits. The Workgroup reviewed the 10 services and requested action plans from the specialty societies to address/explain the office visits associated with these services for review in April 2014. The Workgroup agreed with the specialty societies that the post-operative visits for two services are appropriate and should be maintained and the remaining eight services should be surveyed. **The Workgroup recommends:**

CPT Code	RAW Recommendation
19357	Maintain. Reaffirmed the Feb 2010 approved visits.
20692	Maintain. Current post-operative visits are appropriate. CPT code 20692 is for the application of a multi-planar external fixator system. Post-discharge, patients with multi-planar external fixators require weekly follow-up in order to assess progress of fracture healing and regularly adjust and replace the struts within the system. If a patient does not receive frequent assessment the fracture(s) may not properly heal, thus it is essential that patients be regularly seen post-operatively in the office. Patients also frequently have pin tract infections that require frequent, in-office monitoring.
26356	Survey Jan 2015 with 26357 & 26358
28293	Survey Jan 2015
31588	Survey Sept 2014 with 31582, 31584 & 31587

47135	47135-Survey Sept 2014; 47136-Refer to CPT for deletion
65780	Survey
66170	Survey
66172	Survey
67113	Survey with 67108. Refer CPT code 67112 to CPT Editorial Panel for deletion at Oct 2014 meeting.

CPT Code 33235

Additionally, AMA staff reviewed 090-day global services that have more than one 99215 office visit. Based on 2012 Medicare utilization data, only one service (code 33235), reported more than 1,000 times per year, included a 99215. However, AMA staff reviewed the archives folder and the recommendation submitted to CMS for the May 1994 recommendation for code 33235 or tracking number AS13 indicated **two 99214** office visits, not two 99215 office visits. This is consistent with CPT code 33234. This was an error in the database/physician time file has been corrected.

V. CPT code 64412 (Tab 36 of April 2014 meeting) – *Informational Item*

In April 2013, CPT code 64412 *Injection, anesthetic agent; spinal accessory* (work RVU = 1.18) was identified via the High Growth screen. It is primarily performed (58%) by internal medicine, family and general practice physicians. In October 2013, the Relativity Assessment Workgroup reviewed the action plan submitted by the American College of Physicians (ACP), which indicated ACP would survey for presentation at the April 2014 RUC meeting. In February 2014, the level of interest process was conducted and ACP and AAFP indicated no interest in surveying or commenting on CPT code 64412 and ASA, AAPM&R, ISIS all indicated a level 2=comment.

Since ACP had indicated they would survey this service, the RAW did not have any further discussion regarding why the large growth in Medicare utilization occurred, nor did it discuss any possible misreporting of this service. The Medicare frequency went from 30 in 2006 to 5,413 in 2012.

Upon further analysis, it appears that half of the current utilization is now coming from the state of Michigan (*see attached spreadsheet*). The growth is being performed primarily by internal medicine physicians and a re-survey will not address the misreporting of this service. It appears that physicians are reporting 64412 *Injection, anesthetic agent; spinal accessory* (work RVU = 1.18) instead of 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66) or 20553 *Injection(s); single or multiple trigger point(s), 3 or more muscle(s)* (work RVU = 0.75).

AMA staff reached out to ACP, AAFP, ASA, AAPM&R and ISIS and requested action to address the inappropriate reporting of this service, such as the addition of a CPT parenthetical or deletion of the code. ASA, AAPM&R, AAN and ISIS submitted a letter for this April 2014 agenda indicating they will develop a CPT Assistant article to clarify the proper use of 64412 and that the RAW review utilization in 3 years. AMA staff questions why a parenthetical would not be develop to stop this inappropriate reporting immediately for the CPT 2015 cycle. AMA staff notified the CPT Editorial Panel for the possible addition of the editorial revision to CPT 2015.

VI. Informational Data

The following reports were included as informational items:

- Referrals to the CPT Editorial Panel
- Referrals to the CPT Assistant Editorial Board
- Potentially Misvalued Services Progress Report
- Full CMS/Relativity Assessment Status Report

AMA/Specialty Society RVS Update Committee **Tab 53**
Research Subcommittee
April 24, 2014

Members Present**:** Scott Collins, MD (Chair), M. Douglas Leahy, MD (Vice Chair), James Georgoulakis, PhD, JD, David Hitzeman, DO, Charles Koopmann, Jr, MD, Walt Larimore, MD, Lawrence Martinelli, MD, Marc Raphaelson, MD, Sandra Reed, MD, Christopher Senkowski, MD, Peter Smith, MD, Samuel D. Smith, MD, Stanley W. Stead, MD, MBA, George Williams, MD

I. Research Subcommittee March 4, 2014 Conference Call Meeting Report

The Research Subcommittee report from the March 4, 2014 Conference Call is included in Tab 53 of the April 2014 agenda materials for approval by the RUC.

II. Review of Education Material

The American Physical Therapy Association (APTA) submitted an updated version of a podcast script for use as educational material for its membership. The Research Subcommittee noted that the standard RUC Survey Overview presentation will be utilized; however, the specialty society plans to delete five slides related to pre-, intra- and post time since these definitions are found in the survey instrument. **The Research Subcommittee found the podcast modifications to be appropriate and recommended approval of the educational tool.**

III. Requirement to Present Summary Data to RUC if Survey is Conducted- Discussion

At the January 2014 RUC Meeting, a RUC member brought up a concern regarding the current ability for specialty societies to conduct a survey and then request to resurvey, without ever having to submit a summary of the original survey data to the RUC. The RUC member proposed that if a survey is conducted, then a summary of the original data would need to be submitted to the RUC. The RUC referred the proposal to the April 2014 Research Subcommittee meeting.

At the April meeting, several Research Subcommittee members stated that they support the proposal in order to increase transparency, whereas other subcommittee members expressed reservations. Additionally, the American College of Surgeons (ACS) submitted a letter prior to the meeting opposing the requirement to submit these data because it would be both burdensome for specialties societies to collate and the RUC to review. The Subcommittee members agreed that it would be useful to review all the specialty society requests to delay the survey of codes over the past five years and determine the stated reasons for these requests. This should help the Research Subcommittee understand the reasons for these delays and determine if requiring aggregate data would be worthwhile.

The Research Subcommittee deferred this proposal until the September 2014 meeting and requested that AMA staff provide a report listing all of the impacted proposals from the past five years.

IV. Specialty Society Request for Review of Pre-service and Post-service Intensity

The American College of Surgeons (ACS) submitted an informational letter to the RUC requesting for the review of the intensity values assigned to the pre-service and immediate post-service components of physician work. These intensity values are inputs in the formula for calculating intra-service work per unit of time (IWPUT).

The ACS representative provided an overview of their letter, stating that the letter included relevant historical information from the Harvard Study and also a detailed analysis comparing pre-service and immediate post service intensities to Evaluation and Management (E/M) code intensities. ACS emphasized that they believe that the "scrub, dress and wait" portion of pre-service time is particularly misvalued relative to E/M codes. In the letter, ACS noted that scrub, dress and wait has an IWPUT of 0.0081 whereas a 99211 has an IWPUT of 0.027.

When asked for a recommendation for an alternate method for pre- and immediate post-service intensity, ACS representative elaborated that they do not have a specific solution to recommend. The primary purposes of their letter were to implore other specialty societies to examine their respective codes and to point out inconsistencies between the intensity values of pre-service and immediate post-service work relative to E/M codes.

The Research Subcommittee and Doctor Levy discussed that the appropriate response to this information is to use it as further evidence that the building block and reverse building block methodologies are inappropriate to use when valuing services in the RBRVS. This information further validates this reasoning, since it confirms that the intensities were originally arbitrarily derived. Since the RUC has always placed an emphasis on magnitude estimation, this data should be used in any arguments to CMS and other stakeholders who may advocate for the use of the building block methodology to value a specific service.

V. Specialty Society Recommendations for RUC Survey

In February, 2014, AMA staff solicited comments from Specialty Societies regarding three separate survey templates in Qualtrics. Summaries of the specialty society policy-related and non-policy related recommendations were included in Tab 53 of the April 2014 agenda materials. The members thanked the specialty societies providing so many detailed and thoughtful comments. Given constraints on time and the inability to adequately process all these comments at this meeting, there was agreement that further discussion and review will be needed. **The Research Subcommittee requested for AMA Staff to create a more concise, summary of recommendations and deferred the item until a future Subcommittee meeting.**

VI. Review of Specialty Society Requests Pertaining to Issues on April RUC Agenda

Tab 8 Sacroiliac Joint Fusion (27279X and 27280):

After the Sacroiliac Joint Fusion survey requests were sent out to potential respondents, an inappropriate communication was emailed on March 6 by an orthopaedic surgeon without any involvement of the societies. The communication was organized by the company, Globus Medical, Inc.

The specialties responded by immediately seeking guidance from AMA RUC Staff. The specialties agreed to include a communication question in the survey instrument to determine if respondents had received the inappropriate email. The societies also agreed to remove code 63030 from the reference service list, as the inappropriate communication had asked recipients to select 63030 as the key reference service. Six responses were excluded that had conflicts (financial conflict and/or communication conflict).

The Research Subcommittee requested that the society provide an aggregated and split out version of the survey data. The presenting society explained that this would not be possible for this meeting.

The Research Subcommittee found the actions of the specialty societies sufficient and recommended for the tab to be presented at the April 2014 meeting without modification.

The Subcommittee also clarified that in the future, they want all societies to provide summary survey data that both aggregates the potentially compromised responses and separates out the clean data from the potentially compromised data.

Tab 23 Corneal Hysteresis Determination (9214X1):

The surveying specialties did not seek approval from the Research Subcommittee prior to using a targeted sample for their survey. A subcommittee member pointed out that since the procedure is performed by fewer than 200 health care providers across the country, a targeted sample was the only viable option to obtain adequate survey data. A random sample would have drawn largely from individuals with no experience in performing the procedure. The specialty society representative stated that their society had been unaware of the requirement for pre-approval of using a targeted survey sample.

The Research Subcommittee accepted the usage of a targeted survey sample and recommended for the tab to be presented at the April 2014 meeting without modification.

Tab 38 Endovascular Ablation (36475, 36476, 36478, 36479):

After the survey requests were sent out, an inappropriate communication was emailed on March 10 from the American Venous Forum (AVF), a non-RUC participating professional society, without the involvement of the surveying societies. AVS had sent the communication to their legal counsel prior to distribution and were informed that since AVS is not bound by the RUC process, they were legally allowed to distribute the communication to their membership.

The surveying societies responded by temporarily closing the survey until further guidance was given by AMA RUC staff. Thereafter, a communication question was added to survey instrument that were fielded after March 10th to determine if respondents had received the inappropriate email. Per the specialties, all potentially contaminated surveys were excluded. The surveying societies also provided a breakdown of their survey data before and after the breach.

The Research Subcommittee found the actions of the specialty societies sufficient and recommended for the tab to be presented at the April 2014 meeting without modification.

VII. Other Business

RUC Survey – Transition to the Online RUC Survey Tool (*Informational Only*)

The Chair noted that an updated online survey timeline is provided in the agenda packet.

AMA/Specialty Society RVS Update Committee **Tab 54**
Administrative Subcommittee Report
April 24, 2014

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

I. Review Rotating Seat Policies and Election Rules

The Subcommittee reviewed the rotating seat policies and election rules. The Subcommittee noted that this body reviewed the candidates for the primary care and internal medicine rotating seats and confirmed that all candidates met the rotating seat criteria and will be placed on the ballot for election at this meeting.

II. Attestation from Vendors Supplying Survey Sample

At the January 2014 meeting, a RUC member proposed that if a targeted survey is utilized using contact information provided from a company/vendor, an attestation should be required stating that the company/vendor provided no further communication regarding valuation or reimbursement. The RUC referred this issue to the Administrative Subcommittee to determine what action should be taken.

The Administrative Subcommittee discussed this issue and recommends:

1. The RUC require attestation statements from companies/vendors attesting that they have not and will not contact potential RUC survey respondents.
2. The RUC add a question to the survey instrument for respondents to confirm that they have not received correspondence directly from the company/vendor.

AMA staff will work with the AMA Office of General Counsel to draft language for review by the Administrative Subcommittee in September 2014.

Members of the Administrative Subcommittee expressed concern that the CPT Editorial Panel consider adoption of a code as Category III if it is not a service performed by enough physicians to allow for collection of data. It was noted that most of these new technology coding proposals are supported by the respective specialty society.

III. RUC Advisors serving as temporary RUC Alternate Members

A RUC member proposed that the RUC create a policy that when a Specialty Society RUC Advisor fills in for a RUC member during a RUC meeting he/she should not serve as an Advisor for the remainder of the CPT cycle. The RUC referred the proposal to the Administrative Subcommittee to determine what action should be taken.

Currently the RUC Structure and Functions document specifies if a RUC Alternate Member serves as a RUC Advisor, he/she may not serve as a RUC Alternate Member the remainder of the meeting. *III.B.3.Organization and Structure Advisory Committee Designation.* This proposal is suggesting expanding the time period for an entire cycle as well as establishing a rule if a RUC Advisor serves as a RUC Alternate.

The Administrative Subcommittee discussed this issue and determined that further extending what capacity RUC participants serve as for an entire cycle would place too many restrictions on the physicians who volunteer and the specialty societies involved, specifically smaller specialty societies. The Subcommittee determined that RUC Members and Alternates appropriately serve as an expert when serving in that capacity and only RUC Advisors advocate for their associated specialty society.

The Administrative Subcommittee reaffirmed the current policy that any RUC Advisors who temporarily fill in for a RUC Alternate at a meeting (or RUC Alternate as a RUC Advisor) must continue to serve the remainder of that meeting in that capacity.

AMA/Specialty Society RVS Update Committee **Tab 09**
Subcutaneous Implantable Defibrillator Procedures
Facilitation Committee #1

Members Present: Doctors Peter Smith (Chair), Amr Abouleish, Margie Andreae, Ron Burd, Thomas Cooper, J. Leonard Lichtenfeld, Allan Glass, Larry Martinelli, William Donovan and George Williams

3327XX ***Insertion or replacement of permanent subcutaneous implantable defibrillator system; with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed***

The Facilitation committee had a brief conversation with the specialty societies about the unique aspects of this new technology service. The committee members noted that, due to a lack of inter- and intra-family comparator codes at the median level, the 25th percentile work RVU was more appropriate. The Committee reviewed reference code 64570 *Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator* (work RVU= 9.10, intra time= 90 minutes) and agreed that this service offers an appropriate comparison to the recommended value. **The Facilitation Committee recommends a work RVU of 9.10 for CPT code 3327XX.**

3327X1 ***Insertion of subcutaneous implantable defibrillator electrode***

The Facilitation Committee noted the relativity within the family and agreed with the specialty societies that the 25th percentile work RVU of 7.50 is more appropriate. The members agreed that code 3327X1, with intra-service time of 60 minutes, is appropriately valued less than the insertion or replacement code (3327XX), with intra-service time of 90 minutes. **The Facilitation Committee recommends a work RVU of 7.50 for CPT code 3327X1.**

3327X2 ***Removal of subcutaneous implantable defibrillator electrode***

The Facilitation committee had concerns that the 25th percentile work RVU of 6.05 was too high in relation to the insertion code (3327X1) due to 15 minutes less intra-service time. Therefore, the committee reviewed CPT code 28039 *Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater* (work RVU= 5.42, intra time= 45 minutes) and agreed that with identical intra-service time and comparable total time, a direct work RVU crosswalk is appropriate. **The Facilitation Committee recommends a work RVU of 5.42, a direct crosswalk to CPT code 28039, for CPT code 3327X2.**

3327X3 ***Repositioning of previously implanted subcutaneous implantable defibrillator electrode***

The Facilitation Committee discussed with the specialty societies that a misleading vignette was used in the survey for 3327X3. The vignette described a patient receiving repositioning within the global period of the insertion service. The specialties noted that while over 90% of the respondents did indicate that this patient was typical, the 75th percentile performance rate was less than one, as this service is new technology. Furthermore, the committee noted that if repositioning is performed in the global period of the placement, a CPT modifier 78, would be required, which would remove duplicative work value from 3327X3. In addition, the full-day discharge management code (99238) was reduced to a half-day because the physician has already discussed and relayed instructions to the patient during the initial procedure. After reviewing the relativity of the previously accepted recommendations for this family, the Committee agreed that the median work value of 6.50 appropriately placed this code correctly, using magnitude estimation, within the family. **The Facilitation Committee recommends a work RVU of 6.50 for CPT code 3327X3.**

9364XX ***Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)***

The Facilitation Committee reviewed the survey data and agreed that the respondents overestimated the work involved in the service, given a median intra-service time of 20 minutes. To determine an appropriate value, the committee reviewed CPT 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 time= 20 minutes) and agreed that with identical intra time, a direct crosswalk is appropriate. **The Facilitation Committee recommends a work RVU of 3.65, a direct crosswalk to CPT code 15002, for CPT code 9364XX.**

9328XX ***Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator system***

The Facilitation Committee reviewed the survey data and agreed that the 25th percentile work RVU of 0.74 appropriately places this service in rank order with similar services. The committee reviewed reference code 93280 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead pacemaker system* (work RVU= 0.77, intra time= 17 minutes) and noted that these services should be valued similarly. **The Facilitation Committee recommends a work RVU of 0.74 for CPT code 9328XX.**

9328X1 ***Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis; implantable subcutaneous lead defibrillator system***

The Facilitation Committee reviewed the survey data and agreed with the specialty societies that the 25th percentile work RVU of 0.85 is an appropriate value for this service. The committee noted that this work value and intra-service time is identical to the key reference code 93282 *Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead implantable cardioverter-defibrillator system* (work RVU= 0.85, intra time= 15 minutes). **The Facilitation Committee recommends a work RVU of 0.85 for CPT code 9328X1.**

AMA/Specialty Society RVS Update Committee **Tab 12**
Transcatheter Placement of Carotid Stents
Facilitation Committee #3

Members Present: Doctors James Waldorf (Chair), Dale Blasier, Scott Collins, Anthony Hamm, DC, David Hitzeman, Walt Larimore, Sandra Reed, Samuel Smith and Jennifer Wiler.

37218X Transcatheter placement of ~~an~~ intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation

The Facilitation Committee reviewed the survey results for CPT code 37218X and noted that the RUC did not agree with the survey 25th percentile work RVU as presented by the specialty societies. The Committee also noted the key reference service was not an appropriate reference it required more work and 30 minutes more intra-service time. The Committee recommends and the specialty societies agreed to crosswalk 37218X to CPT code 29915 *Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)* (work RVU = 15.00 and 90 minutes intra-service time, 270 minutes total time). **The Committee recommends a work RVU of 15.00 for CPT code 37218X.**

AMA/Specialty Society RVS Update Committee **Tab 18**
Transversus Abdominis Plane (TAP) Anesthetic Block
Facilitation Committee #2

Members Present: Doctors Marc Raphaelson (Chair), James Blankenship, Chad Rubin, Doug Leahy, Alan Lazaroff, William Mangold, Greg Przybylski, David Regan, Joseph Schlecht, Edward Vates and Jane White.

64486X Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance when performed)
The Facilitation Committee noted that the survey 25th percentile work RVU for 64486X if 1.50 was too high. Therefore, the Committee recommends a direct crosswalk to CPT code 67505 *Retrobulbar injection; alcohol* (work RVU = 1.27 and 10 minutes intra-service time). The Committee recognizes that this procedure may be performed by an anesthesiologist who did not participate in the preceding surgery; compared to pre-service Package 2b (Difficult patient Straightforward procedure), the Committee recommends decreasing the pre-service evaluation time, and increasing the pre-service positioning time to 5 minutes as determined by the survey median. The Committee recommends 5 minutes evaluation, 5 minutes positioning and 5 minutes scrub, dress and wait pre-time, 10 minutes intra-service time and 10 minutes immediate post service time. For additional support the Committee referenced CPT codes: 32562 *Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day* (work RVU = 1.24 and 10 minutes intra-service time) and 45305 *Proctosigmoidoscopy, rigid; with biopsy, single or multiple* (work RVU = 1.25 and 10 minutes intra-service time). **The Committee recommends a work RVU of 1.27 for CPT code 64486X.**

64487X Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by continuous infusion(s) (includes imaging guidance when performed)
The Facilitation Committee noted that the survey 25th percentile work RVU for 64487X was too high. The Facilitation Committee recommends a direct crosswalk to CPT code 64445 *Injection, anesthetic agent; sciatic nerve, single* (work RVU = 1.48 and 15 minutes intra-service time). The Facilitation Committee noted the incremental difference of 0.13 between single and continuous codes 64447 *Injection, anesthetic agent; femoral nerve, single* (work RVU = 1.50) and 64448 *Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)* (work RVU = 1.63), as well as the incremental difference of 0.33 between single injection and continuous infusion codes 62311 *Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)* (work RVU = 1.17) and 62319 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)* (work RVU = 1.50). Based on this, the Facilitation Committee considered an increment of 0.21 as well bracketed by these other single vs. continuous infusion codes. The Committee recognizes that this procedure may be performed by an anesthesiologist who did not participate in the preceding surgery; compared to pre-service Package 2b (Difficult patient Straightforward procedure), the Committee recommends decreasing the pre-service evaluation time, and increasing the pre-service positioning time to 5 minutes as determined by the survey median. The Committee recommends 5 minutes evaluation, 5 minutes positioning and 5 minutes scrub, dress and wait pre-time (maintaining the conclusions about duplicative work referenced above), 15 minutes intra-service time and 10 minutes immediate post service time. **The RUC recommends a work RVU of 1.48 for CPT code 64487X.**

64488X Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance when performed)
The Facilitation Committee reviewed code 64488X and recommends the survey 25th percentile work RVU of 1.60 and the specialty societies agreed. The Committee recognizes that this procedure may be performed by an anesthesiologist who did not participate in the preceding surgery; compared to pre-service Package 2b (Difficult patient Straightforward procedure), the Committee recommends decreasing the pre-service evaluation time, and increasing the pre-service positioning time to 5 minutes as determined by the survey median. The Committee recommends 5 minutes pre-eval, 5 minutes pre-positioning and 5 minutes scrub, dress and wait pre-time, 15 minutes intra-service time and 10 minutes immediate post service time. The Committee noted that although the intra-service time is 15 minutes for both 64487X and 64488X, this service is more intense because there are two injection sites for this code. For additional support the Committee referenced CPT codes 64448 *Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)* (work RVU= 1.63 and 15 minutes intra-service time) and CPT code 19285 *Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance* (work RVU = 1.70 and 15 minutes intra-service time). **The RUC recommends a work RVU of 1.60 for CPT code 64488X.**

64489X Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by continuous infusions (includes imaging guidance when performed
The Facilitation Committee reviewed code 64489X and recommends the survey 25th percentile work RVU of 1.80 and the specialty societies agreed. The Committee recognizes that this procedure may be performed by an anesthesiologist who did not participate in the preceding surgery; compared to preservice Package 2b (Difficult patient Straightforward procedure), the Committee recommends decreasing the preservice evaluation time, and increasing the preservice positioning time to 5 minutes as determined by the survey median. The Committee maintained the conclusions about possible duplicative work and recommends 5 minutes evaluation, 5 minutes positioning and 5 minutes scrub, dress and wait pre-time, 20 minutes intra-service time and 10 minutes immediate post service time. The incremental increase in value compared to 64488X also fits well into the range of added value for placement of continuous infusion catheter vs. single injection as mentioned above. For additional support the Committee referenced CPT codes 64646 *Chemodenervation of trunk muscle(s); 1-5 muscle(s)* (work RVU = 1.80 and 20 minutes intra-service time) and 45315 *Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique* (work RVU = 1.80 and 20 minutes intra-service time). **The RUC recommends a work RVU of 1.80 for CPT code 64489X.**

CPT Code	Pre-Eval	Pre-Posit	Pre-SDW	Intra-Time	Immed Post Time	Rationale	Recommended Work RVU
64486X Single Unilateral	5	5	5	10	10	Crosswalk to code 67505 (work RVU=1.27)	**1.27**
64487X Continuous Unilateral	5	5	5	15	10	Crosswalk to code 64445 (work RVU=1.48)	**1.48**
64488X Single Bilateral	5	5	5	15	10	Survey 25th percentile	**1.60**
64489X Continuous Bilateral	5	5	5	20	10	Survey 25th percentile	**1.80**

AMA/Specialty Society RVS Update Committee
Tab 22 Transient Elastography of Liver
Facilitation Committee #1

Members Present: Peter Smith, MD (Chair), Margie Andreae, MD, Ron Burd, MD, Thomas Cooper, MD, William Donovan, MD, William Fox, MD, Allan Glass, MD, Gregory Harris, MD, Charles Koopmann, MD, J. Leonard Lichtenfeld, MD, Larry Martinelli, MD, George Williams, MD

912XX1 *Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report*

The Facilitation Committee noted that the survey results for physician work and time were invalid due to the use of an incorrect survey instrument (000 survey), instead of the correct survey instrument (XXX survey). Additionally, the survey did not meet the minimum standard for respondents.

Therefore, the objective was to develop a RUC recommendation that could be used to develop an interim value with a required re-survey with the correct survey instrument and sufficient responses.

The Facilitation Committee had a detailed discussion with the specialty societies about the aspects of this new technology service, including the physician work and time involved. The Facilitation Committee considered recommendations forwarded from the full RUC, including recommended values and potential crosswalks. There were no identified crosswalks that met the RVW estimate expectations of the RUC and the survey pre-, intra- and post-times. The latter being invalid, the facilitation committee selected a crosswalk to CPT code 95981 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming* (**work RVU= 0.30, pre-time= 2 minutes, intra-time= 10 minutes, post-time= 5 minutes**). This code was RUC reviewed in 2008. These times were felt to be acceptable to the committee and the specialty, based on a review of a sample report and the description of physician work. This is supported by a similar code that was RUC surveyed in 2007 CPT code 93982 *Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report.* This code also has work RVU = 0.30, pre-time= 2 minutes, intra-time= 10 minutes, and post-time= 2 minutes.

The Facilitation Committee recommends an interim work RVU of 0.30, a pre-service time of 2 minutes, an intra-service time of 10 minutes and a post-service time of 5 minutes for CPT code 912XX1.

AMA/Specialty Society RVS Update Committee **Tab 24**
EOG VNG
Facilitation Committee #3

Members Present: Doctors James Waldorf (Chair), Dale Blasier, Scott Collins, Anthony Hamm, DC, David Hitzeman, Sandra Reed, Samuel Smith, Allan Tucker and Jennifer Wiler.

92541 ***Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording***
The Facilitation Committee reviewed the survey results for 92541 and agreed with the specialty societies to reduce the pre-service and post-service time. Typically this service is performed with 3 other services in this family. Therefore, the recommended reductions of 1/3 of the pre and post-service times are appropriate. The Committee recommends 3 minutes pre-service, 10 minutes intra-service and 3 minutes immediate post-service time. The Committee determined that the survey median and 25th percentile work RVUs did not appropriately value this service relative to this family of services. The Committee recommends maintaining the current work RVU of 0.40 for CPT code 92541. For additional support the Committee referenced 92082 *Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)* (work RVU = 0.40) which requires the same physician work to perform. **The Committee recommends a work RVU of 0.40 for CPT code 92541.**

92542 ***Positional nystagmus test, minimum of 4 positions, with recording***
The Facilitation Committee reviewed the survey results for 92542 and agreed with the specialty societies to reduce the pre-service and post-service time. Typically this service is performed with 3 other services in this family. Therefore, the recommended reductions of 1/3 of the pre and post-service times are appropriate. The Committee recommends 3 minutes pre-service, 10 minutes intra-service and 3 minutes immediate post-service time. The Committee determined that although 92542 requires the same physician time as 92541, 92542 is a more intense service which requires re-positioning the patient multiple times while evaluating the patient throughout the procedure. The Committee determined the survey 25th percentile work RVU of 0.48 appropriately accounts for the work required to perform this service**. The Committee recommends a work RVU of 0.48 for CPT code 92542.**

92544 ***Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording***
The Facilitation Committee reviewed the survey results for 92544 and agreed with the specialty societies to reduce the pre-service and post-service time. Typically this service is performed with 3 other services in this family. The Committee recommends 3 minutes pre-service, 5 minutes intra-service and 3 minutes immediate post-service time. The Committee determined the survey 25th percentile work RVU of 0.27 appropriately accounts for the work required to perform this service**. The Committee recommends a work RVU of 0.27 for CPT code 92544.**

92545 ***Oscillating tracking test, with recording***
The Facilitation Committee reviewed the survey results for 92545 and agreed with the specialty societies to reduce the pre-service and post-service time. Typically this service is performed with 3 other services in this family. The Committee recommends 3 minutes pre-service, 5 minutes intra-service and 3 minutes immediate post-service time. The Committee determined the survey 25th percentile work RVU of 0.25 appropriately accounts for the work required to perform this service**. The Committee recommends a work RVU of 0.25 for CPT code 92545.**

92543 ***Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording***

The Facilitation Committee discussed the difficulty of the survey respondents valuing this service as the typical number of irrigations performed per patient is four. **The Committee recommends referring CPT code 92543 to CPT to better define this service, such as having one code to describe the initial irrigation and an add-on code to describe each additional irrigation.** The Committee recognized that it needed to establish an interim value for 92543 until this service could be redefined by CPT. The Committee recommends directly crosswalking 92543 to similar service, CPT code 92550 *Tympanometry and reflex threshold measurements* (work RVU =0.35 and 3 minutes pre-service, 10 minutes intra-service and 3 minutes immediate post-service time). For additional support the Committee compared 92543 to 94621 (work RVU = 1.42), which is comparable when comparing the total service and total number of irrigations performed (0.35 x 4 irrigations = 1.40 work RVUs). **The Committee recommends an interim work RVU of 0.35, 3 minutes pre-time 10 minutes intra-time and 3 minutes immediate post-service time for CPT code 92543 and referral to CPT.**

AMA/Specialty Society RVS Update Committee **Tab 25**
Interventional Transesophageal Echocardiography (TEE)
Facilitation Committee #2

Members Present: Doctors Marc Raphaelson (Chair), James Blankenship, John Gage, Doug Leahy, Alan Lazaroff, William Mangold, Gregory Przybylski, Sam Silver, MD, Joseph Schlecht, DO, Stan Stead, MD, Jane White, PhD, RD, FADA, LDN,

93312 Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
The Facilitation Committee reviewed the survey results from 131 physicians and determined that a direct crosswalk to CPT code 43247 *Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body* (work RVU=3.18) is appropriate for this service; the crosswalk should subtract from 43247 3 minutes of preservice positioning time and 5 minutes of scrub/dress/wait time. The Committee recommends crosswalk to the CMS-approved interim value of CPT code 43247, which was published in 2013 and which is below the RUC-recommended value. Both the surveyed code and the crosswalk code have identical intraservice times of 30 minutes. This recommended value falls between the survey 25th and 50th percentile values. For additional support the committee also compared the code to 32557 *Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance* (work RVU=3.12), with identical intraservice time of 30 minutes. The recommended value for this service is appropriately lower than the added values for the two components, which are billed when each component is performed by a different provider. **The committee recommends a work RVU of 3.18 for CPT code 93312.**

93313 Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only
The Facilitation Committee reviewed the survey results from 38 physicians and determined that the median survey value is appropriate for this service. The committee discussed the appropriate pre-service time for the physician to wait for a second operator to place the probe. In the rare case when two operators are present, the committee determined that the pre-service time should be reduced to 5 minutes. **The Committee recommends a work RVU of 1.00 for CPT code 93313.**

93314 Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only
The Facilitation Committee reviewed the survey results from 54 physicians and determined that the median survey value is appropriate for this service. The committee discussed the appropriate pre-service time for the physician to wait for a second operator to acquire images. **The Committee recommends a work RVU of 2.80 for CPT code 93314.**

93315 Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
The facilitation committee reviewed the survey results from 42 physicians and determined that the median survey value is appropriate for this service. The committee discussed that this service is more complex than 93312, because the population is pediatric patients with complex anatomy and should be valued slightly higher than the adult service. The committee also discussed that the survey median times preserve rank order and the intensity of the work lines up appropriately. The recommended value for this service is appropriately lower than the added values for the two components, which are billed when each component is performed by a different provider. **The committee recommends a work RVU of 3.29 for CPT code 93315.**

93316 Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only

The Facilitation Committee reviewed the survey results from 17 physicians and determined that the median survey value is appropriate for this service. The committee discussed the appropriate pre-service time for the physician to wait for a second operator to place the probe. In the rare case when two operators are present, the pre-service time should be reduced to 5 minutes. **The Committee recommends a work RVU of 1.50 for CPT code 93316.**

93317 Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only

The Facilitation Committee reviewed the survey results from 22 physicians and determined that the median survey value is appropriate for this service. The committee discussed the appropriate pre-service time for the physician to wait for a second operator to acquire images. **The Committee recommends a work RVU of 3.00 for CPT code 93317.**

93318 Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis

The facilitation committee reviewed the survey results from 55 physicians and determined that the 25th percentile value of 2.40 is appropriate for this service. The committee noted that RUC has approved compelling evidence for this entire family of codes, and agreed that compelling evidence is met specifically for this code, because of a change in technology. **The committee recommends a work RVU of 2.40 for CPT code 93318.**

AMA/Specialty Society RVS Update Committee **Tab 30**
Laparoscopic Hysterectomy
Facilitation Committee #1

Members Present: Doctors Peter Smith (Chair), Margie Andreae, Ron Burd, Thomas Cooper, William Fox, Allan Glass, Charles Koopmann, Larry Martinelli, Geraldine McGinty and George Williams

The Facilitation Committee deliberated for over 90 minutes and are using magnitude estimation. The Facilitation is recommending direct crosswalks for all eight laparoscopic hysterectomy codes. The specialty society concurred with this approach. The recommended work RVUs are all below the survey 25th percentile results. Additionally, the specialty society reduced all the full 99238 visits to a half day 99238.

These recommendations result in appropriate rank order and consistent differentials related to uterine size and procedural differences (total hysterectomy vs cervical sparing hysterectomy and whether or not BSO is performed). These differentials were used to confirm the selected crosswalks, but not to determine the values recommended.

The Committee recommends:

CPT Code	Intra-Time	Direct Crosswalk Code	Crosswalk Intra-Time	Recommended Work RVU	Current Value	Reduction
58541	75	59150	70	**12.29**	14.7	-16%
58542	88	27416	90	**14.16**	16.56	-14%
58543	110	64911	120	**14.39**	16.87	-15%
58544	120	60500	120	**15.60**	18.37	-15%
58570	90	53440	90	**13.36**	15.88	-16%
58571	90	29915	90	**15.00**	17.69	-15%
58572	120	28446	120	**17.71**	20.09	-12%
58573	130	43771	120	**20.79**	23.11	-10%

58541 Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
The Committee recommends a direct crosswalk to 59150 *Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy* (work RVU = 12.29 and 70 minutes intra-service time). **The Committee recommends a work RVU of 12.29 for CPT code 58541.**

58542 Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
The Committee recommends a direct crosswalk to 27416 *Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])* (work RVU = 14.16 and 90 minutes intra-service time). **The Committee recommends a work RVU of 14.16 for CPT code 58542.**

58543 Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
The Committee recommends a direct crosswalk to 64911 *Nerve repair; with autogenous vein graft (includes harvest of vein graft), each nerve* (work RVU = 14.39 and 120 minutes intra-service time). **The Committee recommends a work RVU of 14.39 for CPT code 58543.**

58544 Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
The Committee recommends a direct crosswalk to 60500 *Parathyroidectomy or exploration of parathyroid(s);* (work RVU = 15.60 and 120 minutes intra-service time). **The Committee recommends a work RVU of 15.60 for CPT code 58544.**

58570 Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;
The Committee recommends a direct crosswalk to 53440 *Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)* (work RVU = 13.36 and 90 minutes intra-service time). **The Committee recommends a work RVU of 13.36 for CPT code 58570.**

58571 Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
The Committee recommends a direct crosswalk to 29915 *Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)*(work RVU = 15.00 and 90 minutes intra-service time). **The Committee recommends a work RVU of 15.00 for CPT code 58571.**

58572 Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;
The Committee recommends a direct crosswalk to 28446 *Open osteochondral autograft, talus (includes obtaining graft[s]) (*work RVU = 17.71 and 120 minutes intra-service time). **The Committee recommends a work RVU of 17.71 for CPT code 58572.**

58573 Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
The Committee recommends a direct crosswalk to 43771 *Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only (*work RVU = 20.79 and 120 minutes intra-service time). **The Committee recommends a work RVU of 20.79 for CPT code 58573.**