AMA/Specialty Society RVS Update Committee
Meeting Minutes
April 22-25, 2015

I. Welcome and Call to Order

Doctor Barbara Levy called the meeting to order on Thursday April 23, 2015 at 1:00 pm. The following RUC Members were in attendance:

Barbara Levy, MD	Amr Abouleish, MD, MBA*
Margie C. Andreae, MD	Allan A. Anderson, MD*
Michael D. Bishop, MD	Jennifer Aloff, MD*
James Blankenship, MD	Gregory L. Barkley, MD*
Dale Blasier, MD	Eileen Brewer, MD*
Albert Bothe, MD	Jimmy Clark, MD*
Ronald Burd, MD	Gregory DeMeo, MD*
Scott Collins, MD	Jane Dillon, MD*
Thomas Cooper, MD	Verdi. J DiSesa, MD*
Anthony Hamm, DC	William D. Donovan, MD, MPH, FACR*
David F. Hitzeman, DO	Jeffrey Paul Edelstein, MD*
Charles F. Koopmann, Jr., MD	William F. Gee, MD*
Robert Kossmann, MD	Gregory Harris, MD, MPH*
Walt Larimore, MD	M. Douglas Leahy, MD, MACP*
Alan Lazaroff, MD	Mollie MacCormack, MD*
J. Leonard Lichtenfeld, MD	Paul Martin, DO, FACOFP*
Scott Manaker, MD, PhD	Eileen Moynihan, MD*
Geraldine B. McGinty, MD	Scott D. Oates, MD*
Margaret Neal, MD	Christopher K. Senkowski, MD, FACS*
Gregory Przybylski, MD	M. Eugene Sherman, MD*
Marc Raphaelson, MD	Samuel Silver, MD*
Sandra Reed, MD	Holly Stanley, MD*
David Regan, MD	Robert J. Stomel, DO*
Chad Rubin, MD, FACS	G. Edward Vates, MD*
Joseph Schlecht, DO	Adam Weinstein, MD*
Peter Smith, MD	Jane White, PhD, RD, FADA, LDN*
Samuel D. Smith, MD	Jennifer L. Wiler, MD*
Stanley W. Stead, MD, MBA	
James C. Waldorf, MD	
George Williams, MD	*Alternate

II. Chair's Report

- Doctor Levy welcomed everyone to the RUC Meeting.
- Doctor Levy welcomed the following Centers for Medicare & Medicaid Services (CMS) staff and representatives attending the meeting:
    - Jessica Bruton, MPA - Health Insurance Specialist
    - Edith Hambrick, MD - CMS Medical Officer
    - John McInnes, MD, JD - Acting Director, Division of Practitioner Services
    - Steve Phurrough, MD - CMS Medical Officer
    - Michael Brown – Consultant, Social & Scientific Systems, Inc.

- Doctor Levy welcomed the following Contractor Medical Directors:
  - Richard W. Whitten, MD, FACP
- Doctor Levy welcomed the following Member of the CPT Editorial Panel:
  - Patrick Jacob, MD– Panel Member Observer
- Doctor Levy and the RUC said farewell to departing RUC members:
  - Anthony Hamm, DC
  - Charles Koopmann, MD
  - Eileen Moynihan, MD
  - David Regan, MD (IM rotating seat)
  - Samuel Smith, MD (rotating seat)
- Doctor Levy welcomed new RUC members:
  - Peter K. Smith, MD – RUC Chair
  - Michael D. Bishop, MD – AMA Representative
  - Peter A. Hollmann, MD – AMA Alternate Representative
- The RUC took a moment of silence in memoriam for Stephen M. Levine, PT, DPT, MSHA, FAPTA (1962-2015)
  - RUC HPCAC Member (APTA) since 1994.
  - Steve also served on various RUC Subcommittees and Workgroups over the past two decades.
  - Although his contributions to the HCPAC and RUC's work were significant, we will most remember Steve for his friendship.
  - Stephen M. Levine Memorial Scholarship Fund
    - University of Maryland – School of Medicine, Department of Physical Therapy and Rehabilitation Science https://medschool-umaryland.givecorps.com
- Doctor Levy explained the following RUC established thresholds for the number of survey responses required:
  - Codes with ≥1 million Medicare Claims = **75 respondents**
  - Codes with Medicare Claims 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 shared the following procedural rules for RUC members:
  - Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue and it will be reflected in the minutes
  - RUC members or alternates sitting at the table may not present or debate for their society
  - Expert Panel – RUC Members exercise their independent judgment and are not advocates for their specialty
- 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 invite 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 shared the following guidelines related to voting:
  - RUC votes are published annually on the AMA RBRVS web site each November for the previous CPT cycle.
  - The RUC votes 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
- Doctor Levy announced:
  - That all meetings are recorded for AMA staff to accurately summarize recommendations to CMS.
  - Only use Wi-Fi when necessary and limit to one device so they do not interrupt the work of the RUC.

III. Director's Report

- RUC staff will be sending out a solicitation to all RUC members to indicate which Workgroups and Subcommittees they are and are not interested in serving on or remain serving on. Staff will collate this information and provide it to Doctor Smith to determine the composition of the Workgroups and Subcommittees. The members of the Workgroups and Subcommittees will be announced this summer.

IV. Approval of Minutes of the January 29-31, 2015 RUC Meeting

The RUC approved the January 2015 RUC Meeting Minutes as submitted.

V. CPT Editorial Panel Update (Informational)

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

- Doctor Bothe welcomed Doctor Jacobs as an observer from the CPT Editorial Panel at this meeting. We were fortunate to have Doctor Burd at the last CPT meeting.
- There were 93 tabs on the CPT Editorial Panel's agenda at the last meeting.
- There are a few large scale process changes:
  - CPT completed a review of the literature requirements to support category III and category I codes. The major change has been to move the categorization of articles from the 1992 AHCPR to the 2009 Oxford system. This system helps us rank the quality of articles in support of a proposal.
  - CPT has begun a project to look at potential coding gaps and needed new codes in digital and remote services. These services range from electronic consultations to

remote monitoring of intensive care units. We will be generating some proposals to fill in gaps there.
    - At the CPT meeting next month we will have our annual strategic review session. At that time CPT will discuss low volume services including what is the minimum volume needed to conduct a successful survey, as well as what to do if different information regarding the same service is presented at the CPT and RUC meetings.

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

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

- CMS is working to implement the SGR repeal legislation and ensure that is appropriately handled.
- Andy Slavitt is serving as Acting Administrator and Doctor Patrick Conway is serving as Acting Principal Deputy.
- CMS is currently working on the Notice of Proposed Rulemaking. It is late in their process, so if stakeholders need to meet with CMS officials, please do so as soon as possible.

VII. Contractor Medical Director Update (Informational)

Doctor Richard W. Whitten MD, FACP, Medicare Contractor Medical Director, Noridian, provided the contractor medical director update:

- H.R. 2, the Medicare Access and Chip Reauthorization Act (MACRA) implements repeal of the SGR, as well as a 5 year period of 0.5% annual updates. The legislation also extends the following programs:
    - Existing 1.0 floor on the "physician work" GPCI until January 1, 2018 (Sec. 201)
    - Therapy cap exceptions process (Sec. 202)
    - Ambulance add-ons (Sec. 203)
    - Medicare Low-Volume hospital payments (Sec. 204)
    - Medicare-dependent hospitals (rural: Sec. 205)
    - Specialized Medicare Advantage (MA) plans for special needs (Sec. 206)
    - National Quality Forum activities (Sec. 207)
    - Medicare Home Health Rural 3% Add-On (Sec. 210)
    - Special Diabetes Program (Sec. 213)
    - Abstinence Education (Sec. 214)
    - Maternal, infant, and early childhood home visiting programs (Sec. 218)
    - Funding: Community Health Centers (CHC), National Health Service Corps Fund (NHSC) and Teaching Health Centers (Sec. 221)
    - Children's Health Insurance Program (CHIP) (Sec. 301)
- The legislation also makes changes to Medigap plans. One of the problems has been that for those that have first dollar coverage they have no concerns regarding deductibles or coinsurance so beginning in 2020 new plans will limit coverage to costs above Part B deductible (currently $147/yr) (Sec. 401)
- The legislation implements the following:
    - Income-related premium increases for Parts B and D (Sec. 402)
    - Reimbursements for post-acute care providers to increase by ≤ 1.0 percent in fiscal year 2018 (Sec. 411)
    - Delay of the two-midnight rule thru 9/31/2015 (Sec. 521)

  - DMEPOS – requiring licensure & bid surety bonds for competitive bidding (Sec. 522)
  - Global Surgical Packages (Sec. 523)
    - Reverses the decision to eliminate 10 & 90 day
    - Language that states "Periodically collect information and use to assure payments are accurate..."
    - May delay payment to incent reporting
- Sec. 509(a) allows CMS to renew MAC contracts for up to 10 years without competition. Changes Section 1395kk-1(b)(1)(B) which now authorizes CMS to renew MAC contracts but provides that competitive procedures must be applied no less than every five years. This becomes "ten years".
- Sec. 509(b) provides that the new 10-year competition requirement "shall apply to . . . contracts in effect as of ...the date of the enactment of this Act." Accordingly, CMS may renew NHS's existing MAC contracts for up to an additional five years before re-competing them. These new provisions were put in place because turnover was creating chaos. None of the Part A/B MAC contracts are not currently up for rebid, so the result of these provisions is that they will be extended another 5 years. There are three DME MAC contracts that are currently out for rebid. These will likely remain in competition and the ones that are not out for rebid will be extended for five years.
- ICD-10 is set to be implemented this October. Specialties should be aware that all the draft coverage policies have been on the Medicare Coverage Database for quite some time. It is important to review these and determine if the definitions from ICD-9 have carried through. It is good idea to have your office billing/coding staff provide feedback and coding for both ICD-9 and ICD-10 in preparation.
- Acknowledgement testing has been taking place for some time. The "Front-End" acknowledgement testing, which is a preliminary submission can be done any time. There were three instances of data reported to CMS, which showed a high level of preparedness, however these were the volunteers. The data showed:
  - Acceptance rate nationally of 91.8%
  - Excluded are 8.2% of claims rejected because testers used future dates
- Final end-to-end testing opportunity coming July 20-24. In the past there were many that did not follow-through.
  - 14,929 test claims received
  - 12,149 accepted - 81% and only 3% were due to ICD-10
- Cash flow issues should be considered prior to Oct1st in case of problems. Contractors are not anticipating problems, however it is possible. The contractors encourage:
  - Aggressive approach to appeals, reopening & hearings
  - Immediate feedback to MAC pointing out needed changes (use this input as copy for the appeals)
  - Coordinated specialty society input
  - Comparison MAC-to-MACs to assist making your case
- Be cautious of consultants advising that the transition to ICD-10 will be easy and that they can help. If it is coming from a contractor or a specialty society you can probably trust it, however some information out there does not pass the "sniff test".

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 RUC gave round of applause to Sharon for the AMA's excellent work in repealing the SGR
- The SGR repeal bill is entitled The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.
- MACRA Overview:
    - Developed in bipartisan, bicameral process over 2+ years
    - Supported by over 750 national and state-based physician organizations
    - It was very important to have it pass overwhelmingly in the House in order to influence the Senate. The result was that it passed House of Representatives March 26, 392-37 and Passed Senate April 14, 92-8
    - It was not a forgone conclusion, some conservative groups were trying to shoot it down because it was not entirely paid for
    - Permanently eliminates the SGR, which has been producing Medicare physician payment cuts annually since 2002
- AMA Battle Statistics: March-April 2015
    - The grassroots efforts really made a huge difference, generated 60,229 phone calls and 243,907 emails to Congress from patients & physicians
    - "Repeal SGR Now" social media campaign had potential to reach more than 3,424,533 online users
    - Produced Repeal SGR Now Letter with 750 supporters
- MACRA improvements over current law
    - Instead of 21.2% cut for 2015, there is a 0.5% increase July 2015 thru 2019; 0% 2020-25; After that: those in APM get 0.75%; others get 0.25%
    - Consolidated Merit-based Incentive Payment System (MIPS) with more flexibility, potential for significant bonuses, lower maximum penalties
    - Enhanced technical support, about 75 million overall for measure development and 20 million for technical assistance through QIOs and the regional collaborative particularly for small practices
    - Fee-for service will continue with some changes. For example the quality reporting programs will be consolidated into MIPS with greater flexibility and benchmarks will be set prospectively with the potential for more timely feedback on performance.
    - There will be greater incentives to get into APMs including 5% update bonuses for 5 years which will transition to new 2-sided risk models. In the 2-sided risk models in order to qualify increasing percentages of your patients will have to be Medicare patients involved in the APMs. If you can demonstrate savings this will produce higher payments. Participants will also be exempt from MIPS.
    - To support primary care support in this, if you are in a medical home model, 2-sided risk is not required.
    - Permanent coverage of chronic care management services with no annual wellness or preventive examination. This is much like it is now, however there will be educational campaigns to ensure that physicians and patients know about it. Targeted patients for campaigns will be rural and low income.
- 2019 penalty risks compared
    - Penalty risk is currently as high as 11% and will now be capped at 4%.
    - Once it is completely implemented, scoring will be 30% PQRS, 25% MU (could fall to 15% dependent on ability to comply), 30% VBM resource use and 15% clinical improvement activities, which could include: expanded access, care planning and population management.
    - Goal for MU is interoperability by 2018, and gives CMS the ability to decertify contractors that are not making products interoperable.

- FFS Penalty Risks, Bonuses, Updates Compared
    - Currently the largest penalty you could get was 11% and under MACRA the most will be 9% by 2022.
- Other provisions in MACRA
    - Standard of Care Protection Act
        - This means that the standards being used for quality reporting cannot be the standards used in medical liability lawsuit
    - Indefinite opt-out for private contracting
    - 2-year Extensions, including CHIP, GPCI floor & therapy cap and permanent premium subsidies for low income Medicare beneficiaries.
- The Numbers According to CBO
    - The pay-go rules have been waived, so not fully paid for. The total 10-yr score of $145 billion includes:
        - $175 b more physician spending than current baseline
        - $40 b for other temporary and permanent extensions
    - $73 b savings largely from:
        - Higher premiums (B&D) for high income beneficiaries
        - Reduced updates for hospitals, post-acute and long-term care providers
- MACRA is a complicated law and many regulations are forthcoming. Some of the goals for deadlines are over ambitious and we do not see enough new resources in the bill to think that the Medicare program will be able to meet the deadlines. MACRA is not the law we would have written ourselves. For example regulatory requirements for MU and other programs remain onerous; however securing policy changes will be simpler without a $200 billion price tag.

IX. MPFS Spending and Utilization Growth for 2014 (Informational)

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

- Methods
    - Estimates based on claims processed through Dec 31, 2014. We have to extrapolate a bit because the data is >92% complete.
    - 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:
    - Includes all codes with an RVU and conversion factor
    - As well as carrier priced codes, restricted codes and anesthesia codes
    - Accounts for 29% of Medicare Part B spending (2012)
    - Accounts for 12% of total Medicare spending
- Results for 2014 – Overall
    - MFS spending increased by 0.5% due to:
        - Increase in MFS pay (0.7%)
        - Decrease in utilization per enrollee (-0.3%)
        - Another year of very low spending and utilization growth
- Results for 2014 – Imaging
    - Spending change for imaging is -4%, (6^{th} consecutive year of decline) due to:
        - -2% pay cut
        - -2% change in utilization per enrollee

        - Nearly -1% change in spending due to shifts in site of service (shift to facility)
    - Utilization is flat or decreasing for nearly all categories
    - Big pay reductions for:
        - *MRI* (CPT 70551, 70553, 72148), reduction of 18% for category
        - *Echography: Other* (CPT 76942), reduction of 16% for category
    - Big pay increases for *PET* (78815) and *Echo: Heart* (93306)
- Results for 2014 – Evaluation and Management (E/M)
    - 2% increase in spending, which was all a pay increase because there was 0% change in utilization per enrollee
    - Above-average pay increases for:
        - Hospital and emergency room visits
        - Psychotherapy (CPT 90832-90837)
    - No increase in utilization of established patient office visits
    - For some of the newer codes, such as wellness visits utilization was up 17% (nearly $600 million in total spending for 2014). Transition care management had a roughly 80% increase in utilization (CPT 99495, 99496 – see *Specialist: Other* E&M category)
- Procedures
    - 1% increase in spending and utilization is stable or declining for most categories
    - Exceptions:
        - 9% increase in use of *Oncology: Other* (CPT 0182T) and *Endoscopy: Other* (CPT 31296)
- Other notable results
    - Physical therapy: 6% increase in utilization
    - Chiropractic: 13% increase in pay (CPT 98940-98942)
- Change in utilization of MFS services 2014:
    - Looks much like last year, stable and declining utilization of physician services across the board, with a slightly sharper decline in imaging and tests
    - Stabilized over the last 5 years with a very low level of utilization growth, average has been 0.5% over the last 5 years.
    - Decrease in Utilization Growth Applies to all Major BETOS

X. Relative Value Recommendations for *CPT 2016*:

Soft Tissue Localization Procedures (Tab 4)
Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); Dana Smetherman, MD, (ACR); Eric Whitcare, MD, (ASBS); Charles D. Mabry, MD (ACR)

In February 2015, the CPT Editorial Panel created two new codes to report initial and additional target placement of soft tissue localization device(s).

100X35 ***Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion***
The RUC reviewed the survey results from 38 radiologists and breast surgeons and agreed with the following physician time components: pre-service time of 20 minutes (pre-time package 1A with one minute additional positioning time for placement of the patient in the oblique or lateral decubitus position and one minute less scrub, dress, wait time to match the survey results), intra-service time of 15 minutes, and immediate post-service time of 10 minutes (post-time package 7A). The specialties confirmed that additional deeper local

anesthesia takes place during the intra-service portion of the procedure under image guidance, as necessary.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the 25th percentile work RVU of 1.70 is appropriate. The RUC compared the survey code to the top key reference service 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, intra-service time 15 minutes) and noted that both services have identical intra-service time and similar physician work, which supports a similar valuation for both procedures. Furthermore, the reference code is an apt comparator, since both services involve percutaneous placement of localization device(s) via some analogous form of imaging guidance.

The RUC also compared the survey code to 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-service time of 15 minutes, total time of 49 minutes) and noted that the codes have identical intra-service times and similar total times, supporting a similar work valuation. **The RUC recommends a work RVU of 1.70 for CPT code 100X35.**

100X36 ***Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; each additional lesion (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 38 radiologists and breast surgeons and agreed with the following physician time component: intra-service time of 14 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that a work RVU of 0.85, which is less than the survey 25th percentile, is appropriate. The RUC noted that this value is supported by magnitude estimation, as it is exactly one-half of the base code 100X35. To support The RUC compared the survey code to top key reference code 19286 *Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; each additional lesion (List separately in addition to code for primary procedure)* (work RVU=0.85, intra-service time of 14 minutes) and noted that both services have identical intra-service times and analogous physician work, which supports an identical valuation for both procedures. Furthermore, the reference code is an apt comparator, since both codes are add-on codes that involve percutaneous placement of localization device(s) via some analogous form of imaging guidance.

The RUC also compared the survey code to MPC code 51797 *Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)* (work RVU= 0.80, intra-service time of 15 minutes) and noted that both services have similar physician times, whereas the survey code is somewhat more intense, justifying a somewhat higher work valuation for the survey code. **The RUC recommends a work RVU of 0.85 for CPT code 100X36.**

Practice Expense:
The RUC reviewed and approved the direct practice expense inputs with the following revisions as approved by the Practice Expense Subcommittee:

- The clinical staff time for monitor pt. following service/check tubes, monitors, drains (not related to moderate sedation), was changed from 5 to 0 minutes for 100X36 only (line 35)
- Supply item, cover-condom, transducer or ultrasound probe (SB005) was added for 100X36 only (line 63)
- Supply item, paper, exam table (SB036) was changed from 5 to 0 feet for 100X36 only (line 70)
- Supply item, needle, 18-27g (SC029) was changed from 1 to 2 (line 72)
- Supply item, sodium chloride 0.9% inj (250-1000ml uou) (SH067) was found to be more sodium chloride than appropriate and was revised to supply item, sodium chloride 0.9% inj (10ml uou) (SH066) and changed from 1 to 2 (line 80)
- Supply item, glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide) (SM018) was changed from 0.34 to 0 for 100X36 only (line 89)
- The equipment minute calculations were updated to include the appropriate line items for room, ultrasound, general (EL015) (line 93) and light, exam (EQ168) (line 94)

Esophagogastric Fundoplasty Trans-Oral Approach (Tab 5)
Don Selzer, MD, (SAGES); Shivan Mehta, MD, (AGA); Seth Gross, MD, (ASGE); Bruce Cameron, MD, (ACG)

At the February 2015 CPT Editorial Panel meeting, the Panel established a new code to describe trans-oral esophagogastric fundoplasty.

432XX1 ***Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed***
The RUC reviewed the survey results from 59 general surgeons and gastroenterologists and recommends the following physician time components: pre-service time of 58 minutes, intra-service time of 60 minutes and immediate post-service time of 20 minutes. Seven minutes of additional positioning minutes were added to the standard package time to initially position the patient supine for introduction of general anesthesia lines and then reposition the patient to left lateral decubitus assuring all pressure points are well padded and endoscopy, fundoplication, and anesthesia equipment is positioned to allow access to the patient for the procedure.

The RUC noted that the Research Subcommittee approved a modified 000-day global survey instrument and collect data about site of service and post-operative Evaluation and Management services. The survey respondents indicated that the typical patient is kept overnight for observation, but less than 24 hours. The physician will perform a 99224 *Subsequent observation care, 15 minutes at bedside and on patient's hospital floor or unit* service to review interval chart notes, assure that the patient is hemodynamically stable, assure patient's pain is adequately controlled and the patient is tolerating a liquid diet. In addition, during this visit, the dietary plan is reiterated.

To determine an appropriate work value for 432XX1, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey median work RVU of 9.00 is appropriate. To justify this work value, the RUC compared the surveyed code to the top key reference code 43276 *ERCP; with removal and*

exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged (work RVU= 8.94, intra time = 60 minutes) and agreed that since both codes have identical intra-service times and comparable physician work, the recommended value of 9.00 is appropriate. In addition, the RUC also reviewed the second key reference 43274 *Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent* (work RVU= 8.58, intra time = 68 minutes). The RUC noted that while the reference code has more intra-service time than 432XX1, the surveyed code is a more intense procedure that is performed under general anesthesia and is therefore correctly valued higher. **The RUC recommends a work RVU of 9.00 for CPT code 432XX1.**

Practice Expense
The PE Subcommittee noted that although the standard pre-service time for 000 day globals is zero, the complexity of this facility-only 000-day global code that is performed under general anesthesia is similar to 090-day global codes and requires at least 30 minutes of pre-service time for extensive use of clinical staff.

New Technology
The 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.

Percutaneous Biliary Procedures Bundling (Tab 6)
Jerry Niedzwiecki, MD, Tim Swan, MD, Matt Hawkins, MD, Zeke Silva, MD and Kurt Schoppe, MD (SIR)

Facilitation Committee #3

The Joint CPT-RUC Workgroup on Codes Reported Frequently identified codes that are being reported together greater than 75 percent of the time and as a result the CPT Editorial Panel deleted codes 47500, 47505, 47510, 47511, 47525, 47530, 74305, 74320, 74327, 79580 and 75982 and created 14 new bundled codes 475XX1-475XX14.

Compelling Evidence
The specialty societies presented compelling evidence that the physician work involved in these procedures has changed.

Technique, Knowledge and Technology
The codes currently used for this family of biliary procedures no longer reflect the techniques now used for image-guided, catheter-based biliary procedures. Virtually all the medical devices currently used in biliary catheter procedures have been developed since the current codes were adopted. The past twenty years have witnessed major advances in the knowledge base, including: 1) understanding of how to use imaging guidance such as ultrasound and preoperative planning mapping to avoid hepatic hilar structures and thus prevent bleeding and bile leaks; 2) new insights into how segmental biliary ductal anatomy can help avoid bleeding and septic complications and 3) development of much less aggressive and safer guidewire-based methods which involve more steps and more effort, skill and physician time.

Patient Population

There are three changes to the patient population which have occurred since the last valuation of the current procedures, including: 1) previously the majority of all biliary catheter procedures were used for basic relief of distal ductal biliary obstruction either acutely or chronically often related to pancreatic cancer and/or stone disease. The significant majority of all of the biliary diseases referred for interventional percutaneous treatment now have higher and more complex levels of benign and malignant biliary occlusion including hilar and segmental obstruction; 2) the widespread use of liver transplantation has introduced an entirely different patient population: the postoperative liver transplant patient with ischemic biliary strictures (intrahepatic and/or extrahepatic), which requires major investments of time, skill and effort to obtain access and drain, stent and dilate these complex situations and 3) hepatic surgery for malignancy has also become far more sophisticated and segmental or lobar resections will frequently result in referrals for drainage of biliary leaks from nondilated ducts.

Given these changes, the RUC accepted that there is compelling evidence that the physician work has change for this family of services.

The RUC and specialty societies agreed that the survey data for this family of services was problematic. Specifically, the RUC noted the median intra-service times for 475XX2, 475XX3 and 475XX4 all have identical intra-service time of 60 minutes, rendering the entire survey data suspect. CPT code 475XX3 includes the work of X2 plus the work of an additional access and drain placement. Furthermore, 475XX4 includes the work of X3 plus the work of crossing the occlusion and placement of an internal/external drain. **Given this physician time anomaly, the RUC agreed to provide interim recommendations at this meeting, while allowing the specialty societies to re-survey the entire family of codes for October 2015.**

475XX1 Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; existing access

The RUC reviewed the survey results from 36 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 27 minutes, intra-service time of 20 minutes and immediate post-service time of 18 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize lead placement to avoid obscuring imaging.

To determine an appropriate work value for 475XX1, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25th percentile work RVU of 1.80 is appropriate. To justify this work value, the RUC compared the surveyed code to the top key reference code 49450 *Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU= 1.36, intra time= 10 minutes) and noted that since 475XX1 has double the intra-service time, the recommended value is appropriately greater in comparison. The RUC also reviewed the 2nd key reference code, 49083 *Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance* (work RVU= 2.00, intra time= 25 minutes) and agreed that the two services were similar, but since the reference code has five additional minutes of intra-service time, 475XX1 is appropriately valued slightly less. **The RUC recommends an interim work RVU of 1.80 for CPT code 475XX1.**

475XX2 Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access (eg, percutaneous transhepatic cholangiogram)
The RUC reviewed the survey results from 37 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 41 minutes, intra-service time of 40 minutes and immediate post-service time of 20 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize lead placement to avoid obscuring imaging. As noted above, the RUC agreed with the specialty societies that the intra-service time should not be identical to 475XX3, 60 minutes, which includes the work of 475XX2 plus an additional access and drain placement. Therefore, the RUC recommends the 25th percentile intra-service time of 40 minutes.

To determine an appropriate work value for 475XX2, the RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overestimated the physician work with the 25th percentile work RVU of 4.80. To arrive at an appropriate value, the RUC considered reference code 49405 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous* (work RVU= 4.25, intra time= 40 minutes) and agreed that the physician work and time are very similar between the two services and should therefore be valued identically. The RUC recommends a direct crosswalk from reference code 49405 to 475XX2. To justify a work RVU of 4.25, the RUC reviewed the top key reference code 49407 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal* (work RVU= 4.50, intra time= 45 minutes) and agreed that since both services have analogous physician work and times, both codes should be valued similarly. **The RUC recommends an interim work RVU of 4.25 for CPT code 475XX2.**

475XX3 Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; external
The RUC reviewed the survey results from 37 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 41 minutes, intra-service time of 60 minutes and immediate post-service time of 20 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize lead placement to avoid obscuring imaging.

To determine an appropriate work value for 475XX3, the RUC reviewed the survey respondents' estimated physician work values and agreed that the survey 25th percentile work RVU of 6.00 is appropriate. To justify this work value, the RUC compared the surveyed code to the 2nd key reference code 49407 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal* (work RVU= 4.50, intra time= 45 minutes) and agreed that since 475XX3 has an additional 15 minutes of intra-service time and greater intensity, the recommended value is appropriately higher in comparison. The RUC also compared 475XX3 to the other codes in this family and noted that since this service includes the work of 475XX2 as well as an additional access and placement of a drain, the recommended value of 6.00 accurately places this service between 475XX2 and 475XX4. **The RUC recommends an interim work RVU of 6.00 for CPT code 475XX3.**

475XX4 Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; internal-external

The RUC reviewed the survey results from 36 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 41 minutes, intra-service time of 78 minutes and immediate post-service time of 20 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize lead placement to avoid obscuring imaging. As noted above, the RUC agreed with the specialty societies that the intra-service time should not be identical to 475XX3, 60 minutes, as 475XX4 includes all the work of 475XX3 plus the work of crossing occlusion and placement of an internal/external drain.

To determine an appropriate work value and physician time for 475XX4, the RUC reviewed the survey respondents' estimated physician work values and agreed that the appropriate work value should be between the survey 25th percentile, 6.88, and median, 9.00. To arrive at an appropriate value, the RUC considered reference code 43265 *Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)* (work RVU= 8.03, intra time= 78 minutes) and agreed that the physician work and time are very similar between the two services and should therefore be valued identically. The RUC recommends a direct work RVU crosswalk from reference code 43265 to 475XX4. To justify a work RVU of 8.03, the RUC reviewed MPC code 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)* (work RVU= 7.50, intra time= 60 minutes) and noted that since the surveyed code has 18 additional minutes of intra-service time compared to the MPC code, the recommended valued is appropriately higher in comparison. **The RUC recommends an interim work RVU of 8.03 for CPT code 475XX4.**

475XX5 Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; internal-external

The RUC reviewed the survey results from 37 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 41 minutes, intra-service time of 45 minutes and immediate post-service time of 20 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize lead placement to avoid obscuring imaging.

To determine an appropriate work value for 475XX5, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25th percentile work RVU of 4.50 is appropriate. To justify this work value, the RUC compared the surveyed code to the 2nd key reference code 49407 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal* (work RVU= 4.50, intra time= 45 minutes) and agreed that since both services have identical intra-service time and analogous physician work, both services should be valued identically. The RUC also 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, intra time= 45 minutes) and determined that although both services have identical intra-service

time, the reference code is a more intense procedure compared to 475XX5 and is accurately valued higher. **The RUC recommends an interim work RVU of 4.50 for CPT code 475XX5.**

475XX6 Exchange of biliary drainage catheter (eg. external, internal-external , or conversion of internal-external to external only), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy) and all associated radiological supervision and interpretation

The RUC reviewed the survey results from 36 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 41 minutes, intra-service time of 30 minutes and immediate post-service time of 20 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize lead placement to avoid obscuring imaging.

To determine an appropriate work value for 475XX6, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25th percentile work RVU of 2.88 is appropriate. To justify this work value, the RUC compared the surveyed code to the top key reference code 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU= 2.86, intra time= 20 minutes) and agreed that while the surveyed code has 10 additional minutes of intra-service time, the reference code is a more intense procedure and is accurately valued similar to 475XX6. The RUC also reviewed MPC code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU= 2.78, intra time= 30 minutes) and agreed that both this reference code and 475XX6 have analogous physician work and time and are correctly valued similarly. **The RUC recommends an interim work RVU of 2.88 for CPT code 475XX6.**

475XX7 Removal of biliary drainage catheter, percutaneous, requiring fluoroscopic guidance (eg, with concurrent indwelling biliary stents), including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy) and all associated radiological supervision and interpretation

The RUC reviewed the survey results from 36 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 27 minutes, intra-service time of 20 minutes and immediate post-service time of 18 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize lead placement to avoid obscuring imaging.

To determine an appropriate work value for 475XX7, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25th percentile work RVU of 1.83 is appropriate. To justify this work value, the RUC compared the surveyed code to the top key reference code 49451 *Replacement of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU= 1.84, intra time= 15 minutes) and noted that while 475XX7 has five additional minutes of intra-service time, the reference code is a slightly more intense procedure. Therefore, both codes should be valued similarly. 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 noted that with

identical intra-service times, both this reference code and 475XX7 should be valued similarly. **The RUC recommends an interim work RVU of 1.83 for CPT code 475XX7.**
475XX11 Placement of access through the biliary tree and into small bowel to assist with an endoscopic biliary procedure (eg, rendezvous procedure), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access

The RUC reviewed the survey results from 36 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 41 minutes, intra-service time of 60 minutes and immediate post-service time of 20 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize lead placement to avoid obscuring imaging.

To determine an appropriate work value for 475XX11, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25th percentile work RVU of 5.61 is appropriate. To justify this work value, the RUC compared the surveyed code to the top key reference code 36247 *Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU= 6.29, intra time= 60 minutes) and noted that the reference code has more total time compared to 475XX11, 131 minutes and 121 minutes, respectively, Therefore, the surveyed code is appropriately valued less than the reference code. The RUC also reviewed MPC code 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)* (work RVU= 7.50, intra time= 60 minutes) and again noted an increased total time and intensity for the reference code in comparison to 475XX11 and thus concluded that the recommended value is appropriately lower than this MPC code. **The RUC recommends an interim work RVU of 5.61 for CPT code 475XX11.**

475XX8 Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange or removal when performed, and all associated radiological supervision and interpretation, each stent; existing access
The RUC reviewed the survey results from 44 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 41 minutes, intra-service time of 55 minutes and immediate post-service time of 25 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize lead placement to avoid obscuring imaging.

To determine an appropriate work value for 475XX8, the RUC reviewed the survey respondents' estimated physician work values and agreed that the appropriate work value should be between the survey 25th percentile, 5.88, and median, 8.00. To arrive at an appropriate value, the RUC considered CPT code 43262 *Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy* (work RVU= 6.60, intra time= 60 minutes) and noted that both services have very comparable physician work and time and should therefore be valued identically. The RUC recommends a direct work RVU crosswalk from reference code 43262 to 475XX8. To justify a work RVU of 6.60, the RUC compared the surveyed code to CPT code 43261 *Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple* (work RVU= 6.25, intra

time= 55 minutes) and agreed that both codes have analogous physician work and time and are appropriately valued similarly. **The RUC recommends an interim work RVU of 6.60 for CPT code 475XX8.**

475XX9 Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange or removal when performed, and all associated radiological supervision and interpretation, each stent; new access, without placement of separate biliary drainage catheter
The RUC reviewed the survey results from 42 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 41 minutes, intra-service time of 80 minutes and immediate post-service time of 25 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize lead placement to avoid obscuring imaging.

To determine an appropriate work value for 475XX9, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25th percentile work RVU of 9.00 is appropriate. To justify this work value, the RUC compared the surveyed code to the top two key reference codes 37226 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* (work RVU= 10.49) and 37228 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 11.00) and noted that both reference codes have 10 additional intra-service minutes compared to 475XX9. Therefore, the RUC agreed that the recommended value is appropriately estimated below these two reference codes. **The RUC recommends an interim work RVU of 9.00 for CPT code 475XX9.**

475XX10 Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange or removal when performed, and all associated radiological supervision and interpretation, each stent; new access, with placement of separate biliary drainage catheter (eg, external or internal-external)
The RUC reviewed the survey results from 43 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 41 minutes, intra-service time of 90 minutes and immediate post-service time of 25 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize lead placement to avoid obscuring imaging.

To determine an appropriate work value for 475XX10, the RUC noted that the physician work involved in this procedure includes all the work of 475XX4, balloon dilatation (475XX12) and stent placement. Given this, the RUC used magnitude estimation to accurately value this service at the survey median work RVU of 12.00. To justify this work value, the RUC compared the surveyed code to the top two key reference codes 37226 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* (work RVU= 10.49) and 37228 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 11.00) and noted that while all three services have identical intra-service time,

code 475XX10 is a more intense procedure and should be valued higher. **The RUC recommends an interim work RVU of 12.00 for CPT code 475XX10.**

475XX12 Balloon dilation of biliary duct(s) or of ampulla (sphincteroplasty), percutaneous, including imaging guidance (eg, fluoroscopy) and all associated radiological supervision and interpretation, each duct

The RUC reviewed the survey results from 33 interventional radiologists and agreed with the specialty societies that an intra-service time of 35 minutes for this add-on procedure is appropriate. To determine an appropriate work value, the RUC reviewed the survey respondents' estimated physician work values and determined that they overestimated them at the 25th percentile (work RVUs= 4.00). Given this, the RUC considered CPT code 37185 *Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family* (work RVU= 3.28, intra time= 40 minutes). Both these services have similar physician work and intensity and should therefore be valued identically. The RUC recommends a direct work RVU crosswalk from reference code 37185 to surveyed code 475XX12. To justify a work RVU of 3.28, the RUC reviewed the top key reference service 37222 *Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty* (work RVU= 3.73, intra time= 40 minutes) and noted that since the reference code is a more intense procedure, it is justifiably valued higher than 475XX12. **The RUC recommends an interim work RVU of 3.28 for CPT code 475XX12.**

475XX13 Endoluminal biopsy(ies) of biliary tree, percutaneous, any method(s) (eg, brush, forceps and/or needle), including imaging guidance (eg, fluoroscopy) and all associated radiological supervision and interpretation, single or multiple

The RUC reviewed the survey results from 34 interventional radiologists and agreed with the specialty societies that an intra-service time of 43 minutes for this add-on procedure is appropriate. To determine an appropriate work value for 475XX13, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25th percentile work RVU of 3.51 is appropriate. To justify this work value, the RUC compared the surveyed code to the top key reference code 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* (work RVU= 4.00, intra time= 30 minutes) and noted that while 475XX13 has greater intra-service time, the reference code is a more intense procedure and should be valued slightly higher. The RUC also reviewed reference 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* (work RVU= 3.47, intra time= 45) and agreed that since this code and the surveyed code have nearly identical intra-service time and comparable physician work, the two values should be analogous. **The RUC recommends an interim work RVU of 3.51 for CPT code 475XX13.**

475XX14 Removal of calculi/debris from biliary duct(s) and/or gallbladder, percutaneous, including destruction of calculi by any method (eg, mechanical, electrohydraulic, lithotripsy) when performed, imaging guidance (eg, fluoroscopy) and all associated radiological supervision and interpretation

The RUC reviewed the survey results from 32 interventional radiologists and agreed with the specialty societies that an intra-service time of 60 minutes for this add-on procedure is appropriate. To determine an appropriate work value for 475XX14, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25th percentile work RVU of 4.74 is appropriate. To justify this work value, the RUC compared the surveyed code to the 2nd key reference code 37234 *Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* (work RVU= 5.50, intra time= 60 minutes) and agreed that while both codes have identical intra-service times, the reference code is a more intense procedure and is correctly valued higher than 475XX14. The RUC also reviewed CPT code 61799 *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex* (work RVU= 4.81, intra time= 60 minutes) and agreed that this code and the surveyed code are comparable in both physician work and time and are correctly valued similar to each other. **The RUC recommends an interim work RVU of 4.74 for CPT code 475XX14.**

Practice Expense

The RUC reviewed and approved the direct practice expense inputs with the following revisions as approved by the PE Subcommittee:

- The PE Subcommittee had extensive discussion regarding the pre-service time for these services, reminding the specialty that zero minutes of clinical staff time is standard for 000 and 010 day globals. The PE Subcommittee determined that the standard for extensive use of clinical staff time in the facility setting, of 30 minutes is not appropriate. However, the services do require more pre-service time than the standard for minimal use of clinical staff time in the facility setting of 15 minutes. The PE Subcommittee determined that 19 minutes of pre-service time in the facility setting is appropriate for the services in the family that are done in the facility outpatient setting, similar to recently reviewed gastroenterology procedures, for example esophagoscopy services (CPT codes 43211, 43213, 43214, 43212, 43229). There was additional discussion about clinical staff coming from the physician's office to the facility to consent the patient. The PE Subcommittee agreed that the time would be duplicative of the duties of the clinical staff in the facility. The specialty proposed and the PE Subcommittee agreed that services performed in the inpatient facility setting should have 14 minutes of pre-service time because the 5 minutes to provide pre-service education/obtain consent should be removed.
- Many of the interventional radiology services include three staff to assist the physicians in performing the procedure during the intra-service portion of the service period. Generally an RN assists with the moderate sedation, another staff assists the physician in performing the procedure and a third staff (two staff types, but equal to one staff) acquires the images and circulates (RT acquire images 75% of intra-service time and RN/LPN/MTA circulates 25% of intra-service time). For CPT codes 475XX1 and 475XX7 moderate sedation is not administered, however the specialty society recommended and the PE subcommittee agreed that three staff remain actively engaged in the procedure and necessary to assist the physician in performing the procedure; acquire images and circulate; as well as monitor the patient.

Additionally, the PE Subcommittee recommends 4 hours of monitoring time (15 minutes of RN clinical staff time related to moderate sedation and 45 minutes not related to moderate sedation) for codes that include moderate sedation, and 1 hour (15 minutes of RN/LPN/MTA clinical staff time not related to moderate sedation) for 475XX1 and 475XX7 which do not include moderate sedation. The moderate sedation monitoring equipment is used for all the monitoring time, both following moderate sedation and following the procedure.

- The PE Subcommittee recommends 6 minutes of clinical staff time to clean room/equipment rather than the standard 3 minutes due to the bodily fluids involved and the large amount of equipment.
- The specialty societies clarified that there are no balloon dilation catheters specifically for the biliary tree. The supply item, catheter, balloon, PTA (SD152) used in some of these services is not only an angioplasty balloon; it is appropriately used in these services as a dilation device. The supply item, tray, shave prep (SA067) is used to prepare the area and is needed for all the services except for 475XX1 and 475XX7.
- The supply item, pack, cleaning and disinfecting, endoscope (SA042) which was used a proxy for the necessary cleaning supplies for the room was removed and replaced with 1 supply item, gloves, non-sterile (SB022) and 3 supply items, sanitizing cloth-wipe (surface, instruments, equipment) (SM022), the correct supplies necessary to clean the room for these services.

Do Not Use to Validate
Since these recommendations are interim and will be re-surveyed at the October 2015 RUC meeting, the Do Not Use to Validate for Physician Work flag will be placed on this series of codes in the RUC database.

Percutaneous Image-Guided Sclerotherapy of Fluid Collection (Tab 7)
Jerry Niedzwiecki, MD, (SIR); Michael Hall, MD, (SIR); Tim Swan, MD, (SIR); Zeke Silva, MD, (ACR); and Kurt Schoppe, MD (ACR)

Facilitation Committee #1

At the February 2015 CPT Editorial Panel meeting, the Panel approved a new code to describe percutaneous image-guided sclerotherapy of fluid collections.

Compelling Evidence
The specialty societies presented compelling evidence that the current value associated with the reporting of this service is misvalued.

Change in technology and patient population
The techniques involved in sclerotherapy have evolved with utilization of new sclerosant agents, techniques and protocols available today, which were not used at the inception of the RBRVS. Further, the patient population has changed as advances in diagnostic imaging quality have enabled enhanced visualization and characterization of various fluid collections. Advances in image guidance, particularly the availability of CT, fluoroscopy and ultrasound guidance, have enabled the treatment of collections not previously accessible by a percutaneous approach.

Flawed assumptions in current valuation
The current reporting of this code 20500 *Injection of sinus tract; therapeutic (separate procedure)* is currently Harvard valued and therefore does not adequately value the change in technology, as noted above, for this new procedure.

The RUC agreed with the specialty societies that there is compelling evidence that the current reporting of this procedure is inadequate and undervalued.

491XX1 Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed
The RUC reviewed the survey results from 44 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 22 minutes, intra-service time of 30 minutes and immediate post-service time of 15 minutes. The RUC agreed to add two minutes of positioning time to the package to account for positioning the patient on the angiographic table to optimize lead placement, to avoid obscuring imaging and ensure proper positioning of the operator relative to the imaging equipment. In addition, the RUC discussed that this procedure is typically performed in an existing access and concluded that there would be no concerns of duplicative work, as they are not typically performed on the same day.

To determine an appropriate work value for CPT code 491XX1, the RUC reviewed the survey data and agreed with the specialty societies that the respondents overestimated the work value at a 25th percentile of 4.19 work RVUs. Given this, the RUC reviewed MPC code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed* (work RVU= 2.78, intra time= 30 minutes) and noted that this recently valued MPC code is an appropriate direct crosswalk for two reasons. First, the clinical nature of this reference code is analogous to the surveyed code because both are diagnostic studies with imaging included. In addition, both services involve performing an analogous procedure (e.g. cell washing compared with sclerosant injection). Second, a work RVU of 2.78 appropriately accounts for the physician work in 491XX1, which involves the sclerosant injection procedure step being repeated three separate times. To further justify a work RVU of 2.78, the RUC reviewed CPT code 43217 *Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique* (work RVU= 2.90, intra-service time of 30 minutes, total time of 73 minutes) and agreed that this reference code and the surveyed code have analogous physician time and comparable physician work and should be valued similarly. **The RUC recommends a work RVU of 2.78 for CPT code 491XX1.**

Practice Expense
The specialty society recommended and the PE Subcommittee agreed that the pre-service clinical staff time for minimal use of clinical staff of 15 minutes in the facility is appropriate. Additionally the PE Subcommittee determined that for this service the angiography room (EL011)is not necessary and that the room, radiographic-flouro (EL014) is more appropriate. The RUC reviewed and approved the direct practice expense inputs with revisions as approved by the PE Subcommittee.

Genitourinary Catheter Procedures (Tab 8)
Jerry Niedzwiecki, MD, (SIR); Michael Hall, MD, (SIR); Tim Swan, MD, (SIR); Zeke Silva, MD, (ACR); and Kurt Schoppe, MD (ACR)

In October 2012, the Joint CPT/RUC Workgroup on Codes Reported Together identified the following code pairs as billed together 75% or more of the time: 50392 and 74475, 50393 and 74480, 50394 and 74425, 50398 and 75984. At the October 2014 CPT meeting, the specialties submitted a Code Change Proposal to bundle codes per the workgroup's request, and also refined the descriptors for injection and aspiration procedures to better delineate surgical access requirements.

At the January 2015 RUC meeting, the RUC had significant concerns regarding the global period used for the following CPT codes: 506XX6, 507XX11 and 507XX12. The specialties noted that these codes are almost always billed with another code. Since these codes were designated by CPT as -51 modifier exempt, the RUC was concerned that the pre- and post-service work would be duplicative. The specialties hypothesized that the surveyees may have assumed that the codes were stand-alone codes, and therefore assigned it pre- and post-work. The specialty societies agreed with the RUC that these three codes should be referred to the CPT Editorial Panel. The RUC recommended CPT codes 506XX6, 507XX11 and 507XX12 be referred to the February 2015 CPT Editorial Panel. The CPT Editorial Panel converted these codes to add-on codes at the February 2015 RUC Meeting and new surveys were conducted and presented to the RUC in April 2015.

Prior to valuing these services, the specialty societies noted that for two of these new services, 5039X1 and 5039X2, there is compelling evidence that the current component codes used to report these services are potentially misvalued. The specialties brought forth the following compelling evidence arguments:

Change in technique and technology

- Virtually all the medical devices currently used in the genitourinary catheter procedures have been developed since the current codes were adopted. Advances in understanding of anatomy and avoidance of complications (especially genitourinary sepsis) have led to the development of much less aggressive and safer guidewire-based methods which involve more steps and more effort, skill and physician time such as micropuncture access with gradual stepwise transition to heavy-duty guidewires, tract dilation and placement of nephrostomy catheters over a wire and use of real-time ultrasound guidance for needle access.

Change in patient population

- The population of patients treated with the genitourinary catheter procedures currently described by the family of codes being replaced by the new family of codes has changed considerably. Previously virtually all genitourinary catheter procedures were used for basic relief of urinary obstruction either acutely or chronically, but as a result of major advances in urologic surgery, patients with malignancies, stone disease and other problems are now being managed with innovative reconstructive techniques including the regular need for and use of catheter based procedures, including urinary drainage.

After hearing these arguments, the RUC agreed that there is compelling evidence that the current work values for 5039X1 and 5039X2 are potentially misvalued.

5039X1 Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access
The RUC reviewed the survey results for 45 interventional radiologists and recommends the following physician time components: pre-service time of 36 minutes, intra-service time of 35 minutes and post-service time of 20 minutes.

To determine an appropriate work value for 5039X1, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25th percentile work RVU of 3.15 is appropriate. To justify a work RVU of 3.15, the RUC compared the surveyed code to the top two key reference services chosen: CPT code 32557 *Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance* (work RVU= 3.12, intra time= 30 minutes) and CPT code 49405 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous* (work RVU= 4.25, intra time= 40 minutes). The RUC noted that both services provide comparable physician work and the recommended work value of 3.15 appropriately places 5039X1 in rank order betweeen these two reference services. **The RUC recommends a work RVU of 3.15 for CPT code 5039X1.**

5039X2 Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access
The RUC reviewed the survey results for 45 interventional radiologists and recommends the following physician time components: pre-service time of 25 minutes, intra-service time of 15 minutes and post-service time of 15 minutes.

To determine an appropriate work value for 5039X2, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25th percentile work RVU of 1.42 is appropriate. To justify a work RVU of 1.42, the RUC compared the surveyed code to the second highest chosen key reference code 49083 *Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance* (work RVU= 2.00) and noted that the reference code has slightly more total time than 5039X2, 60 minutes compared to 55 minutes, and is valued appropriately higher. The RUC also reviewed reference code 64445 *Injection, anesthetic agent; sciatic nerve, single* (work RVU= 1.48, intra time= 15 minutes) and MPC code 52000 *Cystourethroscopy (separate procedure)* (work RVU= 2.23, intra time= 15 minutes) and noted that both services provide comparable physician work and the recommended work value of 1.42 appropriately places 5039X2 relative to these two reference services. **The RUC recommends a work RVU of 1.42 for CPT code 5039X2.**

5039X3 Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation
The RUC reviewed the survey results for 45 interventional radiologists and recommends the following physician time components: pre-service time of 39 minutes, intra-service time of 48 minutes and post-service time of 20 minutes.

To determine an appropriate work value for 5039X3, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25th percentile work RVU of 4.70 is appropriate. To justify a work RVU of 4.70, the RUC compared the surveyed code to the top two key reference services chosen: CPT code 49407 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal* (work RVU= 4.50, intra time= 45 minutes) and CPT code 49405 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous* (work RVU= 4.25, intra time= 40 minutes). The RUC agreed that considering the similarities in physician work and time, these two reference services are appropriately valued analogous to 5039X3.

Finally, the RUC noted that physician work involved in 5039X3 is the work involved in 5039X1 plus the work of re-accessing a system in a peripheral calyx. Therefore, the physician is accessing the system twice in 5039X3 and justifies a work RVU 1.55 difference greater than 5039X1. **The RUC recommends a work RVU of 4.70 for CPT code 5039X3.**

5039X4 Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access

The RUC reviewed the survey results for 46 interventional radiologists and recommends the following physician time components: pre-service time of 39 minutes, intra-service time of 60 minutes and post-service time of 20 minutes.

To determine an appropriate work value for 5039X4, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that neither the 25th percentile (work RVU= 5.00) nor the median work RVU (work RVU= 6.20) accurately values 5039X4. To determine a more accurate value, the RUC reviewed CPT code 52351 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic* (work RVU= 5.75) and noted that both codes have similar physician work and nearly identical total time. Given these similarities, the RUC recommends a work RVU of 5.75, which is a direct crosswalk to CPT code 52351. To justify this value, the RUC compared 5039X4 to CPT code 52342 *Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 5.85, intra time= 60 minutes) and noted that since both codes have identical intra-service time and comparable physician work, the recommended value is appropriately valued analogous to this reference code.

Finally, the RUC noted that the work involved in 5039X4 contains the physician work of 5039X3 plus the additional work of transversing the ureter and placing the catheter into the bladder and having it then travel externally to the patient. The RUC agreed that the additional incremental work of 1.05 above the recommended value of 4.70 for CPT code 5039X3 is accurate. **The RUC recommends a work RVU of 5.75 for CPT code 5039X4.**

5039X13 Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; via pre-existing nephrostomy tract
The RUC reviewed the survey results for 45 interventional radiologists and recommends the following physician time components: pre-service time of 36 minutes, intra-service time of 45 minutes and post-service time of 20 minutes.

To determine an appropriate work value for 5039X13, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25th percentile work RVU of 4.20 is appropriate. To justify a work RVU of 4.20, the RUC compared the surveyed code to MPC code 31628 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe* (work RVU= 3.80) and noted that since this reference code has 5 fewer minutes than the surveyed code, 40 minutes compared to 45 minutes, 5039X13 is appropriately valued higher. In addition, the RUC reviewed CPT code 49407 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal* (work RVU= 4.50) and agreed that with identical intra-service time, these two codes should be valued similarly.

Finally, the RUC noted that the work involved in 5039X13 contains the physician work of 5039X2 plus the additional work of traversing the ureter with a new catheter analogous to 5039X4, where this new catheter extends from the bladder, through the ureter, is coiled in the kidney, and extends external to the patient. The RUC agreed that the additional work increment between this procedure and the injection procedure is accurate. **The RUC recommends a work RVU of 4.20 for CPT code 5039X13.**

5039X5 Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation
The RUC reviewed the survey results for 44 interventional radiologists and recommends the following physician time components: pre-service time of 20 minutes, intra-service time of 20 minutes and post-service time of 15 minutes.

To determine an appropriate work value for 5039X5, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25th percentile work RVU of 2.00 is appropriate. To justify a work RVU of 2.00, the RUC compared the surveyed code to the key reference code 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU= 2.86, total time= 60 minutes) and noted that the reference code has slightly more total time compared to the surveyed code and is appropriately valued higher. The RUC also reviewed CPT code 47000 *Biopsy of liver, needle; percutaneous* (work RVU= 1.90, intra time= 20 minutes) and agreed that this reference code should be valued similarly to 5039X5. **The RUC recommends a work RVU of 2.00 for CPT code 5039X5.**

506XX6 Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation
The RUC reviewed the survey results for 34 interventional radiologists and recommends 45 minutes of intra-service time for this add-on procedure. To determine an appropriate work

value, the RUC agreed that the survey 25th percentile work RVU of 3.16 accurately accounted for the physician work involved in 506XX6. To justify a work RVU of 3.16, the RUC compared the surveyed code to CPT code 37185 *Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family* (work RVU= 3.28, intra time= 40 minutes) and noted that both services have analogous physician work and time and should therefore be valued similarly. In addition, the RUC reviewed 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* (work RVU= 3.47, intra time= 45 minutes) and agreed that this reference code and 506XX6 are analogous procedures, with identical physician time. Therefore, the recommended value appropriately places the surveyed code near this reference code. **The RUC recommends a work RVU of 3.16 for CPT code 506XX6.**

5069X7 Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; via a pre-existing nephrostomy tract

The RUC reviewed the survey results for 33 interventional radiologists and recommends the following physician time components: pre-service time of 39 minutes, intra-service time of 45 minutes and post-service time of 20 minutes.

To determine an appropriate work value for 5069X7, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey median work RVU of 4.60 is appropriate. To justify a work RVU of 4.60, the RUC compared the surveyed code to CPT code 49407 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal* (work RVU= 4.50) and noted that both services have identical intra-service time, 45 minutes, and should therefore be valued similarly. The RUC also reviewed CPT code 50385 *Removal (via snare/capture) and replacement of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision and interpretation* (work RVU= 4.44, intra time= 45 minutes) and agreed that this reference code also provides an accurate anchor point to the recommended value.

Finally, the RUC noted that 5069X7 is analogous to the physician work involved in 5039X13. However, the placement of the ureteral catheter does not have external connections to the skin surface. Therefore, during deployment of the stent, there is significant risk of stent migration and malposition . This adds additional intensity compared to 5039X13 and the recommended value appropriately values the surveyed code above this reference code. **The RUC recommends a work RVU of 4.60 for CPT code 5069X7.**

5069X8 Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access, without separate nephrostomy catheter

The RUC reviewed the survey results for 33 interventional radiologists and recommends the following physician time components: pre-service time of 39 minutes, intra-service time of 62 minutes and post-service time of 20 minutes.

To determine an appropriate work value for 5069X8, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25th percentile work RVU of 6.00 is appropriate. To justify a work RVU of 6.00, the RUC compared the surveyed code to the second highest chosen key reference code 36247 *Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU= 6.29) and agreed that since both services have comparable physician work and nearly identical intra-service time, 60 minutes compared to 62 minutes, both should be valued similarly. The RUC also reviewed CPT code 52342 *Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 5.85, intra time= 60 minutes) and agreed that both this reference code and 5069X8 should be valued similarly.

Finally, the RUC noted that 5069X8 is analogous to the physician work involved in 5069X7 except that there is not a pre-existing nephrostomy tract. Therefore, the additional work increment of placing the ureteral stent in a new access is accurately valued at 1.40 work RVUs. **The RUC recommends a work RVU of 6.00 for CPT code 5069X8.**

5069X9 Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access, with separate nephrostomy catheter
The RUC reviewed the survey results for 33 interventional radiologists and recommends the following physician time components: pre-service time of 39 minutes, intra-service time of 75 minutes and post-service time of 20 minutes.

To determine an appropriate work value for 5069X9, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey median work RVU of 7.55 is appropriate. To justify a work RVU of 7.55, the RUC compared the surveyed code to the key reference code 36247 *Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU= 6.29) and noted that the surveyed code has more intra-service time compared to the reference code, 60 minutes compared to 75 minutes, and is therefore appropriately valued higher. The RUC also reviewed CPT code 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* (work RVU= 7.27, intra time= 80 minutes) and agreed that this reference code is accurately valued similar to the surveyed code.

Finally, the RUC noted that the work involved in 5069X9 contains the physician work of 5069X8 plus the additional work of placing a nephrostomy tube. The RUC agreed that the additional work increment involved in the tube placement is accurately valued at 1.55 work RVUs. **The RUC recommends a work RVU of 7.55 for CPT code 5069X9.**

507XX11 Ureteral embolization or occlusion, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation
The RUC reviewed the survey results for 34 interventional radiologists and recommends 60 minutes of intra-service time for this add-on procedure. To determine an appropriate work

value, the RUC agreed that the survey 25th percentile work RVU of 4.03 accurately accounted for the physician work involved in 507XX11. To justify a work RVU of 4.03, the RUC compared the surveyed code to CPT code 37186 *Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy* (work RVU= 4.92, intra time= 60 minutes) and noted that while both procedures have identical intra-service time, the reference code is slightly more intense than 507XX11 and should therefore be valued higher. The RUC also reviewed CPT code 63621 *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion* (work RVU= 4.00, intra time= 60 minutes) and agreed that both services have identical physician time and should be valued similarly. **The RUC recommends a work RVU of 4.03 for CPT code 507XX11.**

507XX12 Balloon catheter dilation, ureteral stricture, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation
The RUC reviewed the survey results for 36 interventional radiologists and recommends 60 minutes of intra-service time for this add-on procedure. To determine an appropriate work value, the RUC agreed that the survey 25th percentile work RVU of 3.80 accurately accounted for the physician work involved in 507XX12. To justify a work RVU of 3.80, the RUC compared the surveyed code to the top key reference service 37222 *Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty* (work RVU= 3.73, intra time= 40 minutes) and noted that while the reference code has 20 minutes less of intra-service time, code 37222 is a more intense procedure and is justifiably valued similar to the surveyed code. In addition, the RUC reviewed CPT code 17314 *Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks* (work RVU= 3.06, intra time= 60 minutes) and agreed that 507XX2 is a more complex service and should be valued higher. **The RUC recommends a work RVU of 3.80 for CPT code 507XX12.**

CPT Referral:
Prior to the meeting, the specialties indicated that CPT code 50395 *Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous*, which was identified as part of the family, will be referred to the CPT Editorial Panel to clear up any confusion with overlap in physician work with 5039X3. **The RUC recommends CPT code 50395 be referred to the CPT Editorial Panel.**

Medicare Utilization Review
CPT code 74425 was identified as part of the family of genitourinary catheter procedures surveyed for the January and April 2015 RUC meetings. The specialty societies noted that this service is now bundled into the new codes established in CPT 2016. While this code is not being deleted, it remains unclear what the typical vignette will be for this procedure once the majority of its utilization has migrated to the new codes. The RUC agreed with the specialty societies that two years of Medicare claims data should be reviewed prior to re-survey. **The RUC recommends a delay to the survey of CPT code 74425 until at least two years of Medicare claims data is available.**

Not Part of Family:
The specialties noted that two CPT codes identified as part of the family, 50391 and 50396, are current stand-alone procedure that do not describe introduction/exchange/removal of catheters within the renal pelvis and should not be considered part of the family of codes under this tab. The RUC agreed that these two codes were not part of the current family under review.

New Technology:
The RUC recommends that this family of codes 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 the following modifications as approved by the Practice Expense Subcommittee:

- The clinical staff time for availability of prior images confirmed, was changed from 3 to 2 minutes for nonfacility setting to meet baseline standards for digital imaging (line 22).
- The clinical staff time for patient clinical information and questionnaire reviewed by technologist, order from physician confirmed and exam protocoled by radiologist, was changed from 0 to 2 minutes for nonfacility setting to meet baseline standards for digital imaging (line 23).
- The clinical staff time for obtain vital signs, was changed from 2 to 5 minutes for a standard level 2 (4-6 vitals) (line 29).
- The specialty had recommended 60 minutes (15 minutes of RN time per hour of monitoring) representing 4 hours of monitoring the patient after moderate sedation, however the PE Subcommittee determined that 15 minutes representing 1 hour of monitoring the patient after moderate sedation (line 43) was appropriate and moved the remaining 45 minutes of monitoring time to the appropriate line for monitoring the patient after procedure, not related to moderate sedation (line 44). The clinical staff type for monitoring the patient after procedure, not related to moderate sedation was changed from RN/LPN/MTA L037D to an RN L051A because that is the staff available in the office for these types of procedures (line 44).
- The clinical staff time for review examination with interpreting MD, was changed from 0 to 2 minutes for nonfacility setting to meet baseline standards for digital imaging (line 53).
- The clinical staff time for exam documents scanned into PACS. Exam completed in RIS system to generate billing process and to populate images into Radiologist work queue, was changed from 0 to 1 minute for nonfacility setting to meet baseline standards for digital imaging (line 54).
- The PE Subcommittee had a robust discussion about use of the angiography room for these services. Unfortunately, in error, the equipment list for the angiography room has not been included in the PE reference materials for a number of years. AMA staff tracked down a list from 2003 and the equipment appears to remain unrevised since that time. The specialty advisors reviewed the equipment list in detail and verified that the angiography room, and not a subset of mobile equipment, is needed for these services.
- The equipment minute calculations were updated to include the appropriate line items for PACS Workstation Proxy (ED050) (line 140).

At the April 2015 meeting, the add-on codes (506XX6, 507XX11 and 507XX12) were reviewed and the clinical staff time for prepare and position patient/ monitor patient/ set up IV, was changed from 1 to 0 minutes as the time is captured in the base codes (line 33).

Intracranial Endovascular Intervention (Table 9)
John Ratliff, MD, (AANS); Jerry Niedzwiecki, MD, (SIR) ; Gregory N. Nicola, MD (ASNR); Zeke Silva, MD, (ACR); Kurt Schoppe, MD, (ACR); Timothy Swan, MD (SIR)

In February 2015, the CPT Editorial Panel created three new codes to describe percutaneous endovascular revascularization of occluded cerebral vessels and intracranial prolonged infusion of agents that do not involve thrombolytic agents.
CPT codes 61640-61642 were identified as part of this family of services. The specialty societies indicated the balloon dilatation of intracranial vasospasm codes are not part of the family of services. These services are of the same anatomic distribution but a completely different intervention and are not commonly used. Additionally, these codes assume that a separate diagnostic angiography is reported prior to the intervention. The specialty societies indicated that this would be very confusing for surveyees to value the variable coding techniques for both sets of services. The RUC determined that although CPT codes 61640-61642 may present difficulties in conducting a survey, it has been nearly 10 years since their last RUC review and they should be surveyed. **The RUC recommended that CPT codes 61640-61642 be surveyed for October 2015.**

CPT codes 75896 and 75898 were also identified as part of this family of services. The specialty societies requested to refer these services to the CPT Editorial Panel as a coding change proposal has already been submitted for review at the May 2015 CPT meeting to delete code 75896 and a multispecialty coding change proposal is scheduled to be addressed in a future CPT cycle. The new codes approved for intracranial thrombolysis and intracranial mechanical thrombectomy are expected to be utilized instead of 75898. The work remaining in 75798 will be appropriately surveyed by physicians who perform such work. The RUC is scheduled to review the utilization of 75898 at the October 2016 Relativity Assessment Workgroup meeting.

6164X1 Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)

The RUC reviewed the survey results from 54 physicians for CPT code 6164X1 and determined that the survey 25the percentile work RVU of 17.00 appropriately accounts for the physician work required to perform this service. The RUC agreed with the specialty society recommended 58 minutes pre-service time, 100 minutes intra-service time and 53 minutes immediate post service time. The pre-service evaluation time of 40 minutes is appropriate to complete the many interventions such as the history and physical, review films, medications and consent forms for emergent procedure, prior to the patient entering the imaging suite.

CMS questioned if an Evaluation and Management (E/M) service would be reported prior to the decision to send the patient to the angiography suite. The specialty societies indicated that a consultation with the decision for surgery (57 Modifier) could be reported on the same day but that is not typical for this service. This is in emergent procedure and the patient is taken straight to catheter lab.

The RUC agreed with the additional 20 minutes post-service time to package 9B *General Anesthesia or Complex Regional Block/Complex Procedure*. The physician will conduct a thorough neurological exam prior to going back to ICU, complete ICU orders, complete documentation and supervision and interpretation (S&I). The RUC noted that the 99233 *Subsequent hospital care, per day, for the evaluation and management of a patient,* visit is necessary as all patients return to the ICU, have been intubated and just undergone an intracranial procedure where axis side needs to be addressed. The patient is also followed by a neuro-intensivist who focuses on care such as ventilatory management, fluid management, neurologic exam, cardiac status and blood pressure.
The specialty societies indicated that three vascular territories are included in this service: right carotid, left carotid and vertebrobasilar/posterior cerebral are all included in 6164X1. The RUC compared the surveyed code to the top two key reference services 37231 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed* (work RVU = 15.00 and 135 minutes intra-service time) and 37182 *Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)*(work RVU = 16.97 and 150 minutes intra-service time) and determined that the surveyed code requires less intra-service time but as indicated by the respondents is more intense and complex. The survey 25th percentile work RVU of 17.00 appropriately values this service relative to similar services. **The RUC recommends a work RVU of 17.00 for CPT code 6164X1.**

6164X2 Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory
The RUC reviewed the survey results from 53 physicians for CPT code 6164X2 and determined that the survey 25th percentile work RVU of 12.00 appropriately accounts for the physician work required to perform this service. The typical patient has had an aneurysm and now requires further intervention. The RUC recommends 41 minute pre-service time, 90 minutes intra-service time and 45 minutes immediate post-service time. The RUC agreed with the additional 17 minutes post-service time to package 8B *IV Sedation/Complex Procedure* so that the physician may apply dressings, monitor and assess the patients' neurological status, document the procedure and conduct the radiological S&I. The RUC agreed that one 99233 *Subsequent hospital care, per day, for the evaluation and management of a patient* is necessary as to assess the patients neurologic condition, review interval charts, record patient progress, write orders for IV fluids, vasoactive agents, imaging and labs, answer family questions and discuss on going care with the unit team. The specialty societies noted that the CPT coding specifies that 6164X2 may not be reported with 6164X1.

The RUC compared the surveyed code to the top two key reference services 37211 *Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day* (work RVU = 8.00) and 37243 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction* (work RVU = 11.99 and 60 minutes intra-service time) and determined that the surveyed code requires less intra-service time but as indicated by the respondents more intense and complex to perform. The survey 25th percentile work RVU of 12.00 appropriately values this service relative to similar services. **The RUC recommends a work RVU of 12.00 for CPT code 6164X2.**

6164X3 Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; each additional vascular territory (List separately in addition to the primary code)

The RUC reviewed the survey results from 51 physicians for CPT code 6164X3 and determined that the survey 25th percentile work RVU of 5.50 appropriately accounts for the physician work required to perform this service. The RUC recommends 45 minutes intra-service time for this add-on procedure. The RUC compared the surveyed code to the top two key reference services 36228 *Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure)* (work RVU = 4.25 and 30 minutes intra-service time) and 37235 *Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)* (work RVU = 7.80 and 80 minutes intra-service time) and determined that the surveyed code as indicated by the respondents is more intense and complex to perform. The survey 25th percentile work RVU of 5.50 appropriately values this service relative to similar services. **The RUC recommends a work RVU of 5.50 for CPT code 6164X3.**

Practice Expense

CPT codes 6164X1-6164X2 are facility-only codes therefore the RUC does not have any direct practice input recommendations.

New Technology

The RUC recommends that CPT codes 6164X1-6164X3 be placed on the New Technology/New Services list to be reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

<u>Paravertebral Block Injection (Tab 10)</u>

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At the February 2015, the CPT Editorial Panel established three codes to identify paravertebral block (injections) at single or multiple levels as well as for continuous infusion for the administration of local anesthetic for post-operative pain control and thoracic and abdominal wall analgesia. The specialty societies indicated that CPT codes 64420, 64421, 64479, 64480, 64490-92 are not part of this family of services. CMS questioned if the aforementioned codes provide anesthesia for any of the same areas as the new codes 644XX1-644XX2. The specialty societies indicated that other codes are for peripheral nerve blocks for the extremities and are not related to the paravertebral nerve blocks. Additionally, CPT codes 62310, 62311, 62318, 62319 are not part of the paravertebral block injection family. A separate coding proposal for these interlaminar epidural codes with imaging guidance codes 77001, 77002 and 77003 was submitted for the May 2015 CPT meeting. Additionally, the specialty societies noted that 77001-77003 will not be reported with these new codes 644XX1-644XX3.

644XX1 Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed)
The RUC reviewed the survey results from 79 physicians for CPT code 644XX1and agreed with the specialties that the survey 25th percentile work RVU of 1.75 appropriately accounts for the work required to perform this service. The RUC recommends 19 minutes pre-time, 15 minutes intra-time and 10 minutes immediate post-service time. The specialty societies noted that an Evaluation and Management (E/M) service is not reported on the same day as this service.

The specialty societies indicated that the anesthesiologist uses ultrasound to conduct a pre-scan to review the relevant anatomy prior to prepping the patient, to confirm that what the physician is planning to do is a feasible solution. The ultrasounds also allows the physician to view where he/she is going, mark the skin and know what to expect to see prior to prep and drape. The specialty societies noted that typically a different physician performs this paravertebral block pre-operatively. This ensures that the patient has adequate analgesia for post-operative pain control. The specialty society indicated that it is not common to perform the paravertebral block intra-operatively because sitting the patient up during a procedure is less comfortable and more difficult. In addition, it would only be performed post-operatively if there was a change in procedure plans or the physician is specifically consulted to perform the block post-operatively due to pain. The specialty society indicated that it is typical that a different anesthesiologist is performing the block than the anesthesiologist who providing anesthesia for the procedure itself. This allows for efficiency in an operating room, one team provides the block and then the room is overturned quickly to the second team providing analgesia for the procedure and performing the procedure. Additionally, in practice the general anesthesiologist dos not typically perform these invasive blocks; acute or chronic pain anesthesiologists are specifically trained and skilled to provide these services. The specialty societies noted that the block is administered in a separate pre-operating room, not performed in the same operating room that will be used for the surgical procedure.

CMS questioned if the block provided contributes to the anesthesia necessary for the procedure. The specialty societies indicated that the block in no way provides a meaningful contribution to the anesthetic needed. The involvement of the surgical procedure itself goes well beyond the boundaries of what the block provides.

The RUC compared the surveyed code to the top two key reference codes 64490 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level* (work RVU =1.82) and 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) all which require the same intra-service time, 15 minutes, and similar intensity and complexity to perform. For additional support the RUC referenced MPC codes 93351 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional* (work RVU = 1.75 and 20 minutes intra-service time) 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 15 minutes intra-service time). **The RUC recommends a work RVU of 1.75 for CPT code 644XX1.**

644XX2 Paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s), (includes imaging guidance, when performed) (list separately in addition to code for primary procedure)
The RUC reviewed the survey results from 60 physicians for CPT code 644XX2 and determined that the survey 25th percentile work RVU of 1.10 appropriately accounts for the work required to perform this add-on service. The RUC recommends 15 minutes intra-service time. The RUC noted that this add-on service can only be reported once, regardless of how many blocks are performed. The parenthetical following the code states "(Do not report 644XX2 more than once per day)". The specialty societies noted that add-on service 644XX2 can only be reported once because it also encompasses the second and subsequent injection sites. CPT code 644XX2 will be reported 25-35% of the time with 644XX1.

CMS questioned if 644XX2 would be reported if 644XX1 did not achieve the appropriate anesthesia necessary for the patient. The specialty societies indicated that if 644XX1 is not performed appropriately you would not report 644XX2, because 644XX1 is still for the first level whether or not the initial injection was successful or not. The specialty societies indicated that the physician may need to perform blocks at more than one level to expand the effect of the anesthetic block and achieve the adequate coverage for the planned surgical site. The additional injection site is synonymous with an additional level. **The RUC recommended that a CPT Assistant article be developed to define injection site/level for CPT codes 644XX1 and 644XX2.**

The RUC compared this add-on code to its corresponding base code 644XX1 and agreed with the specialties that a work RVU of 1.10 appropriately accounts for the physician work performed. The RUC compared the surveyed code to the top two key reference services 64491 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)* (work RVU = 1.16) and 64480 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.20), noting all these services require 15 minutes intra-service time and similar intensity and complexity to perform. The RUC also referenced MPC code 64484 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.00) and determined that the survey 25th percentile work RVU of 1.10 appropriately values this service compared to similar services. **The RUC recommends a work RVU of 1.10 for CPT code 644XX2.**

644XX3 Paravertebral block (PVB) (paraspinous block), thoracic continuous infusion by catheter (includes imaging guidance, when performed)
The RUC reviewed the survey results from 57 physicians for CPT code 644XX3 and agreed with the specialties that the survey 25th percentile work RVU of 1.90 appropriately accounts for the work required to perform this service. The RUC recommends 19 minutes pre-time, 20 minutes intra-time and 15 minutes immediate post-service time. The specialty societies noted the anesthesiologist will report a separate E/M service for removal of the continuous infusion catheter. **The RUC noted that the CPT Assistant article should also clarify that a separate E/M will be reported for the removal of the continuous infusion catheter for 644XX3.**

CMS questioned if CPT code 64421 *Injection, anesthetic agent; intercostal nerves, multiple, regional block* is not part of the family, why in the frequency information section does it indicate that this service was previously reported with 64421. The specialty societies indicated that CPT code 64421, intercostal never block, is typically performed 10-15 cm away from midline providing anesthetic of a single individual intercostal nerve, whereas a paravertebral block is done directly next to the neuroforamen in the potential space between the reflection of the pleura, ribs and spine and allows you to have local anesthetic spread that will go up and down multiple levels next to the neuroforamen. An intercostal nerve block will block one level where a paravertebral block will affect multiple levels. The intercostal nerve blocks and paravertebral blocks are very different technical procedures and have very different outcomes from an area of surgical or anesthesia coverage.

The RUC compared the surveyed code to top key reference service 64446 *Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement)* (work RVU = 1.81) and determined that the surveyed code requires the same physician intra-service time as CPT code 64446, 20 minutes, but is slightly more intense and complex to perform. For additional support the RUC referenced 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), which requires the same physician work and time to perform. **The RUC recommends a work RVU of 1.90 for CPT code 644XX3.**

Practice Expense
The PE Subcommittee noted there are no direct practice expense inputs in the facility setting. For the non-facility setting, the specialty recommended and the PE Subcommittee agreed the removal of minor supplies which were duplicative of the packs requested. The PE Subcommittee also agreed that a reduction to 2/3 the physician intra service time for the clinical labor assist physician in performing the procedure is appropriate to account for multitasking. Additionally the Subcommittee corrected equipment minutes for 644XX1 an 644XX2 to account for the use of equipment during the entire service period including recovery time. The RUC recommends the direct practice expense inputs as approved by the PE Subcommittee.

Referral to CPT Assistant
The specialty societies indicated that the physician may need to perform blocks at more than one level to expand the effect of the anesthetic block and achieve the adequate coverage for the planned surgical site. The additional injection site is synonymous with an additional level. **The RUC recommended that a CPT Assistant article be developed to define injection site/level for CPT codes 644XX1 and 644XX2.**

Additionally, the specialty societies noted the anesthesiologist will report a separate E/M service for removal of the continuous infusion catheter (644XX3). **The RUC noted that the CPT Assistant article should also clarify that a separate E/M will be reported for the removal of the continuous infusion catheter for 644XX3.**

<u>Trabeculoplasty by Laser Surgery (Tab 11)</u>
Steve Kamenetzky, MD, (AAO); David Glasser, MD, (AAO) and Cindie Mattox,MD (AAO)

CPT code 65855 was identified by the RUC potentially misvalued services screen for more than one postoperative visit in a 010-day global code. The code was changed from 090-day to

010-day global period when it was last valued in 2000. However, the descriptor was not updated to reflect that change. CPT code 65855 describes multiple laser applications to the trabecular meshwork through a contact lens to reduce intraocular pressure. The current practice is to perform only one treatment session of the laser for glaucoma during a 010-day period and then wait for the effect on the intraocular pressure. The new descriptor removes the language "1 or more sessions" in order to clarify this change in practice.

65855 ***Trabeculoplasty by laser surgery***
The RUC reviewed the survey results from 73 ophthalmologists for CPT code 65855 and recommend the following physician time components: 20 minutes pre-time, 10 minutes intra-time and 15 minutes immediate post-service time.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the 25th percentile work RVU of 3.00 accurately values the physician work of CPT code 65855. The RUC noted that when the code was previously reviewed in August 2000 as part of the 2nd 5-year review, it included three 99213 post-operative visits and the survey respondents now indicate that it has one 99213 post-operative visit. The specialty determined that one 99212 post-operative visit is more appropriate for the work required for this service. Additionally the RUC noted that the intra-service time of this procedure was reduced from 15 to 10 minutes. To justify a work RVU of 3.00, the RUC compared the surveyed code to the top key reference code 66761 *Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)* (work RVU = 3.00, 7 and minutes of pre-service time, 10 minutes of intra-service time and 10 minutes of post service time), which has identical intra-service time. The RUC noted that although 66761 has two post-operative visits, the surveyed code has significantly more pre-service and post-service time and a similar total time, justifying the identical physician work value. For additional support the RUC compared the surveyed code to 27250 *Closed treatment of hip dislocation, traumatic; without anesthesia* (work RVU = 3.82), which has more intra-service time and greater intensity and complexity than the surveyed code justifying the higher work value. **The RUC recommends a work RVU of 3.00 for CPT code 65855**.

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with the following revisions as approved by the Practice Expense Subcommittee:

- The clinical staff pre-service time was revised to 0 minutes, in the nonfacility setting and 15 minutes in the facility setting. 15 minutes is the standard time for minimal use of clinical staff for a 10 day global.
- The clinical staff time in the nonfacility for provide pre-service education/obtain consent was changed from 0 to 3, to meet standards (line 23).
- The clinical staff time in the nonfacility for clean room/equipment by physician staff was changed from 0 to 3, to meet standards (line 35).
- The clinical staff time in the facility for discharge mgmt same day (0.5 x 99238) (enter 6 min) was changed from 6 to 0, as there is no clinical staff time associated with discharge for this service (line 42).
- The equipment minutes in the nonfacility were calculated to include the appropriate line item.

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.

Retinal Detachment Repair (Tab 12)
Steve Kamenetzky, MD, (AAO); David Glasser, MD, (AAO) and John Thompson, MD (AAO)

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 RUC requested these services be surveyed for work and review the practice expense for the January 2015 RUC meeting. CPT code 67113 was identified in this screen and the AAO indicated that 67108 was a related service along with 67112. In October 2014, the CPT Editorial Panel deleted 67112 and revised five codes. Although, the revisions to these codes were considered editorial, they, along with 67110 were added as part of the family of services to be reviewed at the January 2015 RUC meeting.

At the January 2015 meeting, the specialty society reported that they did not submit survey data for the following CPT codes 67101, 67105, 67107, 67108, 67110 and 67113. For 67108 and 67113, it was due to concern over the CMS final decision to transition all surgical codes with 010- and 090-day global period to 000-day globals. Specifically, the specialty was concerned that CMS would choose to use the reverse building block methodology to value the 090-day globals as a 000-day globals. For 67101, 67105, 67107 and 67110, the specialty indicated that they did not submit survey data for these services as the CPT changes to these services were editorial and they did not believe that these codes were part of the same family as CPT codes 67108 and 67113. The RUC had a robust discussion regarding these services, and determined that CPT codes 67101, 67105, 67107, 67108, 67110 and 67113 should all be surveyed as a family for the April 2015 RUC meeting. The RUC reiterated its clear position that given that CPT code 67101, 67105, 67107, 67108, 67110 and 67113 were identified through the RAW process under the 090-day global post-operative visit screen (either directly or indirectly as being part of the same family), the current potentially misvalued code project cannot stop as a long-term strategy is formed to address the surgical global transition. Therefore, the RUC recommended that survey data be presented for CPT codes 67101, 67105, 67107, 67108, 67110 and 67113 at the April 2015 RUC Meeting.

67101 ***Repair of retinal detachment, 1 or more sessions; cryotherapy or diathermy, including drainage of subretinal fluid when performed***
The RUC agreed with the plan by the specialty to refer this code to the CPT Editorial Panel for a change in the current descriptor. The Specialty noted that Diathermy is no longer used for this procedure and also that they plan on proposing to delete the "1 or more sessions" descriptor language. **The RUC recommends that CPT Code 67101 be referred to the CPT Editorial Panel.**

67105 ***Repair of retinal detachment, 1 or more sessions; photocoagulation, including drainage of subretinal fluid when performed***
The RUC agreed with the plan by the specialty to refer this code to the CPT Editorial Panel for a change in the current descriptor. The Specialty noted that they plan on proposing to delete drainage of subretinal fluid from the code descriptor as that is no longer performed in the typical case. The Specialty also noted that they plan on proposing to delete the "1 or more sessions" descriptor language. **The RUC recommends that CPT Code 67105 be referred to the CPT Editorial Panel.**

67107 ***Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, cryotherapy, photocoagulation, and drainage of subretinal fluid***
The RUC reviewed the survey results from 61 ophthalmologists and retina specialists for CPT code 67107 and agreed with the Specialty that the survey 25th percentile work RVU of 16.00 appropriately accounts for the work required to perform this service. The RUC recommends51 minutes pre-time, 90 minutes intra-time and 15 minutes immediate post-service time. In the RUC's preliminary review comments prior to the meeting, members raised concern regarding the number and complexity of the post-operative visits for this service. Currently this Harvard-valued service includes four and a half 99213 post-operative visits. Following a robust discussion, the specialty society recommended and the RUC agreed that five 99213 visits are appropriate. The Specialty noted that some of these patients may develop redetachment or subretinal fluid and may need another intervention, which can be headed off before there is serious loss of vision if it is caught early, thus the need for frequent monitoring. The reason for the uniformity in the level of post-operative visits is that each visit requires a dilated exam of the entire peripheral retinal in addition to looking at the anterior segment of the eye and checking the pressure and look for areas where the retina is not attaching properly. The RUC accepted this explanation for the number of post-operative visits.

The RUC compared the survey code to CPT code 43770 *Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)* (work RVU= 18.00, intra-service time of 90 minutes, total time of 367 minutes) and noted that both services have identical intra-service time, though reference code has more total time (367 minutes vs. 290 minutes), supporting a work RVU of 16.00 for the survey code. 2nd key reference code. For additional support the RUC compared the survey code to CPT code 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* (work RVU=16.00, intra-service time 90 minutes, total time of 250 minutes) and noted that both procedures have identical intra-service time, whereas the survey code has more total time (290 minute vs. 250 minutes), supporting a work RVU of at least 16.00 for the survey code. **The RUC recommends a work RVU of 16.00 for CPT code 67107.**

67108 ***Repair of retinal detachment; with vitrectomy, any method, including when performed air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique***
The RUC reviewed the survey results from 59 ophthalmologists and retina specialists for CPT code 67108 and determined that the survey 25th percentile work RVU of 17.13 appropriately accounts for the work required to perform this service. The RUC recommends 51 minutes pre-time, 90 minutes intra-time and 20 minutes immediate post-service time. The RUC noted that this code describes the retinal detachment repair using vitrectomy, which is an intraocular procedure more complex procedure than code 67107. The RUC's preliminary review comments prior to the meeting, raised concern regarding the number and complexity of the post-operative visits for this service. Currently this Harvard-valued service includes five 99213 post-operative visits. Following a robust discussion, the specialty society recommended and RUC agreed to maintain five 99213 post-operative visits. As the Specialty also explained in code 67107, some of these patients may develop redetachment or subretinal fluid and may need another intervention, which can be headed off before there is serious loss of vision if it is caught early, thus the need for frequent monitoring. The reason for the

uniformity in the level of post-operative visits is that each visit requires a dilated exam of the entire peripheral retinal in addition to looking at the anterior segment of the eye and checking the pressure and look for areas where the retina is not attaching properly. The RUC accepted this explanation for the number of post-operative visits.

The RUC compared the surveyed code to CPT code 27446 *Arthroplasty, knee, condyle and plateau; medial OR lateral compartment* (work RVU= 17.48, intra-service time of 90 minutes, total time of 345 minutes) and noted that both procedures having identical intra-service time, while the survey code is a more intense procedure, justifying a work RVU of 17.13 for the survey code. To further justify a work RVU of 17.13, the RUC reviewed 2nd key reference code 67043 *Vitrectomy, mechanical, pars plana approach; with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation* (work RVU = 17.40, intra-service time 75 minutes, total time of 275 minutes) and noted that the survey code has more intra-service time and total time, further supporting a work RVU of at least 17.13 for the survey code. **The RUC recommends a work RVU of 17.13 for CPT code 67108.**

67110 ***Repair of retinal detachment; by injection or other gas (eg, pneumatic retinopexy)***
The RUC reviewed the survey results from 58 ophthalmologists and retina specialists for CPT code 67110 and determined that a the current work RVU of 10.25, which is the current value and below the survey 25th percentile, appropriately accounts for the work required to perform this service. The RUC recommends 18 minutes pre-time, 30 minutes intra-time and 10 minutes immediate post-service time. The RUC noted that this service describes the retinal detachment repair by injecting gas into the vitreous, which is performed instead of surgery if possible. In the RUC's preliminary review comments prior to the meeting, members raised concern regarding the number and complexity of the post-operative visits for this service. Currently this Harvard-valued service includes four and a half 99213 post-operative visits. Following a robust discussion, the specialty society indicated and the RUC agreed that six 99213 post-operative visits are appropriate. As the specialty explained in the previous codes in this family, early intervention is important to head off any potential problems during the post- operative period. Some of these patients may develop redetachment or subretinal fluid and may need another intervention, which can be headed off before there is serious loss of vision if it is caught early, thus the need for frequent monitoring. The reason for the uniformity in the level of post-operative visits is that each visit requires a dilated exam of the entire peripheral retinal in addition to looking at the anterior segment of the eye and checking the pressure and look for areas where the retina is not attaching properly. The reason for an additional post-operative visit relative to CPT codes 67107 and 67108 is because the risk of retinal redetachment is greater during the post-operative period. The RUC accepted this explanation for the number of post-operative visits.

The RUC compared the surveyed code to CPT Code 22315 *Closed treatment of vertebral fracture(s) and/or dislocation(s) requiring casting or bracing, with and including casting and/or bracing by manipulation or traction* (work RVU= 10.11, intra-service time of 30 minutes) and noted that both services have identical intra-service times, whereas the survey code is a more intense procedure, justifying a work RVU of 10.25 for the survey code. For additional support the RUC compared the survey code to CPT code 52647 *Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)* (work RVU= 11.30, intra-service time of 45 minutes, total time of 219 minutes) and noted that although the survey code is less intra-service time (30 minutes vs 45 minutes), it is a more intense procedure and therefore should be valued similarly. **The RUC**

recommends a work RVU of 10.25 for CPT code 67110.

67113 ***Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, including, when performed, air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens***
The RUC reviewed the survey results from 60 ophthalmologists and retina specialists for CPT code 67113 and determined that the survey 25th percentile work RVU of 19.00, appropriately accounts for the work required to perform this service. The RUC recommends 51 minutes pre-time, 120 minutes intra-time and 20 minutes immediate post-service time. The RUC noted that code 67113 describes the most complex retinal detachment repairs which are often accompanied by extensive fibrosis of the vitreous and scarring of the retina. In the RUC's preliminary review comments prior to the meeting, members raised concern regarding the number and complexity of the post-operative visits for this service. Currently this service includes seven 99213 post-operative visits. Following a robust discussion, the specialty societies recommended and the RUC agreed that six 99213 visits are appropriate. As the specialty explained in the previous codes in this family, early intervention is important to head off any potential problems during the post- operative period. Some of these patients may develop redetachment or subretinal fluid and may need another intervention, which can be headed off before there is serious loss of vision if it is caught early, thus the need for frequent monitoring. The reason for the uniformity in the level of post-operative visits is that each visit requires a dilated exam of the entire peripheral retinal in addition to looking at the anterior segment of the eye and checking the pressure and look for areas where the retina is not attaching properly. The reason for an additional post-operative visit relative to CPT codes 67107 and 67108 is because the risk of retinal redetachment is greater during the post-operative period. The RUC accepted this explanation for the number of post-operative visits.

The RUC compared the surveyed code to CPT code 35256 *Repair blood vessel with vein graft; lower extremity* (work RVU=19.06, intra-service time of 120 minutes, total time of 347 minutes) and noted that both services have identical intra-service time and similar total times, which supports a similar work value for both procedures. For additional support the RUC compared the survey code to CPT code 67445 *Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of bone for decompression* (work RVU= 19.12, intra-service time of 120 minutes, total time of 352 minutes) and noted that both services have identical intra-service time and similar total times, which further justifies a work RVU of 19.00 for the survey code. **The RUC recommends a work RVU of 19.00 for CPT code 67113.**

Practice Expense
The PE Subcommittee corrected the equipment minute calculations to include the appropriate line items for cryosurgery system, ophthalmic (EQ095) (line 81) and table, power (EF031) (line 82) for CPT code 67110.

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.

Destruction/Treatment of Retinopathy (Tab 13)
Steve Kamenetzky, M.D., (AAO): David Glasser, MD; (AAO) and John Thompson, M.D (ASRS)

At the February 2015 CPT Editorial Panel meeting, the Panel revised two codes (67227 and 67228) to describe destruction and/or treatment of retinopathy to exclude the language "one or more sessions".

67227 Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), cryotherapy, diathermy
The RUC reviewed the survey results from 32 ophthalmologists and recommend the following physician time components: pre-service time of 11 minutes, intra-service time of 30 minutes and immediate post-service time of 10 minutes. The RUC discussed the site-of-service for this procedure and noted that while a slight majority of the survey respondents found the typical location to be the physician's office (56%), the Medicare claims data shows roughly 51% percent are done in the facility. Furthermore, the volume for this procedure in the Medicare population is just over 200, so ascertaining the typical site-of-service is difficult. Given this explanation, the RUC agreed that pre-service time package 1b (Facility, straightforward patient and procedure with sedation) is appropriate. The RUC also approved one-half day discharge management day service (99238) and one 99213 Evaluation and Management service.

Finally, the RUC noted that the global period changed for these procedures from a 090- to a 010-day global. The specialty explained that this was appropriate because the within a 90 day period physicians were performing anywhere between two and four sessions. However, within the 10 day period, it is typical for only one session to be performed. Therefore, moving to a 010-day global period will provide a more accurate valuation for these services.

To determine an appropriate work value for CPT code 67227, the RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty society that the survey 25th percentile work RVU of 3.50 accurately accounts for the physician work involved in this service. To justify a work RVU of 3.50, the RUC compared the survey code to the second key reference code 17283 *Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 2.1 to 3.0 cm* (work RVU= 2.69, intra time= 30 minutes) and noted that while both services have identical intra-service time, code 67227 has more total time, 93 minutes compared to 60 minutes, and is therefore appropriately valued higher than the reference code. The RUC also reviewed CPT code 62267 *Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes* (work RVU= 3.00, intra time= 30 minutes) and again agreed that since the surveyed code has more total time, with identical intra-service time, code 37227 is appropriately valued higher than this reference code. **The RUC recommends and work RVU of 3.50 for CPT code 67227.**

67228 Treatment of extensive or progressive retinopathy, (eg, diabetic retinopathy), photocoagulation
The RUC reviewed the survey results from 42 ophthalmologists and recommend the following physician time components: pre-service time of 23 minutes, intra-service time of 25 minutes, and immediate post-service time of 10 minutes. The RUC noted that this photocoagulation code has more pre-service time than the cryotherapy code, 67227. This is appropriate because

in 67227 there isn't much to evaluate; whereas in 67228 the physician must first do an evaluation to determine if it's appropriate to do the procedure and then to identify where to put the laser spots. The RUC also approved one 99213 Evaluation and Management service in the 010-day global period.

To determine an appropriate work value for CPT code 67228, the RUC reviewed the survey respondents' estimated work RVUs and agreed with the specialty society that the survey 25th percentile work RVU of 4.39 accurately accounts for the physician work involved in this service. To justify a work RVU of 4.39, the RUC compared the survey code to the reference code 62264 *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day* (work RVU= 4.42, intra time= 30 minutes) and noted that while the reference code has five additional minutes of intra-service time, code 67228 is a more intense procedure and is correctly valued slightly higher. The RUC also reviewed CPT code 36558 *Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older* (work RVU= 4.84, intra time= 30 minutes) and agreed that with slightly more intra-service time and total time, this reference code is appropriately valued higher than 67228. The RUC also reviewed CPT code 62264 *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day* (work RVU= 4.42, intra time= 30 minutes) and noted that while the reference code has 5 additional minutes of intra-service time, the surveyed code is slightly more intense than 62264 and is accurately valued almost identically. **The RUC recommends a work RVU of 4.39 for CPT code 67228.**

Practice Expense
The clinical staff pre-service time was revised to 18 minutes in the non-facility and 30 minutes in the facility as is standard for extensive use of clinical staff for 010 day global services. The clinical staff time for clean room/equipment by physician staff was changed from 0 to 3 to meet the standard time. The RUC reviewed and approved the direct practice expense inputs with revisions as recommended by the Practice Expense Subcommittee.

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

Radiologic Exam Hip and Pelvis (Tab 14)
Zeke Silva, MD, (ACR); Kurt Schoppe, MD, (ACR); Daniel Wessell, MD, (ACR); William Creevy, MD, (AAOS); John Heiner, MD, (AAOS);

In 2011, the RUC identified CPT code 73500 as being reported with 72170 greater than 75% of the time together on the same date of service. Due to the large volume of work given to the interested specialty societies, creation of a bundled code solution was not expected prior to the CPT 2016 CPT cycle. Therefore, in October 2014, the CPT Editorial Panel deleted 6 codes and created 8 codes: 6 codes to report bundled hip and pelvis radiologic exams, and 2 codes to report radiologic exams of the femur.

The specialty societies noted that following their survey process for the new eight codes in this tab at the January 2015 RUC meeting, at least one of the codes did not meet the required respondent threshold based on an estimated utilization over one million times annually in the Medicare population. The specialties noted that for most of the codes in the family they did

receive a sufficient number of surveys, but delayed presentation of the entire group of services to ensure relativity comparisons within the family. The RUC discussed whether the current number of surveys would suffice or whether additional surveys should be acquired to reach the required thresholds for all codes in the family and agreed to consider the survey data at the April 2015 RUC meeting.

72170 ***Radiologic examination, pelvis; 1 or 2 views***
The RUC reviewed their previous recommendation for this service from the April 2011 meeting and maintained that the recommended work RVU of 0.17 for CPT code 72170, as approved by CMS, is correct. Below is the April 2011 RUC Recommendation as reaffirmed by the Committee in April 2015:

> The RUC reviewed the survey results from 46 physicians for CPT code 72170. The RUC recommends pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 2 minutes. The RUC reviewed the survey work values and agreed with the specialties that there is no compelling evidence to change the current work value for this service. To justify the current work RVU of 0.17 for 72170, the RUC reviewed the key reference service 73510 *Radiologic examination, hip, unilateral; complete, minimum of 2 views* (work RVU= 0.21) and agreed that the reference code should be valued higher due to greater intra-service time, 5 minutes compared to 4 minutes, and greater number of views. In addition, the RUC reviewed 72170 in comparison to the analogous code 72190 *Radiologic examination, pelvis; complete, minimum of 3 views* (work RVU= 0.21) and agreed that the reference code should be valued higher due to a greater number of views, 3 compared to 1 or 2. **The RUC recommends a work RVU of 0.17 for CPT code 72170.**

7350X1 ***Radiologic examination, hip, unilateral, with pelvis when performed; 1 view***
The RUC reviewed the survey results from 75 radiologists and orthopaedic surgeons and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes, and post-service time of 1 minute.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 0.18 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.18, the RUC reviewed the top key reference services: 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU= 0.22, total time of 6 minutes) and noted that the reference service has more total time and a similar intensity of physician work, supporting a work RVU of 0.18 for the survey code. To further support a work RVU of 0.18, the RUC reviewed CPT code 73030 *Radiologic examination, shoulder; complete, minimum of 2 views* (work RVU= 0.18, intra-service time of 4 minutes) and noted that although CPT code 73030 has slightly more intra-service time, the survey code is somewhat more intense and should be valued similarly. **The RUC recommends a work RVU of 0.18 for CPT code 7350X1.**

7350X2 ***Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views***
The RUC reviewed the survey results from 76 radiologists and orthopaedic surgeons and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 4 minutes, and post-service time of 1 minute.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 0.22 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.22, the RUC reviewed the second key reference services: 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU= 0.22, total time of 6 minutes) and noted that the reference service has identical total time and a similar intensity of physician work, supporting a work RVU of 0.22 for the survey code. To further support a work RVU of 0.22, the RUC reviewed CPT code 92567 *Tympanometry (impedance testing)* (work RVU= 0.20, intra-service time of 4 minutes, total time of 6 minutes) and noted that both services have identical pre-service, intra-service and post-service times, though the survey code is somewhat more intense and should be valued slightly higher. **The RUC recommends a work RVU of 0.22 for CPT code 7350X2.**

7350X3 ***Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views***
The RUC reviewed the survey results from 72 radiologists and orthopaedic surgeons and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 5 minutes, and post-service time of 1 minute.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 0.27 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.27, the RUC reviewed CPT code 74020 *Radiologic examination, abdomen; complete, including decubitus and/or erect views* (work RVU= 0.27, intra-service time of 3 minutes) and noted that CPT code 74020 has less intra-service time and slightly more intensity, supporting a work RVU of 0.27 for the survey code. To further support a work RVU of 0.27, the RUC reviewed CPT code 72050 *Radiologic examination, spine, cervical; 4 or 5 views* (work RVU= 0.31, intra-service time of 5 minutes, total time of 8 minutes) and noted that both services have identical intra-service time, though 72050 has more total time, justifying a slightly lower value for the survey code. **The RUC recommends a work RVU of 0.27 for CPT code 7350X3.**

7352X1 ***Radiologic examination, hips, bilateral, with pelvis when performed; 2 views***
The RUC reviewed the survey results from 78 radiologists and orthopaedic surgeons and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 4 minutes, and post-service time of 1 minute.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 0.22 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.22, the RUC reviewed the second key reference service 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU= 0.22, total time of 6 minutes) and noted that CPT code 72100 has identical total time and a similar intensity of physician work, supporting a work RVU of 0.22 for the survey code. To further support a work RVU of 0.22, the RUC reviewed CPT code 92567 *Tympanometry (impedance testing)* (work RVU= 0.20, intra-service time of 4 minutes, total time of 6 minutes) and noted that both services have identical pre-service, intra-service and post-service times, though the survey code is somewhat more intense and should be valued slightly higher. **The RUC recommends a work RVU of 0.22 for CPT code 7352X1.**

7352X2 ***Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views***
The RUC reviewed the survey results from 77 radiologists and orthopaedic surgeons and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 5 minutes, and post-service time of 1 minute.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 0.29 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.29, the RUC reviewed top key reference code 72110 *Radiologic examination, spine, lumbosacral; minimum of 4 views* (work RVU= 0.31, intra-service time of 5 minutes) and noted that both services have identical intra-service time, and similar intensity and therefore should be valued similarly. To further support a work RVU of 0.29, the RUC reviewed CPT code 72050 *Radiologic examination, spine, cervical; 4 or 5 views* (work RVU= 0.31, intra-service time of 5 minutes, total time of 8 minutes) and noted that both services have identical intra-service time, though 72050 has more total time, justifying a similar value for the survey code. **The RUC recommends a work RVU of 0.29 for CPT code 7352X2.**

7352X3 ***Radiologic examination, hips, bilateral, with pelvis when performed; minimum of 5 views***
The RUC reviewed the survey results from 74 radiologists and orthopaedic surgeons and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 6 minutes, and post-service time of 1 minute.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 0.31 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.31, the RUC reviewed top key reference code 72110 *Radiologic examination, spine, lumbosacral; minimum of 4 views* (work RVU= 0.31, total time of 8 minutes) and noted that both codes have identical total times and similar intensities, therefore they should be valued similarly. The RUC also reviewed second key reference code 72114 *Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views* (work RVU= 0.32, total time of 8 minutes) and noted that both codes have identical total times and similar intensities, further supporting a work RVU of 0.31 for the survey code. **The RUC recommends a work RVU of 0.31 for CPT code 7352X3.**

7355X1 ***Radiologic examination, femur; 1 view***
The RUC reviewed the survey results from 77 radiologists and orthopaedic surgeons and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 3 minutes, and post-service time of 1 minute.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 0.16 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.16, the RUC reviewed top key reference code 73080 *Radiologic examination, elbow; complete, minimum of 3 views* (work RVU= 0.17, intra-service time of 3 minutes, total time of 5 minutes) and noted that both codes have identical pre-service, intra-service and post-service times and similar intensities, therefore they should be valued similarly. To further justify a work RVU of 0.16, the RUC reviewed second key reference code 73100 *Radiologic examination, wrist; 2 views* (work RVU= 0.16, intra-service time of 3 minutes, total time of 5 minutes) and noted that both codes have identical pre-service, intra-service and post-service times and similar intensities, further supporting a work RVU of 0.16 for the survey code. **The RUC recommends a work RVU of 0.16 for CPT code 7355X1.**

7355X2 ***Radiologic examination, femur; minimum 2 views***
The RUC reviewed the survey results from 79 radiologists and orthopaedic surgeons and agreed with the following physician time components: pre-service time of 1 minute, intra-service time of 4 minutes, and post-service time of 1 minute.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 0.18 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.18, the RUC reviewed top key reference code 73030 *Radiologic examination, shoulder; complete, minimum of 2 views* (work RVU= 0.18, intra-service time of 4 minutes) and noted that both services have identical intra-service times and similar intensities, and therefore should be valued similarly. To further justify the work RVU of 0.18, the RUC reviewed top key reference code 73080 *Radiologic examination, elbow; complete, minimum of 3 views* (work RVU= 0.17, intra-service time of 3 minutes, total time of 5 minutes) and noted that the survey code has more intra-service and total time, and therefore should be valued somewhat more. **The RUC recommends a work RVU of 0.18 for CPT code 7355X2.**

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 PE Subcommittee made minor revisions, reducing the clinical staff time for *prepare room, equipment, supplies and prepare and position patient* from 2 to 1 minutes for CPT codes 7350X1 and 7355X1. The RUC reviewed and approved the practice expense inputs with revisions as approved by the PE Subcommittee.

Fetal MRI (Tab 15)
Zeke Silva, MD, (ACR); Kurt Schoppe, MD, (ACR); Beth Kline-Fath, MD, (ACR); Greg Nicola, MD; (ASNR)

In February 2015, the CPT Editorial Panel established two new Category I codes to describe fetal MRI.

747XX1 Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation
The RUC reviewed the survey results from 45 radiologists and neuroradiologists and agreed with the following physician time components: pre-service time of 15 minute, intra-service time of 60 minutes, and post-service time of 15 minute. The RUC noted that during the time of imaging there is considerable direct interaction between the technologist and the physician and sometimes the physician performs aspects of the image acquisition.

The RUC noted that fetal MRI is likely one of the most challenging MRI exams to perform and interpret. Fetal MRI is technically difficult as the fetus is moving through the study. In contradistinction to most other MRI exams, which are directed to a single organ system, these exams must evaluate every organ system in the fetus. Moreover, these exams are typically centered around an underlying intrauterine pathology. Evaluation of organ systems are made more difficult because some changes are normal based on the fetus' gestational age. When a set of abnormalities are identified, it is helpful to attempt to find an underlying syndrome or abnormality to explain the series of findings. In addition to evaluation of the fetus, the placenta, cervix, amniotic fluid, umbilical cord and maternal uterus and ovaries are imaged and examined. Furthermore, many additional maternal structures are within the field of view, including the maternal kidneys, bladder, spinal canal, bony pelvis, and portions of the liver, spleen, pancreas and GI tract. Findings in these structures, whether incidental or related to the fetal findings, require further examination.

The RUC reviewed the respondents' estimated median work RVU of 3.00 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 3.00, the RUC reviewed top key reference 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, intra-service time of 60 minutes, total time of 82.5 minutes) and noted that both service have identical intra-service time and similar intensities and, therefore, should be valued similarly. The RUC also reviewed CPT code 75559 *Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging* (work RVU= 2.95, intra-service time of 50 minutes, total time of 75 minutes) and noted that the survey code has more intra-service time (60 minutes vs. 50 minutes) and total time (90 minutes vs. 75 minutes) and therefore should be valued slightly higher. **The RUC recommends a work RVU of 3.00 for CPT code 747XX1.**

747XX2 Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; each additional gestation (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 45 radiologists and neuroradiologists and agreed with the following physician time component: intra-service time of 35 minutes. The RUC noted that, during the time of imaging, considerable direct interaction between the technologist and the physician occurs and sometimes the physician performs some aspects of the image acquisition.

The RUC noted that fetal MRI is likely one of the most challenging MRI exams to perform and interpret. Fetal MRI is technically difficult as the fetus is moving through the study. In contradistinction to most other MRI exams, which are directed to a single organ system, these exams must evaluate every organ system in the fetus. Moreover, these exams are typically centered around an underlying intrauterine pathology. Evaluation of organ systems are made more difficult because some changes are normal based on the fetus' gestational age. When a set of abnormalities are identified, it is helpful to attempt to find an underlying syndrome or abnormality to explain the series of findings. In addition to evaluation of the fetus, the placenta, cervix, amniotic fluid, umbilical cord and maternal uterus and ovaries are imaged and examined. Furthermore, many additional maternal structures are within the field of view, including the maternal kidneys, bladder, spinal canal, bony pelvis, and portions of the liver, spleen, pancreas and GI tract. Findings in these structures, whether incidental or related to the fetal findings, require further examination.

The RUC reviewed the respondents' estimated median work RVU of 1.85 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 1.85, the RUC reviewed top key reference code 76812 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)* (work RVU= 1.78 minutes, intra-service time of 25 minutes) and noted that the survey code has more intra-service time (35 minutes vs. 25 minutes), though the reference code is somewhat more intense, indicating a work RVU of 1.85 for the survey code is appropriate. To further justify a work RVU of 1.85, the RUC reviewed CPT code 93464 *Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)* (work RVU= 1.80, intra-service time of 30 minutes) and noted that the survey code has more intra-service time and similar intensity, and therefore

should be valued similarly to the reference code. **The RUC recommends a work RVU of 1.85 for CPT code 747XX2.**

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.

Practice Expense
The PE Subcommittee made one minor revision to the clinical staff time for prepare room, equipment, supplies from 2 to 5 minutes for CPT code 747XX1 only, to be consistent with other similar services such as reference codes 72195 and 72148. The RUC reviewed and approved the direct practice expense inputs with revisions as approved by the PE Subcommittee.

Reflectance Confocal Microscopy (Tab 16)
Mark Kaufmann, MD (AAD); Harold Rabinovitz, MD (AAD); Jane Grant-Kels, MD (AAD)

In February 2015, the CPT Editorial panel established six new Category I codes to describe reflectance confocal microscopy for imaging of skin.

At the April 2015 RUC meeting, following the RUC's review and acceptance of physician work and direct practice expense, new information was brought to the attention of the RUC which called into question how much physician work and clinical labor are typically part of these six services. The identified source, the vendor's SEC 10-K Annual Report for the period ending 12/31/2013, included information which alluded to the physician work and clinical labor of a similar procedure possibly taking different time than the estimates originally presented to the RUC. Furthermore, it was also called into question if there were other devices used to perform this service that the RUC was unaware of at the April 2015 RUC meeting and that may necessitate a revised coding structure. The presenters who would have been able to offer an informed opinion on this document were no longer at the meeting when the issue was raised. Therefore, the RUC requested that the specialty re-survey this family of services and resubmit physician work and direct practice expense recommendations for the October 2015 RUC meeting. **The RUC recommends for CPT codes 969XX1, 969XX2, 969XX3, 969XX4, 969XX5 and 996XX6 to be contractor priced.**

Interstitial Radiation Source Codes (Tab 17)
Michael Kuettel, MD, PhD, (ASTRO); Gerald White, MD, (ASTRO); James Goodwin, MD, (ASTRO); Peter Orio, MD (ASTRO)

Facilitation Committee #2

As part of the 75% reported together screen, the RUC identified that CPT code 77778, interstitial radiation source application, complex, is being reported with supervision, handling, loading of radiation source, CPT code 77790. AT the February 2015 Meeting, the CPT Editorial Panel deleted interstitial radiation source codes 77776, 77777 and revised interstitial radiation source code incorporating supervision and handling of brachytherapy sources, 77790, into 77778.

77778 ***Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed***
The RUC reviewed the survey results from 86 radiation oncologists and agreed on the following physician time components: pre-service time of 25 minutes (standard pre-time package 1B with 1 minute shifted from pre-service positioning to pre-service evaluation), intra-service time of 90 minutes and immediate post-service time of 30 minutes (the standard post-time package 9A). The RUC noted that this service will no longer have any bundled post-operative visits, as the specialty society proposed to transition this code from a 090-day global service to a 000-day global period service.

The RUC noted that, in addition to the radiation oncologist, there would always be one urologist, an anesthesiologist and a radiation physicist present during the procedure. The radiation oncologist and the urologist would work closely together with the urologist placing on average 40 needles and the radiation oncologist would place on average 100 seeds into the patient. The specialty confirmed that the work of placement of the seeds is solely done by the radiation oncologist.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty that the median work RVU of 8.78 is appropriate. The RUC compared the survey code to the second key reference service 41019 *Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application* (work RVU of 8.84, intra-service time of 90 minutes) and noted that both services have identical intra-service time and post-service time and should be valued similarly. To further justify a work RVU of 8.78 for the survey code, the RUC reviewed CPT code 52355 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor* (work RVU of 9.00, intra-service time of 90 minutes) and noted that both services have identical intra-service time and similar intensities and therefore should be valued similarly. **The RUC recommends a work RVU of 8.78 for CPT code 77778.**

77790 ***Supervision, handling, loading of radiation source***
The RUC reviewed the survey code in detail and robust discussion with the specialty, determined that it is unclear what physician work would be involved with this service, since it would no longer be used in conjunction with treatment of patients with prostate cancer (76 percent diagnosis codes per 2013 Medicare claims data). The specialties noted that the Medicare volume of 77790 will greatly decrease and confirmed that it was also unclear to what the typical patient would be going forward and also what physician work would be involved. Therefore, the given the uncertainly in use of this code, the RUC agreed with the specialties that this service code be Practice Expense only. The specialties stated that once the bundled 77778 is implemented and the utilization data are available for the remaining 77790, the specialties will be able to more appropriately define the dominant specialty and the typical process of care for physician work. **The RUC recommends a work RVU of 0.00 for CPT code 77790.**

Relativity Assessment Workgroup
The RUC agreed that noted that other services which are reported during the same episode of care as CPT code 77778 should be referred to the Relativity Assessment Workgroup due to concerns of potential inappropriate overlap of those other services. As an example, the RUC referenced that CPT code 77332 is billed together 62% of the time with 77778 (same day, same patient, same provider).**The RUC and the Specialty agreed that the following codes**

should be referred for Relativity Assessment Workgroup review starting at the October RUC meeting:

- ***55875*** *Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy*
- ***77332*** *Treatment devices, design and construction; simple (simple block, simple bolus)*
- ***77333*** *Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)*
- ***77334*** *Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)*
- ***77318*** *Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)*

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 PE Subcommittee noted that in addition to the radiation oncologist, there would always be one urologist, an anesthesiologist and a radiation physicist present during the procedure. The PE Subcommittee concluded that although the service is performed in the radiation oncologist's office and the clinical staff in the office may be assisting with the work of the urologist and anesthesiologist, that time cannot be included in the direct PE inputs for 77778 because the urologist and anesthesiologists will bill separately for the service and therefore the PE inputs would overlap with the separately reported services. For example the urologist would bill CPT code 55875 or 55876. The PE Subcommittee also discussed that this is a larger issue for anesthesia services and that there is currently a workgroup tasked with reviewing the codes included in appendix G. Given the discussion, the PE Subcommittee made a number of revisions to account for overlapping clinical staff time related to the separately reported urology and anesthesiology services reported on the same day. The RUC reviewed and approved the direct practice expense inputs with the following revisions as approved by the Practice Expense Subcommittee:

- The clinical staff time for provide pre-service education/obtain consent, was changed from 3 to 7 minutes in the nonfacility for 77778 only (line 23)
- Because anesthesia will be reported separately the clinical staff time for sedate/apply anesthesia was changed from 2 to 0 minutes, assist physician/complex sedation was changed from 45 to 0 minutes and monitor pt. following complex sedation was changed from 15 to 0 minutes in the nonfacility for 77778 only (line 43, 47 and 49)
- Monitor pt. following service/check tubes. Monitors, drains (not related to moderate sedation) was changed from 45 to 30 minutes in the nonfacility for 77778 only (line 50)
- The clinical staff time for clean room/equipment by physician staff was changed from 3 to 7 minutes in the nonfacility for 77778 only (line 51)
- The clinical staff time for clean surgical instrument package was changed from 10 to 0 minutes in the nonfacility for 77778 only (line 53)
- The clinical staff time for discharge mgmt. same day (0.5 x 99238) (enter 6 min) was changed from 6 to 0 minutes in the facility for 77778 only (line 58)

- The revised equipment minutes reflect the changes made to the clinical staff time including the reduction of monitoring time from 4 hours total to 2 hours total.

Colon Transit Imaging (Tab 18)
Gary L. Dillehay MD, (SNMMI); Scott Bartley, MD, (ACNM); Zeke Silva, MD, (ACR); and Kurt Schoppe, MD (ACR)

In February 2015, the CPT Editorial Panel revised gastric emptying study code 78264 to specify that it is an imaging study and includes study of solid and/or liquid emptying, and also established two indented codes that describe gastric emptying imaging study with small bowel transit up to 24 hours (782X01) and with small bowel and colon transit for multiple days (782X02).

Compelling Evidence
The specialty societies presented compelling evidence for codes 782X01 and 782X02. Although these two new services describe new techniques, they were previously often coded incorrectly using 78264 *Gastric emptying imaging study (eg, solid, liquid, or both);*, making it necessary for the codes to meet RUC compelling evidence requirements. The RUC noted that the patient population changed for these services, to patients that often have abnormal gastric emptying times due to more complex symptoms and the etiologies for those symptoms, such as irritable bowel syndrome or patients with prolonged constipation. To better address these more complex patients, new techniques were developed that include imaging of the small bowel and sometimes the colon. **The RUC agreed that there is compelling evidence that the services described by codes 782X01 and 782X02 were potentially misvalued.**

78264 ***Gastric emptying imaging study (eg, solid, liquid, or both);***
The RUC reviewed the survey results from 116 nuclear medicine physicians and radiologists and agreed with the following physician time components: pre-service time of 5 minute, intra-service time of 10 minutes, and post-service time of 5 minute.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 0.80 and agreed that this value appropriately accounts for the physician work involved. The RUC compared the survey code to the second key reference code 78226 *Hepatobiliary system imaging, including gallbladder when present;* (work RVU= 0.74, intra-service time of 10 minutes, total time of 20 minutes) and noted that both services have identical pre-service, intra-service and post-service times, whereas the survey code is a more intense procedure, justifying a higher work RVU for the survey code. To further justify a work RVU of 0.80, the RUC compared the survey code to MPC code 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU= 0.81, intra-service time 11 minutes, total time of 21 minutes) and noted with similar intra-service times and total times, the services should be valued similarly. **The RUC recommends a work RVU of 0.80 for CPT code 78264.**

782X01 ***Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit, up to 24 hours***
The RUC reviewed the survey results from 36 nuclear medicine physicians and radiologists and agreed with the following physician time components: pre-service time of 5 minute, intra-service time of 15 minutes, and post-service time of 5 minute.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 0.98 and agreed that this value appropriately accounts for the physician work involved. The RUC compared

the survey code to the second key reference code 78227 *Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed* (work RVU= 0.90, intra-service time of 15 minutes, total time of 26 minutes) and noted that the services have similar intra-service and similar total times, whereas the survey code is a somewhat more intense service, justifying a somewhat higher work RVU. To further support a work RVU of 0.98, the RUC compared the survey 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, intra-service time of 15 minutes, total time of 26 minutes) and noted that with identical intra-service times and similar total times, the services should be valued similarly. **The RUC recommends a work RVU of 0.98 for CPT code 782X01.**

782X02 ***Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days***
The RUC reviewed the survey results from 32 nuclear medicine physicians and radiologists and agreed with the following physician time components: pre-service time of 6 minute, intra-service time of 20 minutes, and post-service time of 10 minute.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 1.08 and agreed that this value appropriately accounts for the physician work involved. The RUC compared the survey code to CPT code 93892 *Transcranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection* (work RVU= 1.15, intra-service time of 20 minutes, total time of 40 minutes) and noted that both services have identical intra-service time, whereas 93892 has slightly more total time, justifying a somewhat lower work RVU for the survey code. To further support a work RVU of 1.08, the RUC compared the survey code to CPT code 76813 *Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation* (work RVU= 1.18, intra-service time of 20 minutes, total time of 35 minutes) and noted that both services have identical intra-service time and similar total times, justifying the work RVU recommendation of 1.08 for the survey code. **The RUC recommends a work RVU of 1.08 for CPT code 782X02.**

New Technology
Survey codes 782X01 and 782X02 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.

Referral to CPT Assistant
The RUC recommends that the specialty societies develop a CPT Assistant article for CPT codes 782X01 and 782X02 to provide coding guidance on when it is appropriate to report these services as opposed to only a 78264 gastric emptying imaging study. The RUC noted that the article should address that the entire small bowel would need to be imaged in order to report 782X01 and that two isotopes should have been used in order to report 782X01 (which is not always the case for 78264).

Practice Expense
The PE Subcommittee discussed potential overlap in equipment time between the PACS Workstation Proxy (ED050) and the computer workstation, nuclear medicine analysis-viewing (ED019) and determined that the appropriate clinical staff activity line items are included for equipment item, ED019 (lines 28, 30, 36, 40, 47 and 50) and that although there may be some clinical staff time included in the PACS equipment time when the PACS is not

being used, it is CMS policy to include the entire service period in the equipment minutes. The RUC reviewed and approved the direct practice expense inputs with minor revisions as approved by the PE Subcommittee.

Liver Elastography (Tab 19)

R. Bruce Cameron, MD, (ACG); Dawn Francis, MD, (AGA); Shivan Mehta, MD (AGA)

At the February 2014 CPT Editorial Panel meeting, the Panel created a new CPT Category I code to describe transient elastography of the liver. At the April 2014 RUC meeting, the RUC agreed that its recommendation for physician work and time would be interim due to the specialty's use of an incorrect survey instrument (000 Day Global Period, instead of XXX Global Period) and the survey not reaching the minimum threshold for respondents. Therefore, the specialty re-surveyed this service with the appropriate survey instrument and presented new survey results and recommendations for the September 2014 RUC meeting.

During the RUC's deliberations at the April 2014 meeting, the specialties explained that the actual measurements are typically performed separately by clinical staff and that the physician work of the procedure is in the interpretation and report. The interpretation includes evaluating the patient's history to make a cogent recommendation subsequent to reviewing the measurements. At the September 2014 RUC meeting the specialties indicated that an Evaluation and Management (E/M) service is not typically performed by the same physician that is interpreting the fibroscan measurements. The RUC deliberated this information and recommended referral to the CPT Editorial Panel for the inclusion of a parenthetical that prohibits the reporting of a same-day E/M visit with CPT code 91200.

At the February 2015 CPT Editorial Panel meeting, the Panel's action to add an exclusionary parenthetical to 91200 was rescinded. Thus, E/M will be reportable on the same day with code 91200. Due to this action, the code was added to the April 2015 RUC meeting agenda for re-review.

In February 2015, the specialties requested for their recommendation to be supported by existing survey data from the past year instead surveying this service for a third time. The Research Subcommittee approved this request, noting that a new survey would be unlikely to provide any new information considering this service was last surveyed for the September 2014 RUC meeting. Therefore, the Research Subcommittee approved the societies' request to not perform another survey for the April 2015 RUC meeting and advised the societies to base their recommendation on review of past survey data, expert panel review and use potential crosswalk codes to support their proposal. Separately, the specialties were instructed to also be prepared to present revised practice expense.

91200 Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report

The RUC reviewed the survey results from 31 gastroenterologists and determined to use the 25th percentile intra-service time of 10 minutes. The RUC recommends the following physician time components: pre-service time of 3 minutes, intra-service time of 10 minutes and post-service time of 3 minutes. Two minutes of post-service time was removed from the originally accepted 5 minutes, from September 2014, to ensure no duplication when an Evaluation and Management service is performed on the same day. Finally, the RUC discussed the inclusion of "without imaging" in the descriptor of 91200. The specialties explained that while pictures are being viewed, these should not be considered traditional imaging. These pictures exist to ensure the recordings are accurate.

To determine an appropriate work value, the RUC again noted that the survey respondents overestimated the work at the 25th percentile work RVU of 0.72. Therefore, the RUC considered CPT code 94060 *Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration* (work RVU= 0.27, intra time= 7.5, total time= 13.5) and agreed that both services represent analogous work and physician time and should therefore be valued identically. The RUC recommends a direct crosswalk of work RVUs from 94060 to the surveyed code 91200. To justify a work RVU of 0.27, 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) and agreed that with identical intra-service time, this reference code should be valued nearly identical to the surveyed code. The RUC also considered 93000 *Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report* (work RVU= 0.17, intra time= 5 minutes) and agreed that the physician work involved in 91200 is greater because a) the surveyed code has double the intra-service time (10 minutes vs 5 minutes) and b) the interpretation of liver elastography must be performed in the context of the diagnosis of the patient, while interpretation of ECG is not necessarily contextual. **The RUC recommends a work RVU of 0.27 for CPT code 91200.**

Practice Expense
The Practice Expense Subcommittee noted that per CPT Editorial Panel action an E/M will again be reportable on the same day with code 91200. To be consistent with this action the PE Subcommittee removed or reduced clinical staff time that would overlap with an E/M service, added 2 minutes of clinical staff time for provide pre-service education/obtain consent (line 29). Additionally, the PE Subcommittee added 1 oz. of ultrasound transmission gel (SJ062) which is necessary to perform the procedure (ER101). The RUC reviewed and approved the direct practice expense inputs with revisions as approved by the PE Subcommittee.

Database Flag
Due to the use of the survey 25th percentile for intra-service time and the use of a crosswalk to derive the work value recommendation for CPT code 91200, the record will be flagged in the RUC database as not to be used to validate for physician work.

New Technology
The 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.

Arterial Pressure Waveform Analysis (Tab 20)
Chester Amedia, MD, (RPA); Timothy Pflederer, MD, (RPA); Ramesh Soundarajan, MD (RPA)

In February 2015, the CPT Editorial Panel converted Category III code 0311T to Category I code 9300X1 to describe non-invasive arterial pressure waveform analysis.

9300X1 Arterial pressure waveform analysis for assessment of central arterial pressures, includes obtaining waveform(s), digitization and application of nonlinear mathematical transformations to determine central arterial pressures and augmentation index, with interpretation and report; upper extremity artery, non-invasive

The RUC reviewed the survey results from 34 renal physicians for CPT code 9300X1 and agreed with the specialty that the survey 25th percentile work RVU of 0.17 appropriately accounts for the work required to perform this service. The RUC noted that this service will typically be reported on the same day as a 99214 *Office or other outpatient visit for the evaluation and management (E/M) of an established patient*. Therefore, the RUC reduced the pre-service time to zero, to not double count any physician work already provided with the E/M service. The RUC recommends 5 minutes of intra-service time and 2 minutes of immediate post-service time for interpretation and development of the report. The specialty society indicated that the physician interpretation activities include three basic components: 1) validation, ensure the waveforms are congruent and the study is going to be accurate; 2) summation of central blood pressure waveform, the physician uses the waveform to determine the outgoing and reflected blood pressures (augmentation pressure). Understanding arterial stiffness and left ventricular load is obtained from that waveform; 3) numeric reporting of indices that come from the waveform, which adds to the interpretation of the wave itself.

The RUC referenced 93000 *Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report* (work RVU = 0.17 and 5 minutes intra-service time and 1 minute immediate post-service time), noting that both services require the same physician work and no pre-service time. The RUC compared the survey code to top key reference code 93922 *Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)* (work RVU = 0.25 and 3 minute pre-time, 5 minutes intra-time and 2 minutes immediate post-service time) and noted that these services have identical intra-service times and similar intensities. The RUC also referenced MPC codes 51741 *Complex uroflowmetry (eg, calibrated electronic equipment)* (work RVU = 0.17) and 96374 *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug* (work RVU = 0.18) and determined that the physician work and intra-service time, 5 minutes, are identical for all three services. **The RUC recommends a work RVU of 0.17 for CPT code 9300X1.**

New Technology

The RUC recommends that CPT code 9300X1 be placed on the New Technology/New Services list to be 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 no revisions as submitted by the specialty society and approved by the Practice Expense Subcommittee. The RUC notes the following:

This service is typically billed with an Evaluation and Management service on the same day. The specialty removed any time associated with the Evaluation and Management visit.

Analysis of Neurostimulator Pulse Generator System (Tab 21)
Marc Leib, MD, (ASA); Christopher Merifield, MD, (ISIS); Mitchell Schuster, MD, (ACOG/AUA); Norman Smith, MD, (AUA); Phillip Wise, MD, (AUA)

Codes 95971 and 95972 were identified under the High Volume Growth Screen. The RUC requested that these services be surveyed for work and that PE inputs be developed for the January 2014 RUC meeting. At the January 2014 meeting, the RUC reviewed the survey results for code 95971 and recommended the current work RVU of 0.78. The RUC reviewed the survey results for code 95972 and determined that the survey 25th percentile work RVU of 0.90 appropriately accounts for the work required to perform this service. The RUC agreed that 8 minutes pre-time, 23 minutes intra-service time and 5 minutes immediate post-service time appropriately account for the work required to perform this service. Because of the discrepancy between the code descriptor specifying "1 hour" of work time and the new survey data, the CPT Panel approved a temporary revision to the code descriptor for CPT 2015 to state "up to 1 hour." The RUC recommended that codes 95971, 95972 and 95973 be referred to CPT to address the entire family regarding the time referenced in the CPT code descriptors. Specifically, the descriptor for code 95972 specifies "first hour" but survey results indicate the majority of physicians reporting this code take less than 30 minutes. The RUC reviewed these services again in April 2015, after the new CPT language.

95971 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, intraoperative or subsequent programming
The RUC reviewed the survey results from 33 physicians for CPT code 95971 and agreed with the specialty that the current value is appropriate for this service. The specialty society noted that the current work RVU of 0.78 is below the survey 25th percentile work RVU of 0.98. The specialty society indicated that there is no compelling evidence to warrant an increase in physician work for this service. The survey also supported the current physician time for this service. The RUC recommends maintaining the current time of 8 minutes pre-service time, 20 minutes intra-service time and 5 minutes immediate post service time. The RUC noted that CPT code 95971 is typically reported with an Evaluation and Management (E/M) service on the same date and the reduction of the survey pre-service time from 15 to 8 minutes appropriately accounts for physician pre-service time. The RUC compared the survey code to the top two key reference services *62370 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)* (work RVU = 0.90 and 20 minutes intra-service time) and 62368 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming* (work RVU = 0.67 and 15 minutes intra-service time) and determined these services require similar physician work and time to perform and appropriately valued similarly. For additional support the RUC compared the surveyed code to MPC codes 95991 *Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional* (work RVU = 0.77) and 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 0.78 for CPT code 95971.**

95972 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming

The specialty societies indicated that the survey for CPT 95972 was conducted with an old descriptor that specified *with intraoperative or subsequent programing "first hour".* The specialty societies noted and the RUC agreed that the survey respondents have already indicated on two recent surveys that this service is well under 60 minutes. Therefore, the descriptor changes have not altered the survey respondents' median intra-service time estimates for providing this service. When surveying for "up to 1 hour" in January 2014 the median intra-service time was 23 minutes and when surveying in April 2015, albeit with the wrong descriptor "first hour", the survey median intra-service time was 25 minutes. The RUC agreed that, since this service was not surveyed with the current descriptor, the survey was invalid and the current work and time should be maintained. The RUC recommends 8 minutes pre-service time, 23 minutes intra-service time and 5 minutes immediate post-service time. The RUC noted that, relative to CPT code 95971, CPT code 95972 is more complex, requires more parameters (6-7) and requires updating these parameters to change the polarity of different leads and therefore requires slightly more physician time and work. The RUC noted that CMS did not accept the January 2014 RUC recommendation of 0.90 work RVUs for this service and instead set a work RVU of 0.80 for CPT code 95972. The RUC noted the difference in physician work for 95971 and 95972 is greater than 0.02 work RVUs however, recommend maintaining the current work RVU at this time. The RUC referenced MPC codes 95991 *Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional* (work RVU = 0.77) and 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 0.80 for CPT code 95972.**

Practice Expense

The Practice Expense Subcommittee made revisions to the direct practice expense inputs for CPT code 95971 reduced clinical staff already attributable to E/M, reduced the cleaning room by 2 minutes and correctly calculated the equipment time to include the appropriate line items. The PE Subcommittee notes that for both services the clinical staff intra-service time to assist physicians in performing procedure is 2/3 of the physician intra-service time, the equipment minutes include the entire physician intra-service time. The RUC reviewed and approved the direct practice expense inputs with revisions 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.

XI. CMS Request/Relativity Assessment Identified Codes

Bone Biopsy Excisional (Tab 22)
William Creevy, MD (AAOS)

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 these services be surveyed for work and review the practice expense for the September 2014 RUC meeting. In September, the RUC requested and CMS approved to change the global period from a 010-day global to a 000-day global for both CPT code 20240 and 20245 and the specialty societies surveyed for January 2015. In January 2015, the RUC agreed that CPT code 20245 should be referred to Research Subcommittee to approve a new survey sample which will incorporate a more general population and consider changes to the 000-day global survey template to better value the work of this major procedure. The specialty societies were to present survey data at the April 2015 RUC meeting.

In preparation for the survey, the specialty societies reviewed Medicare utilization data and became aware that CPT code 20245 is being reported for some anatomic areas which are likely not appropriate for a deep bone biopsy service. Therefore, the specialties will be submitting a Code Change Proposal (CCP) for the CPT 2017 cycle to better clarify the meaning of deep bone biopsy. **The RUC recommends CPT code 20245 be referred to the CPT Editorial Panel.**

Closed Treatment of Vertebral Process Fracture (Tab 23)
William Creevy, MD (AAOS); Karin Swartz, MD (NASS); Alexander Mason, MD (CNS); Edward Vates (AANS)

In the Final Rule for 2014, CMS requested review of CPT code 22305. CMS questioned 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 believed it may not be appropriate for a procedure performed outside of the inpatient hospital setting at this frequency to have such a long global period. In October 2013, American Academy of Orthopaedic Surgeons (AAOS) and North American Spine Society (NASS) indicated that 22305 should be referred to CPT for deletion. However, in November 2014, the specialties notified AMA staff that they were considering the possibility of conducting a RUC survey instead. Upon further reflection and discussion, AAOS, NASS, the American Academy of Neurological Surgeons (AANS) and Congress Of neurological Surgeons (CNS) decided deletion is appropriate for 22851 and indicated they plan to present a CPT Code Change Proposal at the October 2015 CPT Editorial Panel meeting. **The specialties requested and the RUC recommends that the Application of Intervertebral Device family of services be referred to CPT for revision.**

Application of Intervertebral Device (Tab 24)
Alexander Mason, MD (CNS); John Ratliff, MD (AANS); William Creevy, MD (AAOS) and Karin Swartz, MD (NASS)

In the July 19, 2011, Proposed Rule for 2012, CMS requests that the RUC review a list of 70 high PFS expenditure procedural codes representing services furnished by an array of specialties. CMS selected these codes based on the fact that they have not been reviewed for at least 6 years, and in many cases the last review occurred more than 10 years ago. In

September 2011, the Relativity Assessment Workgroup (RAW) reviewed these services and recommended that the specialty societies submit action plans for January 2012. In January 2012, the RUC recommended that the RAW review the utilization data as part of the re-review of this service under the High Volume Growth screen. In October 2012, the RAW recommended to review after 2 more years of data. There was a CPT editorial change in 2011 to remove threaded bone from 22851 and the changes may not be apparent in the 2011 preliminary data available. In September 2014, the RAW recommended to survey for April 2015, as this service was initially identified as fastest growing and continued to grow. While preparing to survey CPT code 22851, the American Academy of Orthopaedic Surgeons (AAOS), North American Spine Society (NASS), the American Academy of Neurological Surgeons (AANS) and Congress Of neurological Surgeons (CNS) determined that the service is used in a variety of different cases and with different operative goals. Therefore, the societies believe that a RUC survey using the current CPT descriptor would not provide meaningful survey data. After careful consideration of the existing usages of 22851, as well as accounting for changing practice patterns and new technology, AAOS, NASS, AANS and CNS requested for 22851 to be referred to the CPT Editorial Panel, with the suggestion that a new group of codes be generated to accurately reflect physician work. **The specialties requested and the RUC recommends that the Application of Intervertebral Device family of services be referred to CPT for revision.**

Repair Flexor Tendon (Tab 25)
Daniel Nagle, MD, (ASSH); William Creevy, MD, (AAOS); John Heiner, MD, (AAOS); Mark Villa, MD, (ASPS) and Melissa Crosby, MD (ASPS)

In January 2014, the RUC reviewed 090-day global services (based on 2012 Medicare utilization data) reported at least 1,000 times per year that included more than 6 office visits and identified 10 services, including CPT code 26356. The RUC requested these services be surveyed for work and review the practice expense for the January 2015 RUC meeting. In January 2015, the RUC reiterated its clear position that given that CPT code 26356 was identified through the RAW process under the 090-day global post-operative visit screen, the current potentially misvalued code review cannot stop as a long-term strategy is formed to address the surgical global transition. Therefore, the RUC recommends that survey data be presented for CPT codes (26356, 26357 and 26358) at the April 2015 RUC Meeting.

Compelling Evidence
Prior to valuing this family of procedures, the specialty societies presented compelling evidence that the current work RVUs are potentially misvalued.

Incorrect assumptions during previous valuation
The Harvard work RVUs were based on a review of only intra-service time that was estimated by seven general orthopaedic surgeons, pre and post-work was predicted. Hand surgeons were not included in the Harvard study. The specialties indicated that general orthopaedic surgeons would not have been familiar with these technically complex and low volume procedures. The specialties also indicated that hand surgeons are first boarded in orthopaedic or plastic surgery, and then undergo additional fellowship training in hand surgery.

Anomalous relationship
The Harvard study work RVU incremental difference of 0.59 between codes 26357 and 26358 does not accurately reflect the additional work of harvesting and transferring a free tendon graft from a distant site. Below are four series of without graft and with graft

procedures that indicate the work of the graft is substantially higher than the Harvard estimated 0.59 work differential.

- 25263 *Repair forearm tendon without graft* / 25265 *with graft* (2.06 work RVU difference)
- 26350 *Repair finger/hand tendon without graft* / 25352 *with graft* (1.66 work RVU difference)
- 26410 *Repair hand tendon without graft* / 26412 *with graft* (1.71 work RVU difference)
- 26418 *Repair finger tendon without graft* / 26420 *with graft* (2.47 work RVU difference)

The RUC agreed with the specialty societies that there is compelling evidence that the current work RVUs associated with this family of codes are potentially misvalued.

26356 Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon
The RUC reviewed the survey results from 46 hand, orthopaedic and plastic surgeons and recommends the following physician time components: pre-service time of 58 minutes, intra-service time of 60 minutes and immediate post-service time of 30 minutes. Seven additional pre-service positioning minutes were added to the standard package to ensure padding of bony prominences; application of thermal regulation drapes; assessing position of the extremities and head and adjusting as needed; rotating patient onto hand surgery table; marking, prepping and draping the hand; applying the tourniquet to the proximal arm; elevating and exsanguinating arm; and inflating the pneumatic tourniquet. The additional positioning minutes is consistent with other RUC reviewed codes for upper extremity surgery. The RUC also recommends the following post-operative Evaluation and Management visits: one-half day discharge (99238), four 99212 and two 99213 level visits.

To determine an appropriate work RVU for code 26356, the RUC reviewed the survey respondents' estimated work values and agreed with the specialty societies that the 25th percentile work RVU of 10.03 accurately accounts for the physician work involved in performing this service. To justify a work RVU of 10.03, the RUC compared the surveyed code to the 2nd key reference code 64831 *Suture of digital nerve, hand or foot; 1 nerve* (work RVU= 9.16, intra time= 60 minutes) and noted that while both services have identical intra-service time, code 26356 includes two more office visits than 64831 and, thus, should be valued higher. The RUC also reviewed MPC code 50590 *Lithotripsy, extracorporeal shock wave* (work RVU= 9.77, intra time= 60 minutes) and agreed that since this reference code is a less intense procedure, with less total time, it should be valued less than the surveyed code. In addition, the RUC compared the recommendation to nine other recently reviewed codes with 60 minutes of intra-service time and work RVUs that were higher and lower and agreed that the work RVU of 10.03 correctly ranks 26356 with other specialty codes. Finally, the RUC noted the decrease in intra-service time from 90 minutes, to the survey median time of 60 minutes. The specialties explained that the current times are from a 1995 RUC survey where the RUC did not accept the specialty recommendation for an increased work RVU and then later added the 1995 survey time to the RUC database. These data are marked as not to be used to value physician work. In addition, the societies noted that in 1995, fabrication of a splint was included in the intra-service work. In the current survey instrument, however, a splint is considered a dressing and is included in the post-service work. This difference would reasonably explain the 30 minute difference in survey time. **The RUC recommends a work RVU of 10.03 for CPT code 26356.**

26357 Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, without free graft, each tendon
The RUC reviewed the survey results from 38 hand, orthopaedic and plastic surgeons and recommends the following physician time components: pre-service time of 58 minutes, intra-service time of 85 minutes and immediate post-service time of 30 minutes. Seven additional pre-service positioning minutes were added to the standard package to ensure padding of bony prominences; application of thermal regulation drapes; assessing position of the extremities and head and adjusting as needed; rotating patient onto hand surgery table; marking, prepping and draping the hand; applying the tourniquet to the proximal arm; elevating and exsanguinating arm; and inflating the pneumatic tourniquet. The additional positioning minutes is consistent with other RUC reviewed codes for upper extremity surgery. The RUC also recommends the following post-operative Evaluation and Management visits: one-half day discharge (99238), four 99212 and two 99213 level visits.

To determine an appropriate work RVU for code 26357, the RUC reviewed the survey respondents' estimated work values and agreed with the specialty societies that the median work RVU of 11.50 accurately accounts for the physician work involved in performing this service. To justify a work RVU of 11.50, the RUC compared the surveyed code to the top two key reference codes 23410 *Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute* (work RVU= 11.39, intra time= 90 minutes) and 25447 *Arthroplasty, interposition, intercarpal or carpometacarpal joints* (work RVU= 11.14, intra time= 100 minutes) and agreed that all three services have analogous physician work and time should be valued similarly. In addition, the RUC compared the recommendation to six other recently reviewed codes with similar intra-service time and work RVUs that were higher and lower and agreed that the work RVU of 11.50 correctly ranks 26357 with other specialty codes. Finally, the RUC reviewed MPC code 60220 *Total thyroid lobectomy, unilateral; with or without isthmusectomy* (work RVU= 11.19, intra time= 90 minutes) and noted that this reference code, with similar intra-service time, should be valued similar to code 26357. **The RUC recommends a work RVU of 11.50 for CPT code 26357.**

26358 Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, with free graft (includes obtaining graft), each tendon
The RUC reviewed the survey results from 32 hand, orthopaedic and plastic surgeons and recommends the following physician time components: pre-service time of 58 minutes, intra-service time of 110 minutes and immediate post-service time of 30 minutes. Seven additional pre-service positioning minutes were added to the standard package to ensure padding of bony prominences; application of thermal regulation drapes; assessing position of the extremities and head and adjusting as needed; rotating patient onto hand surgery table; marking, prepping and draping the hand; applying the tourniquet to the proximal arm; elevating and exsanguinating arm; and inflating the pneumatic tourniquet. The additional positioning minutes is consistent with other RUC reviewed codes for upper extremity surgery. The RUC also recommends the following post-operative Evaluation and Management visits: one-half day discharge (99238), four 99212 and two 99213 level visits.

To determine an appropriate work RVU for code 26358, the RUC reviewed the survey respondents' estimated work values and agreed with the specialty societies that the median work RVU of 13.10 accurately accounts for the physician work involved in performing this service. To justify a work RVU of 13.10, the RUC compared the surveyed code to top key reference code 14301 *Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm* (work RVU= 12.65, intra time= 100 minutes) and noted that 26358 has more intra-service time and post-operative office visits compared to the reference code, it should be

valued higher. The RUC also reviewed MPC code 53445 *Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff* (work RVU= 13.00, intra time= 90 minutes) and agreed that while the surveyed code has more intra-service time compared to the MPC code, the reference code has a higher intensity and is appropriately valued nearly identical to 26358. In addition, the RUC compared the recommendation to seven other recently reviewed codes with similar intra-service time and work RVUs that were higher and lower and agreed that the work RVU of 13.10 correctly ranks 26358 with other specialty codes. Finally, the RUC reviewed several pairs of with and without graft hand codes identified in the compelling evidence and agreed that a work differential of 1.60 between 26357 and 26358 was within an appropriate range. **The RUC recommends a work RVU of 13.10 for CPT code 26358.**

Practice Expense
The RUC reviewed and approved the direct practice expense inputs as submitted by the specialty societies without revision as approved by the PE Subcommittee.

Submucosal Ablation of Tongue Base (Tab 26)
John Lanza, MD, (AAO-HNS); Peter Manes, MD (AAO-HNS)

In the NPRM for 2015 MPFS, CMS nominated CPT code 41530 for review as a potentially misvalued code. The nominator stated that CPT code 41530 is misvalued because there have been changes in the PE items used in furnishing the service. The nominator specifically requested that SD109 probe be replaced with a more typically used probe, which costs less and that the replacement be used for equipment code EQ214 radiofrequency generator, to reflect a more appropriate input based on current invoices. The RUC notes that this service was addressed through the ASC/OPPS Cap review which was submitted for 2015. In the Final Rule for 2015, CMS noted that the RUC submitted PE recommendations and requests that work recommendations be submitted as well before CMS revalues this service.

41530 Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session
In April 2015, the RUC reviewed the survey results from 50 otolaryngologists for CPT code 41530 and noted that in comparison to similar 000-day global period services, the survey results were too high. Therefore, the RUC agreed with the specialty society that an appropriate value would be to directly crosswalk the surveyed code to CPT code 15273 *Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children* (work RVU = 3.50). The global period for this service was changed from a 010-day to a 000-day global period. The specialty society noted that this service is typically performed once and the physician will see the patient once post-operatively though not typically on the day of surgery. The RUC recommends pre-service package 4 Difficult Patient/Difficult Procedure with reductions to the scrub, dress, and wait time to align with the survey respondents. The RUC recommends 40 minutes evaluation time, 5 minutes positioning time, 10 minutes scrub, dress, wait time, 20 minutes intra-service time and 20 minutes immediate post-service time. For additional support, the RUC referenced similar CPT code 16035 *Escharotomy; initial incision* (work RVU = 3.74 and 30 minutes pre-time, 20 minutes intra-time and 20 minutes immediate post-service time). **The RUC recommends a work RVU of 3.50 for CPT code 41530**.

Practice Expense
The PE Subcommittee reviewed minor revisions submitted by the specialty to the recommendation approved by the PE Subcommittee at the April 2014 RUC meeting through the ASC/OPPS cap PE review. The revisions were meant to address the concerns raised by CMS in the final rule for 2015. The PE Subcommittee noted that the specialty maintains that the majority of these services are performed in the facility setting; however the CMS Medicare claims data shows that they are typically performed in the physician's office. The PE Subcommittee approved inputs for the office setting, but the RUC determined that the service should not be performed in the office setting and revised the service to be facility only. The direct practice expense inputs for CPT code 41530 were revised for the facility setting only. The RUC reviewed and approved the direct practice expense inputs with revisions as approved by the PE 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.

Future Review
The RUC recommends that the Relativity Assessment Workgroup review the utilization and site of service data for CPT code 41530 in October 2018 after two years of data are available.

Laparoscopic Radical Prostatectomy (Tab 27)
Norman Smith, MD, (AUA); Phil Wise, MD (AUA)

CPT 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. 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 January 2015 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 recommended that the specialty societies submit an action plan for the January 2015 RAW meeting. The RAW reviewed the action plan for 55866 and recommended it be surveyed for April 2015. Additionally, the specialty society should consider surveying 55845 with this service. In April 2015, the RUC noted that the specialty society did not survey 55845 because it was just surveyed in April 2014.

55866 Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed
The RUC reviewed the survey results from 32 urologists for CPT code 55866 and determined that the survey 25th percentile work RVU of 26.80 appropriately accounts for the work required to perform this service. The RUC recommends 68 minutes pre-service time, 180 minutes intra-service time, 30 minutes immediate post-service time, one 99232, one 99238,

two 99213 and one 99214 visit. The RUC agreed that pre-service time package 3-*Facility Straightforward Patient/Difficult Procedure* plus an additional 17 minutes for positioning is appropriate. The patient must be positioned in the lithotomy maximal Trendelenberg position and have all pressure points padded. The survey respondents indicated one 99233 *Subsequent hospital care day,* but the specialty society and RUC agreed it was not typical and removed it. The three post-operative office visits are necessary as one week post-operative surgery the physician will conduct a 99214 to remove the catheter, discuss pathology results, and conduct an initial discussion for penile rehabilitation for erectile function and Kegel exercises for continence. Approximately three weeks after the day of surgery, the urologist will conduct a 99213 visit to check erectile function and conduct another 99213 visit six weeks post-operative surgery to check prostate specific antigen (PSA) screen and review continence.

The RUC compared 55866 to the top two key reference services 55840 *Prostatectomy, retropubic radical, with or without nerve sparing;* (work RVU = 21.36 and 180 minutes intra-service time) and 50543 *Laparoscopy, surgical; partial nephrectomy* (work RVU = 27.41 and 240 minutes intra-service time) and determined that the surveyed code requires slightly more intensity and complexity to perform. The RUC also referenced similar services 23473 *Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component* (work RVU = 25.00), 32670 *Thoracoscopy, surgical; with removal of two lobes (bilobectomy)* (work RVU = 28.52) and 43281 *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh* (work RVU = 26.60) all which require the same intra-service time of 180 minutes and similar physician work to perform. **The RUC recommends a work RVU of 26.80 for CPT code 55866.**

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.

Practice Expense
The RUC recommends the standard 090-day pre-service time inputs, discharge day and post-operative office visits, and one suture removal kit as recommended by the specialty society.

<u>Implantation of Neuroelectrodes (Tab 28)</u>
Barry Smith, MD, (AAPMR); Karin Swartz, MD, (NASS); Marc Leib, MD, JD, (ASA) and Richard Rosenquist, MD (AANS-CNS)

CMS indicated that a stakeholder raised questions regarding whether CPT codes 64553 and 64555 included the appropriate direct PE inputs when furnished in the non-facility setting. It appears that these inputs have not been evaluated recently and therefore CMS nominated these codes as potentially misvalued for the purpose of ascertaining whether or not there are non-facility direct PE inputs that are not included in the direct PE inputs that are typical supply costs for these services. In September 2014, the RUC recommended that these services be reviewed for direct practice expense only at the January 2015 meeting. However in the Final Rule for 2015, CMS requested for both physician work and direct PE inputs to be reviewed. In order for work and direct PE inputs to be reviewed together, the specialty societies indicated they will survey for April 2015. The specialty societies presented survey data at the April 2015 meeting.

During discussion it became clear that for both codes there are differences in the physician work and practice expense when these services are provided in the facility, versus non-facility

setting. In the non-facility office setting the implant is temporary and if successful, the patient will return for a permanent implant in the facility inpatient setting. According to Medicare data this service is typically performed in the physician office, meaning that the services are typical for the temporary implantation of neuroelectrodes. However, the survey respondents reported that 87% of the time they perform the services in the facility setting. This created a problem for the RUC in valuing these services because they are being reported as typical in the non-facility, yet the survey data is predicated on a facility-based permanent procedure.

64553 ***Percutaneous implantation of neurostimulator electrode array; cranial nerve***
The RUC discussed the confusion that survey respondents experienced valuing this service. The descriptor only states which nerve the neurostimulator is implanted in, and most respondents completed the survey as if it is performed in the facility-setting. The 2013 Medicare claims data conflicts with this site of service, reporting that 65% of the time this service is performed in the physician's office. Additionally the supplies and equipment may be different for the temporary and permanent implantation. The RUC recommends referring CPT code 64553 to the CPT Editorial Panel to better define this service, such as having one code to describe temporary or testing implantation and another code to describe permanent implantation. The RUC recognized that it needed to establish an interim value for 64553 until this service could be clarified by CPT. **The RUC recommends maintaining the current work value of 2.36, as interim for CPT code 64553 and referral to the CPT Editorial Panel.**

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

Posterior Tibial Neurostimulation (Tab 29)
Phil Wise, MD, (AUA); Norm Smith, MD, (AUA) Mitchell Schuster, MD (ACOG)

This service was identified through the New Technology/New Services List in April 2010. In January 2015, the Relativity Assessment Workgroup noted there may have been diffusion in technology for this service and requested that the specialty societies survey physician work and review practice expense at the April 2015 meeting.

64566 ***Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming***
The RUC reviewed the survey responses from 36 urologists and obstetricians/gynecologists and recommended the following physicians time components: pre-service time of 7 minutes, intra-service time of 10 minutes and immediate post-service time of 5 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the current work RVU of 0.60, below the 25th percentile, accurately values the physician's work of CPT code 64566. To justify a work RVU of 0.60, the RUC compared the surveyed code to CPT codes 11000 *Debridement of extensive eczematous or infected skin; up to 10% of body surface* (work RVU = 0.60, intra-service time of 10 minutes) and 11300 *Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less* (work RVU = 0.60, intra-service time of 10 minutes) and noted that all three services have identical intra-service time and are accurately valued identically. **The RUC recommends a work RVU of 0.60 for CPT code 64566.**

Practice Expense
The PE Subcommittee noted that the actual time needed for this service is a total of 30 minutes. The physician is involved for 10 minutes, 5 minutes when the needle is placed into the ankle and 5 minutes to monitor the patient. The intra-service time for the clinical staff is not based on the physician's intra-service work time; rather it is based on the total posterior tibial neurostimulation treatment time of 30 minutes. Clinical staff is involved in the procedure for 50% of the total treatment time. During this time the clinical staff assists physician with insertion of needle, checks the leads and removes the leads. In addition the equipment is needed for the entire treatment time of 30 minutes, so 15 minutes has been added to the equipment time calculation. The RUC reviewed and approved the direct practice expense inputs with no revisions as submitted by the specialty society and approved by the Practice Expense Subcommittee.

New Technology
The RUC recommends that CPT code 64566 remain on the New Technology/New Services list to be reviewed by the RUC in two years to ensure correct valuation and utilization assumptions.

Ocular Surface Membrane Placement (Tab 30)
Steve Kamenetzky, MD, (AAO) and David Glasser, MD (AAO)

Facilitation Committee #2

These services were identified through the New Technology/New Services List in February 2010. In January 2015, the Relativity Assessment Workgroup noted there may have been diffusion in technology for these services and requests that the specialty society survey physician work and review practice expense at the April 2015 meeting.

65778 Placement of amniotic membrane on the ocular surface; without sutures
The RUC reviewed the survey results from 38 ophthalmologists and recommend the following physician time components: pre-service time of 23 minutes, intra-service time of 5 minutes and immediate post-service time of 5 minutes. The RUC noted that the pre-service time has increased since the previous valuation when these services were surveyed as new technology. The specialty society explained that during the previous valuation it was felt that an Evaluation and Management service would be performed on the same day and the previous survey data was reduced to account for potential physician work overlap. Using current Medicare utilization data, it is now known that an Evaluation and Management service is not typically reported on the same date of service. Second, it is now known that current practice involves much more evaluation time than previously thought. Because the device is expensive and has a relatively short shelf life, physicians are having their patients come in for a re-evaluation and if they are healed significantly the membrane, which was ordered initially, is sent back and the physician simply bills an Evaluation and Management service. However, if, after assessment, the membrane is needed, code 65778 is reported.

The RUC again noted that the global period was approved to change from a 010- to a 000-day global period. The specialty explained that the practice pattern has changed since the initial valuation as a new technology service. The specialty initially thought that the membrane would be put in and taken out within 10 days. However, as more serious diseases are now treated with this device, it is often left in longer than 10 days. Therefore, reducing the global period to 000-day will provide a more accurate valuation to capture the increased intensity and complexity of this changing service.

To determine an appropriate work value for CPT code 65778, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty society that the respondents overestimated the work involved in this service, with a survey 25th percentile of 1.42 work RVUs. To determine an appropriate value, the RUC considered CPT code 20527 *Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)* (work RVU= 1.00, intra time= 5 minutes) and agreed that this reference code, with identical intra-service time and analogous total time, provides appropriate relativity to the surveyed code. Therefore, the RUC recommends a direct work RVU crosswalk from reference code 20527 to the surveyed code 65778. To justify a work RVU of 1.00, the RUC reviewed the top key reference code 65800 *Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous* (work RVU= 1.53, intra time= 5 minutes) and agreed that while the surveyed code has identical intra-service time to 65800, this reference code is a more intense procedure and is accurately valued higher. **The RUC recommends a work RVU of 1.00 for CPT code 65778.**

65779 Placement of amniotic membrane on the ocular surface; single layer, sutured
The RUC reviewed the survey results from 34 ophthalmologists and recommend the following physician time components: pre-service time of 25 minutes, intra-service time of 30 minutes and immediate post-service time of 10 minutes. The RUC noted an increase in the intra-service time from the previous RUC survey. The specialty society explained that this increase is appropriate because of the shift in patient population. The more straightforward patients are increasingly moving towards the 65778 service, while the more complex patients who have larger areas of necrotic stoma and need more debridement are the ones who receive the sutured service, code 65778. Finally, the RUC recommends one half-day discharge management service (99238) for this facility code.

The RUC again noted that the global period was approved to change from a 010- to a 000-day global period. The specialty explained that the practice pattern has changed since the initial valuation as a new technology service. The specialty initially thought that the membrane would be put in and taken out within 10 days. However, as more serious diseases are now treated with this device, it is often left in longer than 10 days. Therefore, reducing the global period to 000-day will provide a more accurate valuation to capture the increased intensity and complexity of this changing service.

To determine an appropriate work value for CPT code 65779, the RUC reviewed the survey respondents' estimated physician work values and agreed that the survey 25th percentile work RVU of 2.50 accurately accounts for the physician work involved in this service. To justify a work RVU of 2.50, the RUC compared the surveyed code to MPC code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU= 2.78, intra time= 30 minutes) and agreed that while both codes have identical intra-service time, the reference code should be valued slightly higher due to greater intensity. 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 agree that with slightly less total time compared to code 65779, 79 minutes compared to 84 minutes, the reference code is accurately valued slightly less than the surveyed code. **The RUC recommends a work RVU of 2.50 for CPT code 65779.**

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

Do Not Use to Validate
The RUC indicated that since CPT code 65778 used a direct work RVU crosswalk to determine its valuation, the RUC database should include the Do Not Use to Validate for Physician Work flag for CPT code 65778.

Ocular Reconstruction Transplant (Tab 31)
Steve Kamenetzky, MD, (AAO) and David Glasser, MD (AAO)

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 RUC requested these services be surveyed for work and review the practice expense for the April 2015 RUC meeting.

66170 ***Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery***
The RUC reviewed the survey results from 88 ophthalmologists for CPT code 66170 and determined that the survey 25th percentile work RVU of 13.94 appropriately accounts for the work required to perform this service. CPT code 66170 describes fistulization of the sclera (trabeculectomy) for the treatment of glaucoma in the absence of previous disease. The RUC members raised a concern about the number of post operative visits (9) in their comments prior to the meeting. The specialty society indicated that it is important that the fistula stays open post-operatively. The patient is at a risk that the fistula will start to close or filter too well, which will affect the intraocular pressure. The increased or decreased intraocular pressure that puts these patients at risk is typically asymptomatic. These patients are a significant risk for permanent visual loss in a very short period of time. Therefore, the patients must be checked very frequently and it is typical that the physician will have to perform an intervention post-operatively. The physician may remove sutures, needle a bleb or put something on to reduce filtration. All these activities increase the success rate of the procedure. The RUC noted that although the number of post-operative visits was adjusted from all 99213 visits to five 99213 and four 99212 visits, the intensity is relative to other similar services and the frequent and numerous post-operative office visits are essential for optimal patient outcomes. The specialty society noted that the difference in the level of post-operative visits is that the physician is typically examining the patient's intraocular pressure and checking for inflammation when performing 99212 visits and using instrumentation (i.e., removing sutures or placing a bandage lens) or performing a more extensive dilated exam to look at the peripheral retina and optic nerve not just the anterior segment of the eye, when performing 99213 visits.

The RUC recommends 25 minutes pre-time, 45 minutes intra-time and 10 minutes immediate post-service time. The RUC noted that the intra-service time has decreased by 15 minutes from when it was last reviewed 20 years ago, and therefore recommend a lower value to account for any efficiencies gained over time. The RUC agreed that the intra-operative intensity is appropriate as the size of the incision and the amount of space the physician is working in is smaller so the dissection is more intense and critical. The RUC compared the surveyed code to key reference codes 66180 *Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft* (work RVU =15.00 and 60 minutes intra-service time) and 66183 *Insertion of anterior segment aqueous drainage device, without extraocular*

reservoir, external approach (work RVU = 13.20 and 45 minutes intra-service time) all of which require similar physician work, time, intensity and complexity to perform and number of post-operative office visits. 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 13.94 for CPT code 66170.**

66172 ***Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)***
The RUC reviewed the survey results from 74 ophthalmologists for CPT code 66172 and determined that the survey 25th percentile work RVU of 14.81 appropriately accounts for the work required to perform this service. CPT code 66172 describes fistulization of the sclera (trabeculectomy) for the treatment of glaucoma in patients with scarring a previous surgery. The RUC members raised a concern about the number of post operative visits (11) in their comments prior to the meeting. The specialty society indicated that it is important that the fistula stays open post-operatively. The patient is at a risk that the fistula will start to close or filter too well, which will affect the intraocular pressure. The increased or decreased intraocular pressure that puts these patients at risk is typically asymptomatic. These patients are a significant risk for permanent visual loss in a very short period of time. Therefore, the patients must be checked very frequently and it is typical that the physician will have to perform an intervention post-operatively. The physician may remove sutures, needle a bleb or put something on to reduce filtration. All these activities increase the success rate of the procedure. The RUC noted that although the number of post-operative visits was adjusted from twelve 99213 visits to five 99213 and six 99212 visits, the intensity is relative to other similar services and the frequent and numerous post-operative office visits are essential for optimal patient outcomes. The specialty society noted that the difference in the level of post-operative visits is that the physician is typically examining the patient's intraocular pressure and checking for inflammation when performing 99212 visits and using instrumentation (i.e., removing sutures or placing a bandage lens) or performing a more extensive dilated exam to look at the peripheral retina and optic nerve not just the anterior segment of the eye, when performing 99213 visits.

The RUC noted that CPT code 66172 requires two more post-operative office visits compared to CPT code 66170. The specialty societies indicated that the two additional post-operative visits are necessary because patients receiving 66172 have scarring in area where the current fistula made, therefore at higher risk that the fistula will close. The patients are examined more frequently and instrumented more frequently, either with laser to cut sutures, actually cutting sutures or needling the bleb. Patients who receive 66172 are more likely to fail, than the patients who receive 66170 who have unscarred eyes. Additionally, for 66172, the conjunctiva that the physician is working on is extremely thin from the prior scarring therefore more fragile and likely to have complications. If the fistula does not close and the conjunctiva actually leaks, there will be over filtration and low pressure. Therefore, both low and high pressure risks are greater in these patients. The RUC agreed that two more post-operative office-visits are necessary to address the aforementioned complications in patients receiving 66172. The RUC noted that although the number of post-operative visits was adjusted from twelve 99213 visits to five 99213 and six 99212 visits, the intensity is relative to other similar services and the frequent and numerous post-operative office visits are essential for optimal patient outcomes.

The RUC recommends 25 minutes pre-time, 60 minutes intra-time and 10 minutes immediate post-service time. The RUC noted that the intra-service time has decreased by 30 minutes from when it was last reviewed 20 years ago, and therefore recommend a lower value to account for any efficiencies gained over time. The RUC agreed that the intra-operative intensity is appropriate as the size of the incision and the amount of space the physician is working in is smaller so the dissection is more intense and critical. The RUC compared the surveyed code to key reference codes 66180 *Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft* (work RVU =15.00 and 60 minutes intra-service time) and 66183 *Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach* (work RVU = 13.20 and 45 minutes intra-service time) all of which require similar physician work, time, intensity and complexity to perform and number of post-operative office visits. 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 14.81 for CPT code 66172.**

Practice Expense
The PE Subcommittee noted that these services are performed in the facility only. The specialty clarified that equipment items, laser, argon (w-slit lamp adapter) (EQ158) and slit lamp (Haag-Streit), dedicated to laser use (EQ230) are used for a short amount of time in the post-operative visits for a controlled bleed. The RUC recommends the direct practice expense inputs with minor revisions as approved by the PE 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.

Glaucoma Surgery (Tab 32)
Steve Kamenetzky, MD, (AAO); David Glasser MD, (AAO) and Cindie Mattox, MD (AAO)

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 RUC requested these services be surveyed for work and review the practice expense for the April 2015 RUC meeting.

66170 ***Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery***
The RUC reviewed the survey results from 88 ophthalmologists for CPT code 66170 and determined that the survey 25th percentile work RVU of 13.94 appropriately accounts for the work required to perform this service. CPT code 66170 describes fistulization of the sclera (trabeculectomy) for the treatment of glaucoma in the absence of previous disease. The RUC members raised a concern about the number of post operative visits (9) in their comments prior to the meeting. The specialty society indicated that it is important that the fistula stays open post-operatively. The patient is at a risk that the fistula will start to close or filter too well, which will affect the intraocular pressure. The increased or decreased intraocular

pressure that puts these patients at risk is typically asymptomatic. These patients are a significant risk for permanent visual loss in a very short period of time. Therefore, the patients must be checked very frequently and it is typical that the physician will have to perform an intervention post-operatively. The physician may remove sutures, needle a bleb or put something on to reduce filtration. All these activities increase the success rate of the procedure. The RUC noted that although the number of post-operative visits was adjusted from all 99213 visits to five 99213 and four 99212 visits, the intensity is relative to other similar services and the frequent and numerous post-operative office visits are essential for optimal patient outcomes. The specialty society noted that the difference in the level of post-operative visits is that the physician is typically examining the patient's intraocular pressure and checking for inflammation when performing 99212 visits and using instrumentation (i.e., removing sutures or placing a bandage lens) or performing a more extensive dilated exam to look at the peripheral retina and optic nerve not just the anterior segment of the eye, when performing 99213 visits.

The RUC recommends 25 minutes pre-time, 45 minutes intra-time and 10 minutes immediate post-service time. The RUC noted that the intra-service time has decreased by 15 minutes from when it was last reviewed 20 years ago, and therefore recommend a lower value to account for any efficiencies gained over time. The RUC agreed that the intra-operative intensity is appropriate as the size of the incision and the amount of space the physician is working in is smaller so the dissection is more intense and critical. The RUC compared the surveyed code to key reference codes 66180 *Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft* (work RVU =15.00 and 60 minutes intra-service time) and 66183 *Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach* (work RVU = 13.20 and 45 minutes intra-service time) all of which require similar physician work, time, intensity and complexity to perform and number of post-operative office visits. 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 13.94 for CPT code 66170.**

66172 ***Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)***
The RUC reviewed the survey results from 74 ophthalmologists for CPT code 66172 and determined that the survey 25th percentile work RVU of 14.81 appropriately accounts for the work required to perform this service. CPT code 66172 describes fistulization of the sclera (trabeculectomy) for the treatment of glaucoma in patients with scarring a previous surgery. The RUC members raised a concern about the number of post operative visits (11) in their comments prior to the meeting. The specialty society indicated that it is important that the fistula stays open post-operatively. The patient is at a risk that the fistula will start to close or filter too well, which will affect the intraocular pressure. The increased or decreased intraocular pressure that puts these patients at risk is typically asymptomatic. These patients are a significant risk for permanent visual loss in a very short period of time. Therefore, the patients must be checked very frequently and it is typical that the physician will have to perform an intervention post-operatively. The physician may remove sutures, needle a bleb or put something on to reduce filtration. All these activities increase the success rate of the procedure. The RUC noted that although the number of post-operative visits was adjusted from twelve 99213 visits to five 99213 and six 99212 visits, the intensity is relative to other

similar services and the frequent and numerous post-operative office visits are essential for optimal patient outcomes. The specialty society noted that the difference in the level of post-operative visits is that the physician is typically examining the patient's intraocular pressure and checking for inflammation when performing 99212 visits and using instrumentation (i.e., removing sutures or placing a bandage lens) or performing a more extensive dilated exam to look at the peripheral retina and optic nerve not just the anterior segment of the eye, when performing 99213 visits.

The RUC noted that CPT code 66172 requires two more post-operative office visits compared to CPT code 66170. The specialty societies indicated that the two additional post-operative visits are necessary because patients receiving 66172 have scarring in area where the current fistula made, therefore at higher risk that the fistula will close. The patients are examined more frequently and instrumented more frequently, either with laser to cut sutures, actually cutting sutures or needling the bleb. Patients who receive 66172 are more likely to fail, than the patients who receive 66170 who have unscarred eyes. Additionally, for 66172, the conjunctiva that the physician is working on is extremely thin from the prior scarring therefore more fragile and likely to have complications. If the fistula does not close and the conjunctiva actually leaks, there will be over filtration and low pressure. Therefore, both low and high pressure risks are greater in these patients. The RUC agreed that two more post-operative office-visits are necessary to address the aforementioned complications in patients receiving 66172. The RUC noted that although the number of post-operative visits was adjusted from twelve 99213 visits to five 99213 and six 99212 visits, the intensity is relative to other similar services and the frequent and numerous post-operative office visits are essential for optimal patient outcomes.

The RUC recommends 25 minutes pre-time, 60 minutes intra-time and 10 minutes immediate post-service time. The RUC noted that the intra-service time has decreased by 30 minutes from when it was last reviewed 20 years ago, and therefore recommend a lower value to account for any efficiencies gained over time. The RUC agreed that the intra-operative intensity is appropriate as the size of the incision and the amount of space the physician is working in is smaller so the dissection is more intense and critical. The RUC compared the surveyed code to key reference codes 66180 *Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft* (work RVU =15.00 and 60 minutes intra-service time) and 66183 *Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach* (work RVU = 13.20 and 45 minutes intra-service time) all of which require similar physician work, time, intensity and complexity to perform and number of post-operative office visits. 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 14.81 for CPT code 66172.**

Practice Expense

The PE Subcommittee noted that these services are performed in the facility only. The specialty clarified that equipment items, laser, argon (w-slit lamp adapter) (EQ158) and slit lamp (Haag-Streit), dedicated to laser use (EQ230) are used for a short amount of time in the post-operative

visits for a controlled bleed. The RUC recommends the direct practice expense inputs with minor revisions as approved by the PE 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.

Transluminal Dilation Eye Canal (Tab 33)
Steve Kamenetzky, MD (AAO); Michael X. Repka, MD (AAO)

These services were identified through the New Technology/New Services List in April 2010. In January 2015, the Relativity Assessment Workgroup noted there may have been diffusion in technology for these services and requests that the specialty society survey physician work and review practice expense at the April 2015 meeting. The specialty society submitted a letter to the RUC requesting that the RAW re-review these services, remove from the New Technology list and maintain. The specialty noted that these services are very low volume. During the last three years 66174 has not been performed more than 403 times and 66175 has not been performed more than 2,023 times in the Medicare population. The specialty also noted that survey data were not used when the RUC valued these services in April 2010. The Workgroup agreed that a survey is not likely to yield more accurate valuation for these very low volume services. The Workgroup recommended that CPT codes 66174 and 66175 be removed from the New Technology/New Services list and that these services be flagged in the RUC database not to use them to validate physician work. **The RUC reviewed the Workgroup's recommendations and recommends referring codes 66174 and 66175 back to the Relativity Assessment Workgroup for review in 3 years and flag in the RUC database not to use them to validate physician work.**

Database Flag
The RUC recommends that CPT codes 66174 and 66175 be flagged in the RUC database as not to be used to validate physician work.

Mammography (Tab 34)
Ezequiel Silva, III, MD (ACR)

In February 2008, the mammographies G-codes were identified via the CMS/Other Source – Utilization over 250,000 screen. In January 2014, the RUC noted that both CPT codes and G-codes exist to describe screening/diagnostic mammography. The RUC recommended that it analyze the screening/diagnostic mammography services G0202, G0204 and G0206 and CPT codes 77057, 77056 and 77055 in September 2014, after the Proposed Rule is released and CMS addresses the RUC recommendation to convert the direct practice expense medical supply inputs from film to digital. In the NPRM for 2015, CMS stated it will update the direct PE inputs for all imaging codes to reflect the migration from film to digital storage technologies since digital storage is now typically used in imaging. CMS confirmed that the majority of all mammography is digital. As a result, CMS proposed that the CPT codes 77055-77057 be used for reporting mammography to Medicare regardless of whether film or digital technology is used and to delete G0202, G0204 and G0206, which are specific to digital mammography. CMS proposed for CY 2015, to value the CPT codes using the values established for the digital mammography G-codes since digital technology is now the typical service. In addition, since the CPT codes proposed to use for CY 2015 have not been reviewed since they were created in CY 2002, CMS proposed to include 77005, 77056 and 77057 to the list of potentially misvalued codes. In September 2014, the RUC recommended

that these services be surveyed for work and review direct practice expense inputs at the January 2015 meeting. Prior to survey, the RUC requested that this service be referred to CPT to remove "film" from the descriptor for 77057 and survey for work and review direct practice expense inputs for April 2015.

In April 2015, the specialty society requested that these services be referred to the CPT Editorial Panel to describe services such as computer-aided detection (CAD) which are typically performed along with mammography. **The RUC recommends that these services be referred to the CPT Editorial Panel for revision for CPT 2017. The RUC informed the specialty society that their coding change application must be submitted no later than July 8, 2015.**

High Energy Neutron Radiation Treatment (Tab 35)
Michael Kuettel, MD, PhD (ASTRO)

For CY 2014, CMS eliminated several anomalous supply inputs included in the direct PE database, which affected 77422 and 77423, among other services. Commenters indicated that upon reviewing the PE inputs for these services, they noted that the Record and Verify System and the laser targeting system were missing in both of these services, despite being in the original 2005 recommendation. CMS appreciates the commenters' attention to detail. However, CMS does not believe that the Record and Verify System is medical equipment used in furnishing the technical component of the service. CMS referred to discussion of this issue in the PFS 2014 Final Rule with Comment period (78 FR 74317). Further, since these codes have not been reviewed in many years, CMS does not know if the laser targeting system continues to be an appropriate input for these services. Therefore, CMS requested that the RUC examine the inputs for these services to ensure their accuracy.

CPT codes 77422 *High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking* and 77423 *High energy neutron radiation treatment delivery; 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)* are not typically performed in the office setting. In the 2013 Medicare data, CPT code 77422 had a utilization of one and CPT code 77423 had no Medicare utilization.

The specialty recommended and the RUC agreed that due to the complicated nature of the practice expenses for these services and the low Medicare frequency the RUC could not make a practice expense recommendation regarding these services. **The RUC recommends contractor pricing for CPT codes 77422 and 77423.**

Cytopathology Concentration Technique – PE Only (Tab 36)
Jonathan Myles, MD (CAP); Swati Mehrotra (ASC)

In the Final Rule for 2015, CMS requested that this service be reviewed as potentially misvalued, based on comments that the refinements to the practice expense (PE) inputs for CPT code 88112 resulted in a rank-order anomaly, as CPT code 88108 has higher PE RVUs than CPT code 88112, while CPT code 88108 is a less complex service than CPT code 88112. Specifically, commenters stated that it is illogical for a cytology specimen processing technique that involves an additional step and more resources to have an RVU that is less than an associated technique that requires fewer resources. Commenters expressed concern about the potential for misreporting. The RUC determined that CPT codes 88104, 88106,

88160, 88161 and 88162 should also be included in this review as they are part of the same family and if they are not reviewed together new rank-order anomalies could be created.

The RUC reviewed the direct PE inputs only for 88108, 88112, 88104, 88106, 88160, 88161 and 88162 at the April 2015 RUC meeting. Except for CPT code 88112 which was reviewed in 2013, all of the direct practice expense inputs for these services were recently reviewed and accepted by the RUC at its April 2014 meeting. These recommendations were then sent to CMS for implementation. These recommendations and others, voluntarily refined by specialties at that meeting, have yet to be implemented by CMS. Because of the importance of correcting rank order anomalies and several significant errors in the current direct PE inputs for cytopathology codes, this RUC recommendation includes the entire family of codes that were reviewed in April 2014 along with requested code 88112. The recommendations provide standardized definitions and allow for additional refinement of these services so that all of the services are appropriately relative to each other.

Prior to the April 2014 RUC recommendations, which were not implemented, the practice expense for the services had not been reviewed by the RUC since 1999 (88104, 88106, 88108) and 2001 (88160, 88161, 88162). The 88160-88162 are very low volume codes. There is significant change in practice expense for all the codes since the previous review. The most significant changes in practice expense are the following:

- The use of laboratory information systems (LIS) is now typical. Cytology programs became typical later than general anatomic pathology programs, however they are now standard. At time of prior review (1999) hand written reports were typical. Now there are computer generated reports with all the LIS entry and associated labor.
- Standards for Non-GYN specimen preparation have significantly changed with current regulations requiring procedures to prevent cross contamination of material between cases during the preparation/staining process
- Practice expense inputs have changed significantly, especially for 88112 and 88108. Some clinical labor steps and processes were previously included and are no longer necessary; others are excluded and are now requirements under strict laboratory standards.
- Screening times for smears are time consuming and are typically performed by cytotechnologists in non-gynecological cases.

The RUC reviewed and approved the direct practice expense inputs with minor revisions as submitted by the specialty society and approved by the Practice Expense Subcommittee.

Carotid Intima-Media Thickness Ultrasound (Tab 37)
Richard Wright, MD, (ACC); Zeke Silva, MD, (ACR); Kurt Shoppe, MD, (ACR); Gregory Nicola, MD, (ASNR) and 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. In April 2014, the RUC reviewed this service and questioned what type of physicians would be providing this service, primary care or specialists, such as radiologists and cardiologists, as this service becomes more widespread. 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. The RUC recommended 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.

In April 2015, the primary care specialty societies indicated that primary care physicians do not perform this service and therefore they did not survey this service. **Since the April 2014 RUC recommendation was interim, and there was no specialty society interest to re-resurvey this service the RUC rescinds its previous recommendation.**

Prostate Biopsy – Pathology (Tab 38)
Jonathan Myles, MD, (CAP); Swati Methrota, MD, (ASC); Stephen Black-Shaffer MD, (CAP) and Michael McEachin, MD, (CAP)

In CY 2009, CMS first implemented a set of four G codes for the surgical pathology of prostate saturation biopsy services. The number of specimens distinguished the codes: 1-20 for G0416, 21-40 for G0417, 41-60 for G0418, and 60+ for G0419. These G codes were developed to address CMS' concern about the large number of CPT code 88305 claims that would be reported. Over the past 4 years, the definitions for all four G codes changed four separate times without corresponding changes in the code number, creating confusion in the marketplace. During this time the RUC and the pathology specialty societies have maintained that the most accurate way to report prostate biopsy examinations is to utilize 88305 and allow the reporting of multiple units.

For CY 2014, CMS modified the code descriptors of G0416 through G0419 so that these codes could be used for any method of prostate needle biopsy services, rather than only for prostate saturation biopsies. Subsequently, CMS discussed prostate biopsies with stakeholders, and reviewed medical literature and Medicare claims data in considering how best to code and value prostate biopsy pathology services. In considering these discussions and review, CMS expressed concern that, at the time, that the existing coding structure may have been confusing, especially since the number of specimens associated with prostate biopsies had been relatively homogenous. For example, G0416 (10-20 specimens) represented the overwhelming majority of all Medicare claims submitted for the four G-codes. Consequently, CMS believed it would be appropriate to use only one code to report prostate biopsy pathology services and proposed to revise the descriptor for G0416 to define the service regardless of the number of specimens, and to delete codes G0417, G0418, and G0419. In September 2014, the RUC recommended that this service be surveyed for work and a review of the direct practice expense inputs for the April 2015 meeting.

Originally G0416 was created for the saturation technique only, then it was applied to all prostate biopsy techniques, and now it applies to all prostate biopsy specimens whether it is 1 needle core or 100. This new definition was implemented for January 1, 2015 and has only been in effect for 3 months prior to the survey being conducted. CPT code G0416 currently has a physician work value of 3.09. This value and the practice expense inputs have not changed since the code was created in 2009, however in the interim the 88305 technical component was revalued and the professional component reaffirmed. The revised direct practice expense inputs of 88305 have never been accounted for in the value of G0416. The specialty stated their belief that the primary concern of CMS is related to the practice expense component of this code. The practice expense was reviewed at this meeting and an approximate 50% reduction in the direct PE inputs has been approved by the PE Subcommittee.

G0416 Surgical pathology, gross and microscopic examinations, for prostate needle biopsy, any method

The specialties developed a vignette that describes 12 site specific biopsies to be typical. This number is based on statistical analysis of the 2013 5% Medicare claims file. The number of survey respondents that found the vignette to be typical was only 81%. This is likely due to the code having four definitions over the past four years, as well as the current definition only being in place for a short time. In addition, this is the first time that a bundled pathology code has ever been surveyed. This resulted in numerous problems with the survey. First the reference service list (RSL) was an issue, as the current work value of this service is 3.09 and the highest work value for pathology codes in the Medicare Physician Fee Schedule is 2.80. It was therefore impossible to construct a RSL using only pathology codes. The RUC's Research Subcommittee empathized with the issue, but determined that the specialties should move forward with a survey. An RSL was constructed that included pathology, evaluation and management, and other services believed to be recognizable to the survey respondents. All of the services on the RSL had been RUC reviewed and were either XXX or 000 day global period codes.

The pathology specialties conducted a random survey which resulted in 118 responses. The survey median work value was 3.90. CMS came up with its current value of 3.09 by calculating 15% of the biopsy cores at the level of an 88305 and 85% of the biopsy cores at the level of an 88304. The rationale was that the 85% only require the pathologist to determine if cancer is present or not, and that it is prostate tissue. The specialties disagreed, stating that the urologist needs to know a separate diagnosis for each of the needle cores, as well as the size of the cancer for each.

The RUC reviewed the survey results and found that the top key reference service CPT code 88356 *Morphometric analysis*; *nerve* (work RVU = 2.80) was selected by 33% of the respondents, even though the median performance rate was zero. The second key reference service CPT code 17313 *Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks)* (work RVU = 5.56), was selected by 22% of the respondents, even though the median performance rate was zero.

The specialties argued that the survey results are invalid for a number of reasons. First, it is clear to the specialties that the survey respondents did not understand the service being provided. The respondents indicated confusion over the physician work and time required. Second, the survey respondents' comparisons of the surveyed service to the reference services led to a large variability and heterogeneity in survey results. Many of the survey respondents infrequently performed or did not perform their chosen reference service. The specialties determined and the RUC agreed that the work survey results are flawed and provide invalid estimates of physician work and time.

The RUC discussed the CMS imputed work value and determined that it likely undervalues the work of this service. An alternative approach that has been used in the past on occasion, when reliable survey data is impossible to obtain, is the recommendation of an expert panel. The RUC proposed this method and the specialty agreed that they would form an expert panel to determine the work value of this service. **The RUC recommends to maintain the current work value of 3.09 as interim and recommends that the specialties convene an expert**

panel to determine an appropriate work RVU for CPT code G0416 to be presented to the RUC at the October 2015 RUC meeting.

Practice Expense
The RUC concurred with the specialty that the practice expense was likely the primary reason that CMS had requested for this service to be reviewed. The direct practice expense inputs are based on a crosswalk to CPT code 88305 as it was in 2009, when CPT code G0416 was developed. During this time CPT code 88305 technical component has been revalued. The refined direct PE inputs for 88305 had never been accounted for in the value of G0416. This PE recommendation will result in approximately a 50% reduction in the direct PE inputs for this service. The RUC reviewed and approved the direct practice expense inputs with minor revisions as submitted by the specialty society and approved by the Practice Expense Subcommittee.

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

XII. HCPAC Review Board (Tab 39)

Jane White, PhD, RD, FADA, LDN, provided the Health Care Professionals Advisory Committee Review Board report:

- The HCPAC met on Thursday morning and reviewed the proposal for the new and revised codes for physical medicine and rehab evaluation services, specifically physical therapy and occupational therapy evaluation and intervention codes. The HCPAC recognized issues with reference service lists for these codes and that was addressed by the Research Subcommittee.
- The HCPAC held elections for the Chair and Co-Chair. Michael Bishop, MD, will serve as the HCPAC Chair, Jane White, PhD, RD, FADA, LDN was elected as the HCPAC Co-Chair, and Dee Adams Nikjeh, PhD, CCC-SLP from American Speech-Language-Hearing Association, was elected the alternate Co-Chair.

The RUC filed the HCPAC Review Board Report.

XIII. Practice Expense Subcommittee (Tab 40)

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

- Pre-Service Time Standards for Emergent 090-day Global Services
    - The first is the standard pre-service clinical staff time in the facility for emergent 090-day global services.
    - The PE Subcommittee reviewed the analysis prepared by staff, looking at what procedures are performed on the same or prior day as an emergency department service (99281-99285) and were surprised at how few services turned up in that analysis.
    - The Subcommittee had many questions about these codes, including if certain times were previously reduced because they were thought to be emergent and are not included on this list, there may be a possibility that the pre-service time needs to be increased. Additionally, the Subcommittee will need to determine if the RUC should apply the standard only prospectively or if it should be considered both prospectively and retrospectively.

  - In order to address these questions, the Subcommittee determined that a Workgroup should be formed to examine the issue. The Chair of the workgroup will be Doctor Geraldine McGinty and will convene conference calls over the summer and present their recommendations to the full PE Subcommittee at the fall meeting.
- Determining Clinical Staff Time and Equipment Minutes for Scopes
  - The Subcommittee discussed if there need to be adjustments to the standard time for endoscopes and their cleaning when there are multiple lumens or multiple endoscopes are used for the same procedure. The Subcommittee noted that scopes with additional lumens have existed for many years and that additional cleaning time has not previously been allocated. The Subcommittee determined that it is not necessary to change the current scope cleaning standards and that when you use two scopes there are no economies of scale and specialties will continue to be allocated the time to clean each scope.
- The summary of changes to the PE spreadsheets is included in the report.
- A member of the PE Subcommittee noted that there are certain codes that should be considered emergent that are not included on the list of codes. It may be necessary to include additional criteria in order to ensure a more comprehensive list.

The RUC approved the Practice Expense Subcommittee Report.

XIV. Relativity Assessment Workgroup (Tab 41)

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

- **Joint CPT/RUC Workgroup on Codes Reported Together Frequently – Progress Report**
  Doctor Raphaelson indicated that Robert Zwolak, MD, provided a summary of the Workgroup's recent review of two issues from the fourth iteration of the bundled services project. The Joint Workgroup recommends that code pair 37200/75970 be removed from Group 1. Other recommendations for Group 1, accepted by the RAW in January 2015, remain unchanged. The Joint Workgroup also reviewed Group 5 – Surgical Sinus Endoscopy codes and recommended a bundled code solution for the CPT 2018 cycle.

- **Action Plan Review**

  CPT code 92132
  CPT code 92132 was identified through the New Technology/New Services List in April 2010. In January 2015, the Relativity Assessment Workgroup requested that the specialty society submit an action plan to explain what is driving the utilization and whether other measures may be needed, such as a CPT Assistant article. The Workgroup reviewed the action plan submitted by the specialty society and noted that the utilization has grown rapidly. **The Workgroup recommends that CPT code 92132 be surveyed for October 2015, noting that it is the specialty societies' decision whether 92133 and 92134 need to be surveyed with this service.**

  CPT codes 66174 & 66175
  These services were identified through the New Technology/New Services List in April 2010. In January 2015, the Relativity Assessment Workgroup noted there may have been diffusion in technology for these services and requests that the specialty society survey physician work

and review practice expense at the April 2015 meeting. The specialty society submitted a letter to the RUC requesting that the RAW re-review these services, remove from the New Technology list and maintain. **When the RUC reviewed this tab, they referred codes 66174 and 66175 back to the Relativity Assessment Workgroup for review in 3 years and flag in the RUC database not to use them to validate physician work.**

- **Work Neutrality Review (CPT 2012)**
  In February 2011, the CPT Editorial Panel deleted four codes and created four new codes, CPT codes 64633-64636, to describe neurolysis reported per joint (2 nerves per each joint) instead of per-nerve and bundled image guidance.

  In June 2014, the AMA staff analysis showed that in the year 2012 the Destruction by Neurolytic Agent codes was not budget work neutral and that, during the first year of the code's existence, there was 24% more utilization than projected. Therefore, the Relativity Assessment Workgroup review was initiated for this family. **The Workgroup agreed that the specialty societies have taken aggressive action to ensure correct reporting of these services (as outlined in the full Relativity Assessment Workgroup report). The Workgroup recommends that we allow the multiple aforementioned efforts to take effect and re-review the utilization data for these services in April 2017.**

- **CPT Assistant Analysis**
  At the January 2015 meeting a Workgroup member requested that the Relativity Assessment Workgroup review the effectiveness of the RUC referrals for specialty societies to develop CPT Assistant articles. AMA staff compiled the list of 38 RUC referrals for development of CPT Assistant articles in which an article was published and one year of Medicare utilization data was available.

  The Workgroup reviewed these 38 services and related CPT Assistant articles. The Workgroup requested that the specialty societies submit an action plan for the following codes for the Relativity Assessment Workgroup to review at the October 2015 meeting.

CPT Code	Submit Action Plan to Address
13120-13122	Increase in utilization and effectiveness of CPT Assistant article
26080	Harvard Value, previous global change request to 000-day
50605	Appropriateness of General Surgery performing this service
52214-52240	Answer whether it is appropriate to use more than 1 fulguration code per session, whether a parenthetical needed to ensure correct reporting of these services.
63056	Harvard Value for the family of services and effectiveness of CPT Assistant article
69801	Increase in utilization and effectiveness of CPT Assistant article
73580	Increase in utilization and effectiveness of CPT Assistant article
96920-96922	Increase in utilization and effectiveness of CPT Assistant article

The Workgroup determined that:

- CPT assistant articles were almost always effective at addressing the concern. For example, utilization growth slowed for fast growing procedures.
- Occasionally CPT Assistant articles do not appear to address the underlying RUC concern.

- Success or failure in curbing growth is usually apparent with 2 years of data after publication of the CPT Assistant article.

The Workgroup understands the CPT Assistant RUC liaison and staff will review draft CPT Assistant articles prior to publication to ensure address RUC concerns. The Workgroup further recommends that all referrals to CPT Assistant be reviewed for effectiveness after two years of utilization data are available.

The RUC approved the Relativity Assessment Workgroup Report.

XV. Research Subcommittee (Tab 42)

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

- **The RUC reviewed and accepted the February 2015 Research Subcommittee Review report.**
- **Requests for RSL review and Modification to the Standard RUC Survey Template**

Physical Therapy and Athletic Training Evaluations (97161X-97168X)
American Occupational Therapy Association
American Physical Therapy Association

The American Physical Therapy Association (APTA) requested to use a modified XXX-day survey instrument to survey PT evaluation codes 97161X-97164X, with proposed changes to make the survey instrument applicable to physical therapists. These proposed changes included modifications to the definitions of pre-service, intra-service and post-service work. **The Research Subcommittee discussed these revisions and approved the survey instrument, with the revision that "Physical Therapist" be replaced with "qualified healthcare provider" throughout the survey instrument.**

The American Occupational Therapy Association (AOTA) requested to use a modified XXX-day survey instrument to survey OT evaluation codes 97165X-97168X, with proposed changes to make the survey instrument applicable to physical therapists. These proposed changes included modifications to the definitions of pre-service, intra-service and post-service work. **The Research Subcommittee discussed these revisions and approved the survey instrument, with the revision that "Occupational Therapist" be replaced with "qualified healthcare provider" throughout the survey instrument.**

APTA requested for the Research Subcommittee to review two proposed Reference Service Lists (RSLs), one for the 3 evaluation codes (97161X-97163X) and a separate one for the 1 reevaluation code (97164X). Following a robust discussion, **the Research Subcommittee recommended for the Specialty to combine both RSLs and to use the single RSL for all 4 codes (97161X-97164X).**

The Subcommittee had a robust discussion concerning the appropriateness of the inclusion of E/M services in the APTA RSL, which the survey respondents do not have experience performing. The Subcommittee acknowledged that all codes physical therapists perform are unavailable for the RSLs as they are currently under review by the RAW, so there would be no other options than to include services that physical therapists do not have experience in performing. **Therefore, given the unique circumstances, the Subcommittee recommends for the RSL to only include E/M services, though only codes that are level 3 and below.**

The Subcommittee noted that CPT code 99243 is no longer covered by Medicare and should be removed from the reference service lists. Also, the Subcommittee recommended for APTA to remove any ophthalmology services.

The Subcommittee requested for APTA to implement the changes and to resubmit to the Research Subcommittee for electronic review after the RUC meeting.

AOTA requested that the Research Subcommittee to review a single proposed RSL for all 4 of their respective codes (97165X-97168X). **The Subcommittee approved the AOTA RSL without modification.**

- **Moderate Sedation- Survey Methodology**

The Chair noted that new and revised Moderate Sedation services (991X1X-991X6X) were created at the most recent CPT meeting and will be used to report moderate sedation starting in CPT 2017. For the new base moderate sedation codes for when the same physician performs both the moderate sedation and the primary surgical procedure (991X1X, 991X2X), the Joint CPT/RUC Moderate Sedation Workgroup had requested the Research Subcommittee review and consider a proposed survey methodology.

On the Moderate Sedation Workgroup's March 25th conference call, the Workgroup requested for AMA staff to draft an example survey for consideration by the Research Subcommittee. The Workgroup decided the example survey should be a direct survey of the moderate sedation code, using a general vignette (the CPT vignette) that would be applicable regardless of the surgical service. The Workgroup had noted that, for this proposal, the physician time for moderate sedation should be measured only in the pre-service time of the primary procedure, since this is how the RUC currently assigns moderate sedation time. While the Workgroup acknowledged that there may be additional intensity in the intra-service period, they believed that it may be too difficult to articulate that intensity in valuation. The Workgroup noted that the reference service list for this survey mechanism should include codes that would be understood by most of the surveying specialties, such as E/M codes and monitoring codes.

The Research Subcommittee discussed how 991X1X and 991X2X should be surveyed and noted that the following Specialties had indicated interest in surveying these services: Anesthesiology, Cardiology, Gastroenterology, Interventional Radiology, Pediatrics, and Vascular Surgery. **The Subcommittee discussed the draft survey instrument provided by AMA Staff for 991X1X and 991X2X, and approved the survey instrument with minor modification.**

The Research Subcommittee reviewed a proposed RSL submitted by the cardiology and gastroenterology specialties. It was noted that perhaps the RSL should have a somewhat higher RVU range then 0.30 RVUs. **The Research Subcommittee agreed to conduct the review of this reference service list electronically, after the RUC meeting.** AMA staff will initiate this discussion with the Subcommittee the week following the RUC meeting.

The Research Subcommittee acknowledged that CPT codes 991X3X, 991X4X and +991X6X (when the anesthesia services is performed by a separate provider) would be surveyed using a standard RUC survey instrument, unless the surveying specialties decided to submit any proposed modifications at a later time. Therefore, discussion of these services was unneeded.

The Subcommittee discussed the original assumption that the add-on code +991X5X (each additional 15 minutes) should be valued as practice-expense only. The Subcommittee noted that the RUC rules only defines the physician work for moderate sedation services as taking place during the pre-service portion of the primary surgical procedure and valuing this add-on service would not be possible under current RUC rules. AMA staff clarified that services in appendix G that were reviewed over the past several years were valued using the assumption that moderate sedation physician work only occurs during the pre-service portion of the primary surgical procedure.

In addition, the Subcommittee pondered if there is a different level of work intensity for a surgeon during the intra-service portion of the primary surgical procedure, whether the surgeon has their own clinical staff performing the sedation monitoring, relative to if an anesthesiologist or a CRNA is performing the monitoring.

Following a lengthy discussion, the Subcommittee did not reach a consensus. The Chair suggested that the RUC should discuss whether there should be a consideration of additional intra-service intensity for services performed under moderate sedation by the operating physician and requested for interested stakeholders to bring this up for discussion during *Other Business* at the end of the RUC meeting.

- **Research Subcommittee Guidelines and Requirements Document Review**

Clinical Vignettes Section:

Since the last RUC meeting, several specialty staff have expressed confusion regarding what the Research Subcommittee requires in regard to existing codes that do not have a vignette in the RUC database and were not revised by CPT. AMA staff noted their concern that there is a gap in the current Research Guidelines and Requirements document in that it does not state what is required (instead only discussing modified vignettes which are distinct from the RUC database). From the subcommittee's in-person discussion at the January meeting and from the January Research subcommittee report, AMA staff explained their understanding that the Subcommittee's intention was to have the document so that if there is no existing vignette in the RUC database, Research review is now required. A proposed red-line language was included in the materials for the Subcommittee's consideration. **The Subcommittee determined that if no vignette exists, one must be approved by the Research Subcommittee.**

Reference Service List Section:

It was noted that Global Period was accidentally omitted from the data points required for RSL requests. **The Subcommittee approved this correction as proposed.**

Modifications to Standard RUC Survey Templates Section:

The current text of the document does not technically allow for societies to change the term "physician" to a term that would be appropriate for their members, so certain HCPAC societies would need to request a modified survey template every time they want to perform a survey. As this seems burdensome on both the societies and Research, proposed language was included in the materials for the Subcommittee's consideration. **The Research Subcommittee reviewed this proposed change and determined that it would instead be**

more appropriate to amend the proposed language so that specialties could only change the survey instrument without approval to replace "physician" with "a qualified healthcare provider". The Subcommittee approved this proposal, following this modification.

Proposed Definitions:

At the January meeting, the Subcommittee requested for AMA staff to list definitions for terms used in the document, giving "targeted" and "random" as examples, for the Subcommittee's review at its April 2015 meeting. AMA Staff included the draft language as a footnote on page two of the proposed document for the Subcommittee's review and consideration. As many of the terms used are defined in other RUC materials, the draft language only includes proposed definitions for "random sample" and "targeted sample". **The Research Subcommittee agreed that the below proposed definitions will need to undergo further Subcommittee review at the October 2015 meeting prior to the Subcommittee making a recommendation on implementation:**

- *Definition of a Random Sample/Random Survey:* A randomly selected subset of a society's general US membership, excluding members of the society's Advisory Committee. This subset should include only physicians or other qualified healthcare professionals from the appropriate Specialtie(s) with available email addresses. Each individual in the subset is chosen randomly, such that each individual has the same probability of being chosen.

- *Definition of a Targeted Sample:* Any sampling method which falls outside the definition of a Random Sample.

Research Subcommittee Request for AMA Staff to research targeted sample approval trends:

At the January 2015 RUC meeting, a Research Subcommittee member requested for AMA staff to analyze the Subcommittee's approval rate and review frequency for targeted survey sample requests over the past few years. AMA staff noted that, over the past 3 years, the Subcommittee has approved specialty society targeted sample requests without modification 92 percent of the time (34/37 tabs). On average, the Subcommittee reviewed 4 targeted sample requests per RUC meeting.

- **Other Business**

Overview of Updates to RUC Online Survey Tool and Process – Information Only

The Chair noted that an overview of updates to the online tool is provided in the agenda packet. The survey tool is currently being used by on average approximately half of all survey tabs of surveying societies at each meeting; there is no set date for when the tool will be mandatory for all societies to use.

Doctor Levy explained that the rationale for rolling out this centralized RUC survey process eventually to all specialties was largely to respond to concerns expressed by the public and to make the process as transparent, accountable and consistent as possible. Doctor Levy noted that we should make sure that the RUC survey process is as transparent a process as possible and that we can explain this to the public. This issue directly relates to the continued validity

of the RUC process. **All specialties are strongly encouraged to use the Qualtrics survey tool for all future surveys.**

Potential Issues Concerning Newly Created CPT Codes

Several Research Subcommittee members expressed concern regarding the influx over the past few years of new CPT codes being sent to the RUC that nationally have very few physicians trained in the performance of these services. Doctor Bothe, the CPT liaison to the RUC, noted that this concern has come up several times with the CPT Editorial Panel and that the Panel has struggled with if there should be an absolute volume threshold. There are many challenges which inhibit the CPT Editorial Panel's ability to appropriately determine an absolute minimum volume threshold, and that doing so may not necessarily be appropriate. Also, it was noted that, in addition, a sliding scale has not yet been created to take into account the incidence of disease.

Another concern shared by some Subcommittee members is on occasion, what is stated in the CPT Code Change Proposal (CCP) in respect to projected volume for a new service is quite different than what is included in the RUC Summary of Recommendation forms. Doctor Bothe also provided a review of the 5 questions which are currently included in the CCP for determining how commonly the service is performed.

Several Subcommittee members noted that perhaps the RUC should create a list of concerns regarding how the current process is handled. The Research Subcommittee did not make any specific recommendations.

The RUC approved the Research Subcommittee Report.

XVI. Administrative Subcommittee (Tab 43)

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

- ***Disclosures from RUC Participants/Audience***
  Doctor Bishop noted that in September 2014, the RUC requested that the Administrative Subcommittee consider conflicts for individuals that speak to issues from the audience at RUC meetings. The Subcommittee discussed this issue at the January 2015 meeting and noted that currently when participants from the audience speak at the microphone, they introduce themselves and announce any conflicts of interest/financial interests for the codes being reviewed before they make a statement. The Subcommittee stated that participants who intend to speak at the microphone should be aware of what the RUC constitutes as a conflict of interest or financial interest prior to speaking at a RUC meeting. The Administrative Subcommittee recommended identifying the financial disclosure policy on the confidentiality statement that participants sign at the registration desk.

  AMA staff along with the AMA Office of General Counsel drafted a revised confidentiality statement with the financial disclosure notice. **The Administrative Subcommittee slightly modified and recommends a revised confidentiality statement with financial disclosure notice (attached to these minutes), which all RUC participants sign at the registration desk.**

- ***Review Election of Rotating Seats Submission***
  Doctor Bishop noted that the Administrative Subcommittee reviewed the nominations for the internal medicine rotating seat and "any other" rotating seat. The Subcommittee noted that the internal medicine rotating seat had one nominee, therefore "an election will be unnecessary in the case that there is an unchallenged seat and the seat will be awarded to the candidate by voice vote."

The RUC Approved the Administrative Subcommittee Report.

XVII. Rotating Seat Elections (Tab 45)

- James L. Gajewski, MD, Hematology: American Society for Blood and Marrow Transplantation (ASBMT) was elected from hematology to the RUC's Internal Medicine rotating seat.
- Guy R. Orangio, MD, American Society of Colon and Rectal Surgeons (ASCRS) was elected to the RUC's Any Other rotating seat.

XVIII. Other Business

- The RUC discussed the validity of a survey methodology where a the "random" sample was developed by first sending an email to a randomly selected subset of a specialty society's membership asking whether the recipient performed the service in the past and if they were willing to take a survey. The survey link was then separately sent to only the subset of members that responded yes to the initial email (aka the "do-you-do letter"). Many RUC members questioned the validity of this sample methodology and stated that it would seem to be a targeted survey and that Research Subcommittee approval would be needed for a targeted survey. The RUC expressed concerns that although the members selected to receive the initial solicitation were selected randomly; a self-selection bias may be introduced when the recipient is asked if they are willing to participate. AMA staff clarified that this survey methodology has been used in the past by this specialty and others and the RUC currently does not categorize this as a targeted survey. Several RUC members stated that if it is determined that a "do you do" letter is a valid method, then the language of that letter should be uniform and approved by the RUC. The Chair clarified that although the concerns about the survey are valid, there is currently no RUC policy prohibiting specialties from conducting their surveys in this way. **The RUC referred this issue to the Research Subcommittee for review at the October 2015 RUC meeting. The Subcommittee should make a recommendation to the RUC regarding whether this methodology is valid and also if its use should require Research Subcommittee approval going forward.**
- There were a number of codes identified by CMS last summer as high expenditure codes and the codes were reviewed by the RAW in the fall. CMS delayed review of these codes when they proposed the conversion of 090-day and 010-day global codes to 000-day global codes. When CMS finalized that decision they indicated that if they were to request review of high expenditure codes in the future it may not be the same list. The RUC will wait to hear from CMS regarding high expenditure codes in future rulemaking before moving forward with the review process. For this set of codes, because they have already been through a comment period, it may be that CMS finalizes the list in the proposed rule in July. If that language is used the codes will go directly onto the LOI. Moving forward the RUC will not initiate a review based on CMS request, until the codes identified have been through a comment period and are presented as final.

- Moderate Sedation Discussion
    - A RUC member made the case that there is work associated with moderate sedation during a procedure. In order to measure this, the RUC would have to measure the intensity of it and determine how to apply that intensity.
    - A RUC member brought up the RUC staff suggestion of doing two surveys that would be identical other than that one is with moderate sedation and the other is without. This would yield a side-by-side comparison. Staff explained that using appendix G; codes were identified that were as close to 50/50 as possible, for each specialty involved. These are the codes that the survey would be administered for, so that the survey respondents would have experience with both scenarios. It was reiterated that CMS does intend to unbundle moderate sedation and the RUC needs to determine an incremental RVU to be applied when moderate sedation is inherent. The RUC policy has always been that the work of moderate sedation is in the pre-service time and now we are hearing that there is work in the intra-service time.
    - A RUC member suggested that the specialties involved conduct mock surveys for certain procedures using different methodologies and bring the results forward in October in order to determine what works and use that methodology to survey for January.
    - Materials are due to the Research Subcommittee on May 22, 2015.
- A RUC member brought up that for new technology, the RUC should be provided with not only the information provided to CPT, but also information from the manufacturer of the technology. Information from the manufacturer should include physician time, additional services provided with the technology, the company's description of physician work, and any other equipment that can be used to provide the same service.
- There are two codes that CMS has taken information directly from the vendor and those are not marked as such in the database. The RUC determined that language should be added to these codes so that they are not used to validate a RUC recommendation.
- A RUC member brought up that there is a situation in which CPT has certified a code as category I, however the RUC finds that there are not enough physicians performing it for an accurate survey to be conducted. The RUC referred the issues to RUC and CPT staff to study. Staff will bring forward recommendations at the next meeting.
- The RUC thanked Doctor Koopmann for his years of service.
- The RUC thanked Doctor Levy for her exemplary service.

The RUC adjourned at 4:30pm.

AMA/Specialty Society RVS Update Committee **Tab 39**
Health Care Professionals Advisory Committee Review Board
April 23, 2015

Members: Anthony Hamm, DC (Co-Chair), Jane White, PhD, RD, FADA (Alt. Co-Chair), Mirean Coleman, LCSW, Scott Collins, MD, Charles Fitzpatrick, OD, Mary Foto, OTR, James Georgoulakis, PhD, Emily Hill, PA-C, Eileen Moynihan, MD, Dee Adams Nikjeh, PhD, CCC-SLP, Paul Pessis, AuD, Rick Rausch, PT and Lloyd Smith, DPM

I. Introduction

The meeting was called to order at 8:00 AM. Doctor Hamm asked the members to join him in a moment of silence in remembrance of Steve Levine, PT, DPT, MSHA.

II. CMS Update

Doctor Edith Hambrick from CMS attended the HCPAC meeting and gave the HCPAC an update on recent activities at the Agency. She noted that the NPRM is in the final stages of preparation but did encourage interested stakeholders to meet with CMS if they have any issues as soon as possible.

III. New and Revised Codes

Physical Medicine and Rehabilitation Evaluation Services (CPT Codes 97161X-97168XX)
American Occupational Therapy
American Physical Therapy Association

The presenters Mary Foto, OTR, and Richard Rausch, PT, explained that the Physical Medicine and Rehabilitation codes have two components; codes that describe evaluation and codes describing interventions. They explained that only the evaluation codes were moved forward from CPT to be surveyed for the 2017 cycle. They reported that these codes will be surveyed this summer for presentation at the October RUC meeting. Currently, they are working with the Research Subcommittee on the survey instrument. CMS mentioned that they were concerned about the RSL that will be used for the survey as it has a number of E/M codes which may not represent the work of non-physician providers. The presenters agreed that this is a complicated issue noting that they will be discussing this with the Research Subcommittee. The presenters also mentioned that it was likely that only very low level E/M services would be referenced by survey respondents, something that has happened on past surveys.It ws explained that there are few services that are available for a Reference Service List as the intervention codes remain under CPT and then valuation review.

IV. Elections

Doctor Hamm announced that there were was one candidate for Co-Chair (Jane White) and one candidate for Alternate Co-Chair (Dee Adams-Nikjeh). A voice vote was taken and both candidates were approved by the HCPAC.

V. New Business

Mary Foto announced that Judy Thomas is retiring after twenty-three years of service for AOTA. Sherry Smith asked that the HCPAC members to join her in honoring Doctor Hamm's service as Co-Chair.

Members Present: Scott Manaker, MD, PhD, FCCP (Chair), Guy Orangio, MD (Vice Chair), Albert Bothe, MD (CPT), Joel Brill, MD, Neal Cohen, MD, Thomas Cooper, MD, David Han, MD, Timothy Laing, MD, Alan Lazaroff, MD, Geraldine B. McGinty, MD, Eileen M. Moynihan, MD, Margaret Neal, MD, Tye Ouzounian, MD, John Seibel, MD, Robert Stomel, DO, Thomas J. Weida, MD

I. Pre-Service Time Standards for Emergent 90 Day Global Services

At the January 2015 RUC meeting, the Practice Expense (PE) Subcommittee discussed the standard pre-service clinical staff time in the facility for emergent procedures. Upon further review it became clear that the PE Subcommittee and the RUC have previously accepted varying time elements for emergent procedures. The PE Subcommittee is concerned about the pre-service time for emergency 90 day globals since it is unlikely that clinical staff would have the opportunity to perform their pre-service activities for these services.

AMA staff searched for all emergent procedure previously valued by the RUC by querying emergency department services (99281-99285) billed together with a surgical service on the previous or same day. There are a total of thirty-six 10 and 90 day global surgical services that are billed together 50% or more with an emergency department service (99281-99285). The standard for all 10 day global codes performed in the facility is 0 minutes unless the specialty provides evidence that any pre-service time is warranted. For minimal use of clinical staff time in the facility, 15 minutes can be justified and for extensive use of clinical staff time in the facility, 30 minutes can be justified. There are seven 10 day global codes billed together 50% or more with an emergency visit on the previous or same day. The pre-service time for the seven codes is as follows: 5 (28660 & 28630), 15 (12055), 18 (41800), 20 (41250), 26 (36583) and 30 (40830) minutes. The standard for all 90 day global codes performed in the facility is 60 minutes of pre-service clinical staff time. There are twenty-nine 90 day global codes billed together 50% or more with an emergency visit on the previous or same day. Most of these codes have 60 minutes of pre-service clinical staff time in the facility, except for CPT code 44950 *Appendectomy*, which has 15 minutes of pre-service clinical staff time; CPT code 31382 *Partial laryngectomy (hemilaryngectomy); antero-latero-vertical*, which has 65 minutes of pre-service clinical staff and CPT code 29867 *Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty)*, which has 75 minutes of pre-service clinical staff time. The PE Subcommittee notes that CPT code 44960 *Appendectomy; for ruptured appendix with abscess or generalized peritonitis* is billed 49% with an emergency department service and it also has 15 minutes of pre-service clinical staff time in the facility setting.

The PE Subcommittee agreed that the 50% or greater threshold is an accurate measure of what is and is not an emergent service for the purposes of this discussion. A Subcommittee Member raised the concern that the pre-service time in the facility for codes that were thought to be emergent could have been reduced during previous reviews and that we may now know from this analysis that they would not be considered typically emergent based on the parameters that we have applied to the Medicare claims data. The Subcommittee discussed that the analysis was done to inform this discussion and that it may be necessary to do further analysis to determine what the thresholds should be moving forward and what standard should be applied. Additionally, the Subcommittee will need to determine if the RUC should apply the standard only prospectively or if it should be considered both prospectively and retrospectively. Also, the Subcommittee will

need to determine if the specialties should determine what codes are emergent or if the data will have to be analyzed for the set of codes that comes to each PE Subcommittee meeting. A Subcommittee Member also noted that there may be CPT codes that are billed with an emergency visit and are performed in the office setting. **The Subcommittee determined that a Workgroup should be formed to examine the issue. The Chair of the workgroup will be Doctor Geraldine McGinty and the members will be Doctors David Han, Alan Lazaroff, Joel Brill and Tye Ouzounian. The Emergent Procedures Workgroup will provide a recommendation to the PE Subcommittee at the October 2015 PE Subcommittee Meeting.**

II. Determining Clinical Staff Time and Equipment Minutes for Scopes

At the January 2015 PE Subcommittee meeting, during discussion of the direct practice expense inputs for endobronchial ultrasound (EBUS) (31622, 31625, 31626, 31628, 31629, 31632, 31633, 3160X1, 3160X2 and 3160X3), the PE Subcommittee considered the accuracy of the clinical staff time standards for cleaning a scope and determining the equipment minutes when there is more than one scope to clean.

The standard clinical staff time for scope cleaning is:

- 5 minutes for a disposable scope
- 10 minutes for a rigid scope
- 30 minutes for a flexible scope

The Subcommittee determined that for new CPT codes 3160X1 and 3160X2 where 2 scopes, the *fiberscope, flexible, bronchoscopy* (ES017) and *flexible dual-channeled EBUS bronchoscope* (EQ361), are used, the clinical staff time should be 60 minutes (2 flexible scopes) and the equipment time calculation for the *fiberscope, flexible, bronchoscopy* (ES017), should include 30 minutes of cleaning time as is typical and the *flexible dual-channeled EBUS bronchoscope* (EQ361) should include 60 minutes of cleaning time because it is dual channeled. The PE Subcommittee discussed the issue at this meeting, specifically if economies of scale are created when multiple scopes are used. The Subcommittee discussed the possibility of discounting the clinical staff time for cleaning from 60 minutes to 45 minutes when two scopes are used. The Subcommittee also discussed the possibility of determining a number of minutes to add when there is a second lumen on the scope. The Subcommittee heard from Gastroenterology specialists that improvements in technology have enabled machine cleaning for scopes, but that the machines take more time than an individual. The Subcommittee also discussed that scopes with additional lumens have existed for many years and that additional cleaning time has not previously been allocated. The RUC determined that it was not appropriate to make changes to the current scope cleaning standards for a small number of exceptions. The PE Subcommittee determined that scopes with additional channels/lumens should not be allocated additional cleaning time moving forward and the time will be corrected when the EBUS services are reviewed by the RUC in the future. The Subcommittee determined that no further action is needed at this time.

III. Practice Expense Recommendations for CPT 2016 and CMS Request/Relativity Assessment Identified Codes

Tab	Title	PE Input Changes
4	Soft Tissue Localization Procedures	Revisions
5	Esophagogastric Fundoplasty Trans-Oral Approach	No Revisions
6	Percutaneous Biliary Procedures Bundling	Revisions
7	Percutaneous Image-Guided Sclerotherapy of Fluid Collection	Revisions
8	Genitourinary Catheter Procedures	Revisions
9	Intracranial Endovascular Intervention	No PE Inputs
10	Paravertebral Block Injection	Revisions
11	Trabeculoplasty by Laser Surgery	Revisions
12	Retinal Detachment Repair	Revisions Standard 090 Day Global
13	Destruction/Treatment of Retinopathy	Revisions
14	Radiologic Exam Hip and Pelvis	Revisions
15	Fetal MRI	Revisions
16	Reflectance Confocal Microscopy	Revisions
17	Interstitial Radiation Source Codes	Revisions
18	Colon Transit Imaging	Revisions

Tab	Title	PE Input Changes
19	Liver Elastography	Revisions
20	Arterial Pressure Waveform Analysis	No Revisions
21	Analysis of Neurostimulator Pulse Generator System	Revisions
22	Bone Biopsy Excisional	Refer to CPT
23	Closed Treatment of Vertebral Process Fracture	Refer to CPT
25	Repair Flexor Tendon	No Revisions Standard 090 Day Global
26	Submucosal Ablation of Tongue Base	Revisions
27	Laparoscopic Radical Prostatectomy	No Revisions Standard 090 Day Global
28	Implantation of Neuroelectrodes	Revisions
29	Posterior Tibial Neurostimulation	No Revisions
30	Ocular Surface Membrane Placement	Revisions
31	Ocular Reconstruction Transplant	No Revisions
32	Glaucoma Surgery	Revisions
35	High Energy Neutron Radiation Treatment	Recommending Carrier Priced
36	Cytopathology Concentration Technique	Revisions
38	Prostate Biopsy – Pathology	Revisions

AMA/Specialty Society RVS Update Committee **Tab 41**
Relativity Assessment Workgroup
April 23, 2015

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

I. Joint CPT/RUC Workgroup on Codes Reported Together Frequently – Progress Report

Robert Zwolak, MD, provided a summary of the Workgroup's recent review of two issues from the fourth iteration of the bundled services project. The Joint Workgroup recommends that code pair 37200/75970 be removed from Group 1. Other recommendations for Group 1, accepted by the RAW in January 2015, remain unchanged. The Joint Workgroup also reviewed Group 5 – Surgical Sinus Endoscopy codes and recommended a bundled code solution for the CPT 2018 cycle.

II. Action Plan Review

CPT code 92132

CPT code 92132 was identified through the New Technology/New Services List in April 2010. In January 2015, the Relativity Assessment Workgroup requested that the specialty society submit an action plan to explain what is driving the utilization and whether other measures may be needed, such as a CPT Assistant article. The Workgroup reviewed the action plan submitted by the specialty society and noted that the utilization has grown rapidly. **The Workgroup recommends that CPT code 92132 be surveyed for October 2015, noting that it is the specialty societies' decision whether 92133 and 92134 need to be surveyed with this service.**

CPT codes 66174 & 66175

These services were identified through the New Technology/New Services List in April 2010. In January 2015, the Relativity Assessment Workgroup noted there may have been diffusion in technology for these services and requests that the specialty society survey physician work and review practice expense at the April 2015 meeting. The specialty society submitted a letter to the RUC requesting that the RAW re-review these services, remove from the New Technology list and maintain. The specialty stated that these services are very low volume. During the last 3 years 66174 has not been performed more than 403 times in the Medicare population and 66175 has not been performed more than 2,023 times in the Medicare population. The specialty also noted that survey data were not used when the RUC valued these services in April 2010. The Workgroup agreed that survey is not likely to yield more accurate valuation for these very low volume services. The Workgroup recommended that CPT codes 66174 and 66175 be removed from the New Technology/New Services list and that these services be flagged in the RUC database not to use them to validate physician work. **When the RUC reviewed this tab, they referred codes 66174 and 66175 back to the Relativity Assessment Workgroup for review in 3 years and flag in the RUC database not to use them to validate physician work.**

III. Work Neutrality Review (CPT 2012)

In February 2011, the CPT Editorial Panel deleted four codes and created four new codes, CPT codes 64633-64636, to describe neurolysis reported per joint (2 nerves per each joint) instead of per-nerve and bundled image guidance.

In June 2014, the AMA staff analysis showed that in the year 2012 the Destruction by Neurolytic Agent codes was not budget work neutral and that, during the first year of the code's existence, there was 24% more utilization than projected. Therefore, the Relativity Assessment Workgroup review was initiated for this family.

The specialty societies have indicated in their action plan that the utilization numbers for this family of codes are climbing despite the fact that each code now describes one joint (two nerves), while the codes were billed per-nerve prior to 2012. There may be physicians who are still using the code on a per-nerve and not a per-joint basis. The specialty societies developed a *CPT Assistant* article (publication date: February 2015) stressing that each of these codes now includes the entire joint (i.e. two nerves) and not just one nerve, as before. The specialty societies agreed to perform additional education through their publications on this topic.

In January 2015, the Workgroup again discussed this issue and recommended that the specialty societies submit revised introductory language to the CPT Editorial Panel to address any inappropriate coding regarding reporting per nerve instead of per joint issue for CPT 2016. The specialty societies submitted this revised introductory language immediately following the January 2015 RUC meeting. The CPT Editorial Panel is currently reviewing this submission for addition to the CPT 2016 book.

Also in January 2015, the Workgroup also requested that AMA staff compile data on how many times a service is reported on the same patient on the same day. AMA staff compiled the requested data, which show that regardless of the location (cervical, thoracic, lumbar or sacral), an average of 3 facet joints are being reported, based on 2013 Medicare utilization data. *The 2014 preliminary Medicare utilization data was not available to review at this meeting.*

The Workgroup reviewed the additional data and the specialty societies' action plan. The specialty societies noted that some increased utilization may still be due to improper coding, which will be addressed at CPT. They note that some increased utilization is clinically appropriate as physicians and patients opt for this treatment rather than chronic opioid use or more invasive surgery. The specialties also noted that recent coverage policies limit the number of procedures performed on a single patient in a single day. Fourteen specialty societies submitted recommendations for these procedures to all Medicare Contractor Medical Directors. Three Medicare Contractors in 28 states have already adopted new coverage policies based on these recommendations; it is expected that other Medicare Contractors will follow.

Some new restrictions in the performance of these procedures under the new coverage policies include:

- For each covered spinal region (cervical/thoracic or lumbar), no more than two (2) thermal RF sessions will be reimbursed in any calendar year, involving no more than four (4) joints per session.
- Repeat neurotomy procedures involving the same joint will only be considered medically necessary when the patient had ≥ 50% improvement of pain and documented improvement in patient-specific ADLs documented for at least 6 months.
- *Non-thermal RF modalities for facet joint denervation including chemical, low grade thermal energy (<80 degrees Celsius), as well as pulsed RF, are not covered.*

It is anticipated that, if properly executed, these new policies will contribute to appropriate utilization of these procedures.

The Workgroup agreed that the specialty societies have taken aggressive action to ensure correct reporting of these services. The Workgroup recommends that we allow the multiple aforementioned efforts to take effect and re-review the utilization data for these services in April 2017.

IV. CPT Assistant Analysis

At the January 2015 meeting a Workgroup member requested that the Relativity Assessment Workgroup review the effectiveness of the RUC referrals for specialty societies to develop CPT Assistant articles. AMA staff compiled the list of 38 RUC referrals for development of CPT Assistant articles in which an article was published and one year of Medicare utilization data was available.

The Workgroup reviewed these 38 services and related CPT Assistant articles. The Workgroup requests that the specialty societies submit an action plan for the following codes for the Relativity Assessment Workgroup to review at the October 2015 meeting.

CPT Code	Submit Action Plan to Address
13120-13122	Increase in utilization and effectiveness of CPT Assistant article
26080	Harvard Value, previous global change request to 000-day
50605	Appropriateness of General Surgery performing this service
52214-52240	Answer whether it is appropriate to use more than 1 fulguration code per session, whether a parenthetical needed to ensure correct reporting of these services.
63056	Harvard Value for the family of services and effectiveness of CPT Assistant article
69801	Increase in utilization and effectiveness of CPT Assistant article
73580	Increase in utilization and effectiveness of CPT Assistant article
96920-96922	Increase in utilization and effectiveness of CPT Assistant article

The Workgroup determined that:

- CPT assistant articles were almost always effective at addressing the concern. For example, utilization growth slowed for fast growing procedures.
- Occasional CPT Assistant articles do not appear to address the underlying RUC concern.
- Success or failure in curbing growth is usually apparent with 2 years of data after publication of the CPT Assistant article.

The Workgroup understands the CPT Assistant RUC liaison and staff will review draft CPT Assistant articles prior to publication to ensure address RUC concerns. The Workgroup further recommends that all referrals to CPT Assistant be reviewed for effectiveness after two years of utilization data are available.

V. 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

Joint CPT/RUC Workgroup on Codes Reported Together Frequently
Progress Report
April 2015

Joint Workgroup Members: Doctors Kenneth Brin (Chair), Albert Bothe, Kathy Krol, Walt Larimore, Geraldine McGinty, Joseph Schlecht, Mark Synovec and Robert Zwolak

AMA Staff: Maurine Dennis, Zach Hochstetler, Marie Mindeman and Sherry Smith

Background

In January 2015, the Joint CPT/RUC Workgroup on Codes Reported Together Frequently submitted a set of recommendations for six groups of code pairs billed 75% or greater on the same day by the same physician. At that time, the specialty societies involved in two groups (a single code pair from Group 1 and Group 5) requested a phone conference call with the Workgroup to further discuss their rationales, which differed from the Workgroup's initial recommendations.

On April 14, the Joint Workgroup met with the interested specialty societies. Below are the final recommendations from the Workgroup members for these two code groups. These two recommendations represent the closure of the Workgroup's work on this round of billed together data.

Code Pair Groups Recommendations Determined by the Joint Workgroup:

Group 1 – single code pair 37200/75970
The issue prompting the Group 1 discussion was that one code pair, 37200/75970, involved a code pair related to transcatheter biopsy whereas all of the other codes in Group 1 related to balloon angioplasty procedures. The Joint Workgroup members in discussion agreed with the specialties that the work described by these two codes is distinctly different from the work involved in the remainder of the Group 1 codes. Taken separately, this pair would not reach the volume or financial impact threshold for action. **The Joint Workgroup recommended that code pair 37200/75970 be removed from Group 1. The previous recommendation regarding the other code pairs in Group 1, as approved by the RAW in January 2015, would remain unchanged.**

Group 5 – Surgical Sinus Endoscopy
The issue prompting the Group 5 discussion was that the specialty felt that the sinus surgery procedures can involve bilateral procedures, the possible bundling combinations are numerous, and that the multiple procedure reduction accounts for any overlap in services—all leading to coding complexity in revising these codes. The Joint Workgroup discussed the specialty's arguments and did not find them compelling. The Workgroup members acknowledged the specialty's apprehension surrounding the potential complexity of revising this family. However numerous specialties have previously bundled complex sets of codes and it was felt that this code family could be handled similarly. Furthermore, as stated in the Workgroups initial

recommendation, the use of the MPPR is outside the scope of the Workgroup's charge and does not affect the need for bundled codes, which selectively target potential duplication of physician work. Recognizing that the procedures could be performed unilaterally or bilaterally, the Workgroup members felt that potential solutions could be created such as creating bundled codes for cases wherein two ipsilateral sinuses were treated; moreover, the current individual sinus codes could be maintained and utilized when contralateral sinuses were approached. An alternative option might be a revision of the family of codes describing these services with the objective being to eliminate duplicate work and reporting of two codes greater than 75% of the time. It would be the charge to the Specialty Societies to create the best coding solution to resolve the issue.

The Joint Workgroup recommended a bundled code solution for the family of surgical sinus endoscopy services identified in Group 5.

Timeline: CPT 2018 cycle

Respectfully submitted,

Kenneth P. Brin, M.D., Ph.D.
Chair, Joint CPT-RUC Workgroup on Codes Reported Together Frequently

AMA/Specialty Society RVS Update Committee **Tab 42**
Research Subcommittee Meeting
April 23, 2015

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 February 24, 2015 Conference Call Meeting Report

The Research Subcommittee report from the February 2015 conference call included in Tab 42 of the April 2015 agenda materials was approved without modification.

II. Requests for RSL review and Modification to the RUC Survey template

Physical Therapy and Athletic Training Evaluations
American Occupational Therapy Association
American Physical Therapy Association

The American Physical Therapy Association (APTA) requested to use a modified XXX-day survey instrument to survey PT evaluation codes 97161X-97164X, with proposed changes to make the survey instrument applicable to physical therapists. These proposed changes included modifications to the definitions of pre-service, intra-service and post-service work. **The Research Subcommittee discussed these revisions and approved the survey instrument, with the following minor modifications:**

- **Change all "Physical Therapist" language to "qualified healthcare provider" throughout the survey instrument.**

The American Occupational Therapy Association (AOTA) requested to use a modified XXX-day survey instrument to survey OT evaluation codes 97165X-97168X, with proposed changes to make the survey instrument applicable to physical therapists. These proposed changes included modifications to the definitions of pre-service, intra-service and post-service work. **The Research Subcommittee discussed these revisions and approved the survey instrument, with the following minor modifications:**

- **Change all "Occupational Therapist" language to "qualified healthcare provider" throughout the survey instrument.**

APTA requested for the Research Subcommittee to review two proposed Reference Service Lists (RSLs), one for the 3 evaluation codes (97161X-97163X) and a separate one for the 1 reevaluation code (97164X). The Subcommittee noted discomfort with the use of two separate RSLs for codes that are of the same global period and in the same family. **The Subcommittee recommends for the Specialty to combine both RSLs and to use the single RSL for all 4 codes (97161X-97164X).**

The Subcommittee had a robust discussion concerning the appropriateness of the inclusion of E/M services in the RSL, which the survey respondents do not have experience performing. The

Subcommittee acknowledged that all codes physical therapists perform are unavailable for the RSLs as they are currently under review by the RAW, so there would be no other options than to include services that physical therapists do not have experience in performing. **Therefore, given the unique circumstances, the Subcommittee recommends for the RSL to only include E/M services, though only codes that are level 3 and below.**

The Subcommittee noted that CPT code 99243 is no longer covered by Medicare and should be removed from the reference service lists. Also, the Subcommittee recommended for APTA to remove any ophthalmology services.

The Subcommittee requested for APTA to implement the changes and to resubmit to the Research Subcommittee for electronic review after the RUC meeting.

AOTA requested that the Research Subcommittee to review a single proposed RSL for all 4 of their respective codes (97165X-97168X). **The Subcommittee approved the AOTA RSL without modification.**

III. Moderate Sedation- Survey Methodology

New and revised Moderate Sedation services (991X1X-991X6X) were created at the most recent CPT meeting and will be used to report moderate sedation starting in CPT 2017. For the new base moderate sedation codes for when the same physician performs both the moderate sedation and the primary surgical procedure (991X1X, 991X2X), the Joint CPT/RUC Moderate Sedation Workgroup requested the Research Subcommittee review and consider a proposed survey methodology.

On the Moderate Sedation Workgroup's March 25th conference call, the Workgroup reviewed an initial proposed method for how to survey for when the same physician performs both the moderate sedation and the primary surgical procedure with each specialty surveying a surgical service both with and without moderate sedation. The moderate sedation survey results would be the difference between surveying the surgical service with and without moderate sedation. Workgroup members initially expressed some interest in the original presented idea, others expressed discomfort in the indirect nature of determining a derivative recommendation for moderate sedation from surveying various surgical codes both with and without moderate sedation. Others noted the logistic challenges in implementing this idea and difficulty in creating a consensus recommendation between several societies surveying different surgical procedures.

Therefore, the Workgroup requested for AMA staff to draft an example survey for consideration by the Research Subcommittee. The Workgroup decided the example survey should be a direct survey of the moderate sedation code, using a general vignette (the CPT vignette) that would be applicable regardless of the surgical service. The Workgroup had noted that, for this proposal, the physician time for moderate sedation should be measured only in the pre-service time of the primary procedure, since this is how the RUC currently assigns moderate sedation time. While the Workgroup acknowledged that there may be additional intensity in the intra-service period, they believed that it may be too difficult to articulate that intensity in valuation. The Workgroup noted that the reference service list for this survey mechanism should include codes that would be understood by most of the surveying specialties, such as E/M codes and monitoring codes.

The Research Subcommittee discussed how 991X1X and 991X2X should be surveyed and noted that the following Specialties had indicated interest in surveying these services: Anesthesiology,

Cardiology, Gastroenterology, Interventional Radiology, Pediatrics, and Vascular Surgery. **The Subcommittee discussed the draft survey instrument drafted by AMA RUC Staff for 991X1X and 991X2X, and approved the survey instrument with the following modifications:**

- **Change the word "measure" to "estimate" within the "Important" disclaimer on page 1.**
- **Include a copy of the question 2 background definition prior to the key reference service question (Q1).**

The Research Subcommittee reviewed a proposed RSL submitted by the cardiology and gastroenterology specialties. It was noted that perhaps the RSL should have a somewhat higher RVU range then 0.30 RVUs. **The Research Subcommittee agreed to conduct the review of this reference service list electronically, after the RUC meeting.** AMA staff will initiate this discussion with the Subcommittee the week following the RUC meeting.

The Research Subcommittee acknowledged that CPT codes 991X3X, 991X4X and +991X6X (when the anesthesia services is performed by a separate provider) would be surveyed using a standard RUC survey instrument, unless the surveying specialties decided to submit any proposed modifications at a later time. Therefore, discussion of these services was unneeded.

The Subcommittee discussed the original assumption that the add-on code +991X5X (each additional 15 minutes) should be valued as practice-expense only. The Subcommittee noted that the RUC rules only defines the physician work for moderate sedation services as taking place during the pre-service portion of the primary surgical procedure and valuing this add-on service would not be possible under current RUC rules. AMA staff clarified that for services in appendix G that were reviewed over the past several years were valued using the assumption that moderate sedation physician work only occurs during the pre-service portion of the primary surgical procedure.

In addition, the Subcommittee pondered if there is a different level of work intensity for a surgeon during the intra-service portion of the primary surgical procedure, whether the surgeon has their own clinical staff performing the sedation monitoring, relative to if an anesthesiologist or a CRNA is performing the monitoring.

Following a lengthy discussion, the Subcommittee did not reach a consensus. The Chair suggested that the RUC should discuss whether there should be a consideration of additional intra-service intensity for services performed under moderate sedation by the operating physician. If the RUC were to change its existing rule that the work of moderate sedation by the operating physician be incorporated in pre-service work only, then a survey would need to be developed to assess the incremental intensity only in the intra-service period for the new moderate sedation codes (both based and add-on codes).

IV. Research Subcommittee Guidelines and Requirements Document Review

Clinical Vignettes Section:

Since the last RUC meeting, several specialty staff have expressed confusion regarding what the Research Subcommittee requires in regard to existing codes that do not have a vignette in the RUC database and were not revised by CPT. AMA staff noted their concern that there is a gap in the current Research Guidelines and Requirements document in that it does not state what is

required (instead only discussing modified vignettes which are distinct from the RUC database). From the subcommittee's in-person discussion at the January meeting and from the January Research subcommittee report, AMA staff explained their understanding that the Subcommittee's intention was to have the document so that if there is no existing vignette in the RUC database, Research review is now required. A proposed red-line language was included in the materials for the Subcommittee's consideration. **The Subcommittee determined that if no vignette exists, one must be approved by the Research Subcommittee.**

Reference Service List Section:

It was noted that Global Period was accidentally omitted from the data points required for RSL requests. **The Subcommittee approved this correction as proposed.**

Modifications to Standard RUC Survey Templates Section:

The current text of the document does not technically allow for societies to change the term "physician" to a term that would be appropriate for their members, so certain HCPAC societies would need to request a modified survey template every time they want to perform a survey. As this seems burdensome on both the societies and Research, proposed language was included in the materials for the Subcommittee's consideration. **The Research Subcommittee reviewed this proposed change and determined that it would instead be more appropriate to amend the proposed language so that specialties could only change the survey instrument without approval to replace "physician" with "a qualified healthcare provider". The Subcommittee approved this proposal, following this modification.**

Proposed Definitions:

At the January meeting, the Subcommittee requested for AMA staff to list definitions for terms used in the document, giving "targeted" and "random" as examples, for the Subcommittee's review at its April 2015 meeting. AMA Staff included the draft language as a footnote on page two of the proposed document for the Subcommittee's review and consideration. As many of the terms used are defined in other RUC materials, the draft language only includes proposed definitions for "random sample" and "targeted sample". **The Research Subcommittee agreed that the below proposed definitions will need to undergo further Subcommittee review at the October 2015 meeting prior to the Subcommittee makes a recommendation on implementation:**

- *Definition of a Random Sample/Random Survey:* A randomly selected subset of a society's general US membership, excluding members of the society's Advisory Committee. This subset should include only physicians or other qualified healthcare professionals from the appropriate Specialtie(s) with available email addresses. Each individual in the subset is chosen randomly, such that each individual has the same probability of being chosen.

- *Definition of a Targeted Sample:* Any sampling method which falls outside the definition of a Random Sample.

Research Subcommittee Request for AMA Staff to research targeted sample approval trends:

At the January 2015 RUC meeting, a Research Subcommittee member requested for AMA staff to analyze the Subcommittee's approval rate and review frequency for targeted survey sample

requests over the past few years. AMA staff noted that, over the past 3 years, the Subcommittee has approved specialty society targeted sample requests without modification 92 percent of the time (34/37 tabs). On average, the Subcommittee reviewed 4 targeted sample requests per RUC meeting.

V. Other Business

Overview of Updates to RUC Online Survey Tool and Process – Information Only

The Chair noted that an overview of updates to the online tool are provided in the agenda packet. The survey tool is currently being used by on average approximately half of all survey tabs of surveying societies at each meeting; there is no set date for when the tool will be mandatory for all societies to use.

Doctor Levy explained that the rationale for rolling out this centralized RUC survey process eventually to all specialties was largely to respond to concerns expressed by the public and to make the process as transparent, accountable and consistent as possible. Doctor Levy noted that we should make sure that the RUC survey process is as transparent of a process as possible and that we can explain this to the public. This issue directly relates to the continued validity of the RUC process. **All specialties are strongly encouraged to use the Qualtrics survey tool for all future surveys.**

Potential Issues Concerning Newly Created CPT Codes

Several Research Subcommittee members expressed concern regarding the influx over the past few years of new CPT codes being sent to the RUC that nationally have very few physicians trained in the performance of these services. Doctor Bothe, the CPT liaison to the RUC, noted that this concern has come up several times with the CPT Editorial Panel and that the Panel has struggled with if there should be an absolute volume threshold. There are many challenges which inhibit the CPT Editorial Panel's ability to appropriately determine an absolute minimum volume threshold, and that doing so may not necessarily be appropriate. Also, it was noted that, in addition, a sliding scale has not yet been created to take into account the incidence of disease.

Another concern shared by some Subcommittee members is on occasion, what is stated in the CPT Code Change Proposal (CCP) in respect to projected volume for a new service is quite different than what is included in the RUC Summary of Recommendation forms. Doctor Bothe also provided a review of the 5 questions which are currently included in the CCP for determining how commonly the service is performed.

Several Subcommittee members noted that perhaps the RUC should create a list of concerns regarding the current process is handled. The Research Subcommittee did not make any specific recommendations, though some Subcommittee members indicated they may bring these issues up during the RUC meeting under *Other Business*.

AMA/Specialty Society RVS Update Committee **Tab 43**
Administrative Subcommittee
Via E-mail
April 2015

Members: Doctors Michael Bishop (Chair), Margaret Neal (Vice Chair), Margie Andreae, Dale Blasier, Ronald Burd, Anthony Hamm, DC, J. Leonard Lichtenfeld, William Mangold, Jr., David Regan, Joseph Schlecht and James Waldorf.

I. Disclosures from RUC Participants/Audience

In September 2014, the RUC requested that the Administrative Subcommittee consider conflicts for individuals that speak to issues from the audience at RUC meetings. The Subcommittee discussed this issue at the January 2015 meeting and noted that currently when participants from the audience speak at the microphone, they introduce themselves and announce any conflicts of interest/financial interests for the codes being reviewed before they make a statement. The Subcommittee stated that participants who intend to speak at the microphone should be aware of what the RUC constitutes as a conflict of interest or financial interest prior to speaking at a RUC meeting. The Administrative Subcommittee recommended identifying the financial disclosure policy on the confidentiality statement that participants sign at the registration desk.

AMA staff along with the AMA Office of General Counsel drafted a revised confidentiality statement with the financial disclosure notice. **The Administrative Subcommittee slightly modified and recommends the following revised confidentiality statement with financial disclosure notice, which all RUC participants sign at the registration desk.**

II. Review Election of Rotating Seats Submission – Tab 45

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

CPT/RUC Moderate Sedation Workgroup
Conference Call Report March 25, 2015

Members Present: Doctors Albert Bothe (Co-Chair), Amr Abouleish, Michael Bishop, David Ellington, Kathy Krol, Glenn Littenberg, David O'Brien, Guy Orangio, Julia Pillsbury, James Startzell, James Waldorf and Richard Whitten

I. Call to Order and Introductions

The meeting was called to order at 7:00 PM CST. Doctor Bothe discussed the logistics of the workgroup call this evening. He also reminded the group of the confidentiality of the call noting that all were welcome to participate on the call asking only that each caller identify themselves prior to speaking.

II. Review and Approval of December Conference

The minutes of the February Conference Call were approved with no changes by the Workgroup.

III. Review and Discussion of Appendix G Analysis

Doctor Bothe asked staff to describe the Appendix G Analysis that was circulated to the Workgroup. It was explained that this document was updated to reflect the review of pre-service packages in the table. Specifically, specialties were asked to provide a proxy on which pre-service package was appropriate for a particular service. It was reported that although the response was robust with feedback received from specialty societies representing gastroenterology, cardiology, radiology and pulmonology, there are still approximately a dozen codes for which there is no proxy. The goal is to have all of that information completed. Additionally, there were a couple of instances where the Workgroup needed to review the response. For example, existing pre-service time package of 1b or 2b should be retained, rather than modified when assigning proxies to codes without assignment. Staff were directed to contact general surgery and radiology to resolve the difference of opinion on one code, 36590. RUC staff will work with the specialties to resolve those issues and the changes will be reflected on the updated Appendix G Table. The table was also updated with a column that describes how often anesthesia is reported the same day as the primary surgical code. The Workgroup did not have any modifications to the input provided by the specialty societies and it will, therefore, be incorporated in this attached completed analysis. Since some of this information was added after the meeting materials were sent, this document will be circulated again to everyone for their review.

It was noted by a member of the Workgroup that if a society disagrees with a package that was previously assigned, the issue would have to be sent to the RUC for consideration. A concern was raised regarding whether or not specialty societies were content with the overall approach of assigning proxy pre-service time packages. For the purposes of this assignment, RUC staff reported that were not any problems getting the needed information back from the specialties and no group had objected to the assignment of proxies.

IV. Valuation Process for Stand-Alone Codes
Sample Survey Instrument for Moderate Sedation Codes

During the last Workgroup call, there was discussion of the development of a specialized survey instrument that measures the different components of the administration of moderate sedation using the newly created separately-reportable codes. AMA staff gave an overview of a table included in the materials, sharing initial assumptions for who would survey what codes and also

that the +991X5X add-on code would be practice-expense only. One stakeholder questioned why +991X5X was assumed to be PE only. A Workgroup member clarified that CPT only intended for the code to capture practice expense, since the added physician time would already be incorporated into the primary surgical procedure. RUC staff noted that this table was meant as information only and elaborated that any society could survey any code if it would be likely to impact them. RUC staff noted that for the survey codes that would be used for when a separate physician performs the anesthesia service (991X3X, 991X4X and +991X6X), the specialties involved could likely use the standard RUC survey instrument, and if any modifications were necessary, those societies would be expected to make a revision request to the Research Subcommittee for the April Subcommittee meeting.

For the new base moderate sedation codes for when the same physician performs both the moderate sedation and the primary surgical procedure (991X1X, 991X2X), one prior idea that the Workgroup and the Research Subcommittee had previously expressed interest in discussing further was to develop a tool that compared the difference between providing a surgical service with moderate sedation versus with anesthesia services (ie, with an anesthesia professional reporting an anesthesia code). AMA staff provided an overview of a demo example survey and other materials to show how this idea could potentially be implemented. AMA staff also gave an overview of an analysis of the codes in Appendix G which code had the largest proportion of submitted anesthesia claims on the same date. A survey using these codes as the "vignette" may provide one way to measure the incremental work of performing moderate sedation.

Although some Workgroup members initially expressed some interest in the original presented idea, others expressed discomfort in the indirect nature of determining a derivative recommendation for moderate sedation from surveying various surgical codes both with and without moderate sedation. Also, others noted the logistic challenges in implementing this idea and difficulty in creating a consensus recommendation between several societies surveying different surgical procedures. The Workgroup determined that the survey should instead be a direct survey of the moderate sedation code, using a general vignette (the CPT vignette) that would be applicable regardless of the surgical service. The Workgroup noted that the physician time for moderate sedation should be measured only in the pre-service time of the primary procedure, since this is how the RUC currently assigns moderate sedation time. While the Workgroup did acknowledge that there may be additional intensity in the intra-service period, they believe that it may be too difficult to articulate that intensity in valuation. The Workgroup noted that the reference service list for this survey mechanism should include codes that would be understood by most of the surveying specialties, such as E/M codes and monitoring codes.

After a robust discussion, the Workgroup agreed that this approach is more straightforward and appropriate. The Workgroup requested for AMA staff to draft a new demo survey instrument for its review and for submission to the Research Subcommittee. Doctor Littenberg agreed to work with RUC staff to develop an example survey instrument which will include a Reference Service List (RSL). An updated version of a draft example survey will be reviewed by the RUC Research Subcommittee at their April 23rd meeting. Materials for Research Subcommittee review must be complete by March 31.

V. Open Discussion

Staff reported that there have been some comments received from cardiology on the overall scope of the moderate sedation project. Specifically, there is concern regarding Appendix G. Cardiology would like Appendix G to stay in place and only codes where moderate sedation is no longer the dominant method of sedation be removed. Cardiology has submitted a request for reconsideration to the CPT Editorial Panel. RUC staff clarified that the current moderate sedation proposal will not be implemented until CPT 2017. The Workgroup did not agree with this approach and noted that for even codes with a low percentage of anesthesia claims paid on the same date, a duplicate payment remained an issue. When CMS staff received an inquiry about the Agency's position on the scope of the project, staff indicated that cardiology, or other interested parties, should express their concerns and suggestions to the Agency to consider in rulemaking.

Staff will circulate updated survey documents, Appendix G table and CMS NPRM Rule language for review and information.

AMA/Specialty Society RVS Update Committee **Tab 06**
Percutaneous Biliary Procedures Bundling
Facilitation Committee #3

Members Present: Stanley Stead (Chair), Scott Collins, DiSesa, Charles Fitzpatrick, Alan Lazaroff, Len Lichtenfeld, and James Waldorf

The Facilitation Committee re-discussed the concerns many within the committee and the RUC as a whole had with the specialties' survey results for this series of codes. Specifically, the committee noted the median intra-service times for 475XX2, 475XX3 and 475XX4 all have identical intra-service time of 60 minutes, rendering the survey data suspect. CPT code 475XX3 includes the work of X2 plus the work of an additional access and drain placement. Furthermore, 475XX4 includes the work of X3 plus the work of crossing the occlusion and placement of an internal/external drain. Given this physician time anomaly, the committee struggled to arrive at accurate values for the entire set of services, since nearly the entire family consists of incremental work in addition to these base codes.

The specialties agreed that the survey data was inadequate and agreed with the Facilitation Committee that a complete re-survey of this tab at the October 2015 RUC meeting was necessary to ensure accurate values for this complex family of services. However, since this April meeting represents the closing of the CPT 2016 cycle, interim values are recommended below.

The Facilitation Committee carefully considered each code and agreed that these recommendations represent the best magnitude estimates available given the survey limitations.

- For 475XX1 and 475XX3, the committee agreed with the specialties that the survey data was accurate and the survey median times and survey 25th percentile work RVUs were recommended.
- For 475XX2 and 475XX4, the survey data was felt to be inadequate and direct crosswalks were used to determine physician work and time (see table).
- For 475XX5, X6, X7 and X11, the committee agreed with the specialties that the survey data was accurate and the survey median times and survey 25th percentile work RVUs were recommended.
- Since 475XX8, X9 and X10 include the work of the above codes in addition to the work involved in the add-on codes, special attention was made to ensure relativity was correct, resulting in a direct crosswalk for X8 and median work value for X10.
- For 475XX12, X13 and X14 the committee developed interim values as noted in the table.

	Interim			
CPT	**Intra Time**	**Recommended work RVU**	**Physician Work**	**Rationale**
475XX1	20	1.80	Contrast injection through existing access	**Time** = median **wRVU**= 25th
475XX2	40	4.25	New access to bile duct + contrast injection	**Time**= 25th/direct crosswalk to 49405 **wRVU**= direct crosswalk to 49405, lower than survey 25th
475XX3	60	6.00	X2 + additional access + drain placement	**Time** = median **wRVU**= 25th
475XX4	78	8.03	X3 + crossing occlusion + placement of int-ext drain	**Time**= direct crosswalk to 43265 **wRVU**= direct crosswalk to 43265, b/t survey 25th and median
475XX5	45	4.50	X4 – X3 + X6 (drain exchange)	**Time** = median **wRVU**= 25th
475XX6	30	2.88	X1 + tube exchange	**Time** = median **wRVU**= 25th
475XX7	20	1.83	X1 + drain removal	**Time** = median **wRVU**= 25th
475XX11	60	5.61	X4 – drain placement	**Time** = median **wRVU**= 25th
475XX8	55	6.60	X6 + balloon dilatation (X12) + stent placement	**Time**= median **wRVU**= direct crosswalk to 43262, b/t survey 25th and median
475XX9	80	9.00	X11 + balloon dilatation (X12) + stent placement	**Time** = median **wRVU**= 25th
475XX10	90	12.00	X4 + balloon dilatation (X12) + stent placement	**Time** = median **wRVU**= median
475XX12	35	3.28	Balloon dilation of biliary duct(s) *(ZZZ add-on)*	**Time**= median **wRVU**= direct crosswalk to 37185, lower than 25th
475XX13	43	3.51	Endoluminal biopsy(ies) of biliary tree *(ZZZ add-on)*	**Time** = median **wRVU**= 25th
475XX14	60	4.74	Removal of calculi/debris from biliary duct *(ZZZ add-on)*	**Time** = median **wRVU**= 25th

AMA/Specialty Society RVS Update Committee **Tab 07**
Percutaneous Image-Guided Sclerotherapy of Fluid Collection
Facilitation Committee #1

Members Present: George Williams (Chair), Robert Kossmann, Walt Larimore, Charles Mabry, Greg Przybylski, Sandra Reed, David Regan and Samuel Smith

491XX1 Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed

The Facilitation Committee discussed the physician work of this procedure and agreed that CPT code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed* (work RVU= 2.78, intra time= 30 minutes) accurately reflects the physician work involved in the surveyed code 491XX1. Given that the survey respondents overvalued this procedure with an estimated 25th percentile of 4.19 work RVUs, the Facilitation Committee accepted a direct crosswalk of 2.78 work RVUs from 31622 to 491XX1.

The Committee approved this crosswalk for several reasons. First, this code is an MPC code which had its work value approved in 2010. Second, the clinical nature of this reference code is analogous to the surveyed code, as both are diagnostic studies with imaging included as well as performing an analogous procedure (e.g. cell washing compared with scelerosant injection). Finally, this crosswalked value appropriately accounts for the physician work in 491XX1 which involves the sclerosant injection procedure step repeated three separate times. **Due to the length and intensity of this procedure, the Facilitation Committee recommends a direct crosswalk of 2.78 work RVUs for CPT code 491XX1.**

Tab 17 Interstitial Radiation Source Codes
Facilitation Committee #2

Members Present: Marc Raphaelson, MD (Chair), Michael Bishop, MD, David Hitzeman, DO, Charles Koopmann, MD, Steven Krug, MD, Margaret Neal, MD, Chad Rubin, MD, Joseph Schlecht, DO, Peter Smith, MD, Jane White, PhD, RD, FADA, LDN

77778 Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed

The Facilitation Committee heard a detailed overview of the service under review. The specialty society review noted that the following professionals are present during the performance of this procedure: radiation oncologist, radiation physicist, urologist, and anesthesiologist. The Committee is convinced that each professional performs separate work, and all may be working at the same time.

The Committee agreed with the Specialty that the current pre-service, intra-service and post-service descriptions of work in the Summary of Recommendations Form (SOR) for survey code 77778 do not include the work of anyone but the radiation oncologist. The Specialty also shared a copy of an excerpt from the Federal Registrar and explained that, following when the urology code 55875 was last reviewed by the RUC (1995), the Federal Registrar in 1996 clarified that the placement of radiation seeds work for 77778 is solely done by the radiation oncologist.

The Specialty agreed to clarify at RAW the work processes for treatment of prostate cancer with interstitial radiation. Codes performed for this therapy include those listed below. The Specialty will explain which work is done by which provider. The Specialty will also clarify when the work is done, and when it is billed.

- *55875: Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy*
- *77332: Treatment devices, design and construction; simple (simple block, simple bolus)*
- *77333: Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)*
- *77334: Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)*
- *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 Specialty and the Committee recommend using **pre-time package of 1B, modified to reallocate one minute from positioning to evaluation. The times for the procedure would be 20 minute pre-service evaluation, 0 minutes of pre-service positioning, 5 minutes of S/D/W, 90 minutes of intra-service time and 30 minutes of post-service time (standard post-time package of 9A). The Committee supports the median survey RVU of 8.78.** This results in IWPUT 0.085, which is consistent with urology CPT code 55875 at IWPUT 0.0948 and the current 77778 IWPUT of 0.0936.

The Committee did not require revision of 77790 *Supervision, handling, loading of radiation source (Do not report 77790 in conjunction with 77778)* as a PE-only code. The Committee did not require changes to the Practice Expense for either code, as previously modified by the Practice Expense Subcommittee.

In summary, the Facilitation Committee recommends a work RVU of 8.78, a pre-service time of 25 minutes, an intra-service time of 90 minutes and a post-service time of 30 minutes for CPT code 77778. The Committee also recommends that 77790 should be practice-expense only. Finally, the Committee also recommends the referral of CPT codes 55875, 77332, 77333, 77334, 77318 to the Relativity Assessment Workgroup for review of potential duplicative work among these codes.