AMA/Specialty Society RVS Update Committee
Renaissance Hotel – Chicago, Illinois
April 27-May 1, 2016

Minutes

I. Welcome and Call to Order

Doctor Peter Smith called the meeting to order on Thursday, April 28, 2016 at 3:00pm. The following RUC Members were in attendance:

Peter K. Smith, MD
Margie Andreae, MD
Michael D. Bishop, MD
James Blankenship, MD
Robert Dale Blasier, MD
Albert Bothe, MD
Ronald Burd, MD
Scott Collins, MD
Thomas Cooper, MD
Gregory DeMeo, MD
Jane Dillon, MD
Verdi DiSesa, MD
James Gajewski, MD
David F. Hitzeman, DO
Walter Larimore, MD
Alan Lazaroff, MD
M. Douglas Leahy, MD
Scott Manaker, MD
Geraldine McGinty, MD
Margaret Neal, MD
Guy Orangio, MD
Gregory Przybylski, MD
Marc Raphaelson, MD
Joseph R. Schlecht, DO
Stanley Stead, MD
James Waldorf, MD
Jane V. White, PhD, RD, FADA
Jennifer L. Wiler, MD
George Williams, MD

Amr Abouleish, MD, MBA*
Allan Anderson, MD*
Gregory L. Barkley, MD*
Eileen Brewer, MD*
Jimmy Clark, MD*
Joseph Cleveland Jr., MD *
William D. Donovan, MD *
Jeffrey Edelstein, MD*
William Fox, MD*
Michael J. Gerardi, MD*
David Han, MD*
Peter Hollmann, MD*
John Lanza, MD*
Mollie MacCormack, MD, FAAD*
Paul Martin, DO, FACOFP *
Daniel Nagle, MD*
Dee Adams Nikjeh, PhD, CCP-SLP*
Scott Oates, MD*
Sandra Reed, MD*
Christopher Senkowski, MD, FACS*
M. Eugene Sherman, MD*
Samuel Silver, MD, PhD*
Norman Smith, MD*
Holly L. Stanley, MD*
Robert J. Stomel, DO*
G. Edward Vates, MD*
Thomas Weida, MD*
Adam Weinstein, MD*

*Alternate

II. Chair's Report

- Doctor Smith welcomed everyone to the RUC Meeting.

- Doctor Smith welcomed the Centers for Medicare & Medicaid Services (CMS) staff and representatives attending the meeting, and asked that Doctor Hambrick introduce the staff during her update.

- Doctor Smith welcomed the following Contractor Medical Directors:
  - Charles Haley, MD, MS, FACP

- Doctor Smith welcomed the following Members of the CPT Editorial Panel:
  - Albert Bothe, MD – Departing as CPT RUC Member
  - Kathy Krol, MD – Panel Member Observer, Incoming CPT RUC Member
  - Kenneth Brin, MD – CPT Panel Chair

- Doctor Smith recognized departing RUC members:
  - Thomas Cooper, MD
  - Robert Kossmann, MD
  - Geraldine McGinty, MD
  - Joseph Schlecht, MD

- Doctor Smith welcomed the following Researcher:
  - David Chan, MD, PhD
    - Assistant Professor of Medicine, Stanford School of Medicine

- Doctor Smith welcomed the following Researcher:
  - Armando Lara-Millan, PhD
    - RWJF Scholars in Health Policy Research Program University of California, Berkeley/UCSF
    - Proposed a scientific publication related to his observations of the RUC process.
    - All observations de-identified, publication to be reviewed by AMA
    - Publication to be delayed by 1 year, so that code values will be finalized
    - Individual interviews will be accompanied by individual consent, and will be voluntary

- Doctor Smith discussed a meeting with Sean Cavanaugh from CMS on March 23, 2016
  - Progress and Next Steps – Non Face-to-Face Services/Care Collaboration
  - Physical Medicine and Rehabilitation Update/Discussion
  - RUC Recommendations on Data Collection for Services in Surgical Global Periods
  - Importance of Intensity in Valuation

- Doctor Smith reviewed the agenda items under Other Business:
  - Time and Intensity
    - The RUC will continue to elaborate the importance of time and intensity in the RUC recommendations letter with our next submission to CMS
    - ACOG Letter to CMS included in the agenda materials (Tab 54) concerning time and intensity when valuing services
    - ACS Letter to the RUC to discuss scrub, dress and wait intensity (RUC will discuss under other business)

- Doctor Smith explained the following RUC established thresholds for the number of survey responses required:
  - Codes with $\geq$1 million Medicare Claims = **75 respondents**
  - Codes with Medicare Claims from 100,000 to 999,999 = **50 respondents**
  - Codes with <100,000 Medicare = **30 respondents**

- Surveys below the established thresholds for services with Medicare claims of 100,000 or greater will be reviewed as interim and specialty societies will need to resurvey for the next meeting.

- Doctor Smith 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 Smith 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 Smith laid out the following procedural guidelines related to specialty society staff/consultants:
  - Specialty Society Staff or Consultants should not present/speak to issues at the RUC Subcommittee, Workgroup or Facilitation meetings – other than providing a point of clarification

- Doctor Smith laid out the following procedural guidelines related to commenting specialty societies:
  - In October 2013, the RUC determined which members may be "conflicted" to speak to an issue before the RUC:
    1) a specialty surveyed (LOI=1) or
    2) a specialty submitted written comments (LOI=2).
    RUC members from these specialties are not assigned to review those tabs.
  - The RUC also recommended that the RUC Chair welcome the RUC Advisor for any specialty society that submitted written comments (LOI=2), to come to the table to verbally address their written comments. It is the discretion of that society if they wish to sit at the table and provide further verbal comments.

- Doctor Smith shared the following guidelines related to voting:
  - RUC votes are published annually on the AMA RBRVS website each November for the previous CPT cycle.
  - The RUC votes on every work RVU, including facilitation reports
    To insure we have 28 votes, please share voting remotes with your alternate if you step away from the table
  - 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 Smith 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

Sherry L. Smith, MS, CPA, Director of Physician Payment Policy and Systems, AMA provided the following Director's Report:

- The RUC Database has been updated to include 2015 Medicare Claims data. Please ensure you have downloaded the most recent version.

IV. CPT Editorial Panel Update

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

- The CPT Editorial Panel last met in Miami in February and reviewed 29 tabs.
- The telehealth workgroup approved a new modifier which can be attached to certain CPT codes to indicate synchronous telehealth care. Likewise a new appendix will be included in the CPT book to list the approved codes which the modifier can be used with.
- The CPT also considered the status of Category II codes and opted to maintain these codes for the time being.
- Doctor Rubin was the RUC representative to the CPT and the CPT continues to welcome any RUC members who wish to attend.
- Doctor Kathy Krol will be taking over as the CPT liaison to the RUC moving forward as Doctor Bothe has completed his 8 year term limit.

V. Approval of Minutes from January 2016 RUC Meeting

- The RUC approved the January 2016 RUC Meeting Minutes as submitted.

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

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

- Doctor Hambrick introduced staff from CMS attending this meeting:
  - Edith Hambrick, MD - CMS Medical Officer
  - Donta Henson – Analyst, Division of Practitioner Services
  - Ryan Howe – Director, Division of Practitioner Services
  - Steve Phurrough, MD - CMS Medical Officer
- Doctor Hambrick announced that the Agency is working on the notice of proposed rulemaking (NPRM). Comments have been provided and any additional ones should be given to CMS as soon as possible.

VII. Contractor Medical Director Update (Informational)

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

- Medicare consists of many drug benefits and problems often occur at the intersection of these benefits. Discussions have occurred regarding prolonged drug infusions that start at in a physician's office, complete outside of a physician's office, and then the equipment is subsequently returned to the physician's office. There is currently ambiguity regarding where to categorize this since the patient is not under continuous physician observation. CMS has released information for the CMDs on how to pay for these infusions and review of this guidance is underway.

VIII. Washington Update (Informational)

Sandy Marks, AMA staff, provided an update on MACRA:

- The proposed rule for MACRA was posted and is currently under review by the AMA team.
- A presentation was given to explain the changes that MACRA introduces:
    - MACRA permanently eliminated SGR, establishes a path for alternative payment models (APMs), and consolidates reporting programs (MIPS).
    - MIPS is comprised of four components: 1) Quality Measurement; 2) Resource Use; 3) EHR Meaningful Use; and 4) Clinical Practice Improvement Activities.
    - Discussions at this meeting will further elaborate on requirements and options for participation via APMs. An AMA resource, "A Guide To Physician-Focused Alternative Payment Models", is available online at: http://www.ama-assn.org/ama/pub/advocacy/topics/medicare-alternative-payment-models.page.
    - Recent MACRA Requests for Information include: 1) Quality Measure Development Plan; 2) Episode Groups; 3) Patient Condition Groups; and 4) Patient Relationship Codes.
- Additional resources about MACRA are available online: www.ama-assn.org/go/medicarepayment.

IX. Medicare Spending and Utilization Growth for 2015 (Informational)

Dr. Kurt Gillis, AMA staff, provided an update on Medicare Physician Payment Schedule - Spending and Utilization Growth for 2015:

- A presentation was given to review the analysis of Medicare Physician/Supplier Procedure Summary files (PSPS):
    - Estimates are based on claims processed through December 31, 2015 (>92% complete).

- General trends show that spending increased 0.8% due to: a decrease in pay (-0.4%); increase in fee-for-service enrollment (0.2%); and increase in utilization per enrollee (1.0%). Overall, 2015 was another year of low spending and utilization growth

- Imaging, Evaluation & Management, Procedure, and Test -specific spending trends were discussed.

Dr. Gillis presentation is attached to these minutes.

X. Relative Value Recommendations for *CPT 2018:*

Psychiatric Collaborative Care Management Services (Tab 4)
Jeremy S. Musher, MD (APA); Sherry Barron-Seabrook, MD (AACAP); Jennifer Aloff, MD (AAFP); Mary Newman, MD (ACP); John Agens, MD (AGS)

In February 2016, the CPT Editorial Panel created three new codes to describe a model for providing psychiatric care in the primary care setting. This code set is one of several in response to a request from CMS to facilitate appropriate valuation of the services furnished under the Collaborative Care Model (CoCM). This CoCM is used to treat patients with common psychiatric conditions in the primary care setting through the provision of a defined set of services which operationalize the following core concepts: 1) Patient-Centered Team Care/Collaborative Care; 2) Population-Based Care; 3) Measurement-Based Treatment to Target; and 4) Evidence-Based Care.

The RUC reviewed the new code set for Psychiatric Collaborative Care Management, which captures a primary care physician working with a behavioral health manager and consulting psychiatrist to manage patient psychiatric care. The specialty societies requested that this issue be deferred until the October 2016 RUC meeting. The RUC noted that an Ad Hoc Workgroup has been created to provide feedback and guidance to the specialties involved to appropriately survey this code set. The Workgroup will review the unique survey plan before it goes to the Research Subcommittee for approval. **The RUC recommends deferral of the valuation of CPT codes 99492, 99493, and 99494 to the October 2016 RUC meeting.**

Cognitive Impairment Assessment and Care Plan Services (Tab 5)
Jennifer Aloff, MD (AAFP); Kevin Keber, MD (AAN); Donna Sweet, MD (ACP); John Agens, MD (AGS); Robert Zorowitz, MD (ACP); Jeremy Musher, MD (APA)

In February 2016, the CPT Editorial Panel added a new code to describe an evidenced based cognitive service. This was one of several in response to a CMS request to capture cognitive service codes not currently described by Evaluation and Management (E/M) services. This service is provided when a comprehensive evaluation of a new or existing patient exhibiting signs of cognitive impairment is required to establish a diagnosis etiology and severity for the condition. The service includes a thorough evaluation of medical and psychosocial factors potentially contributing to increased morbidity. Typically, these patients are referred by a primary caregiver. There are ten required elements for the service, and all ten must be performed in order for the code to be reported. This service includes two distinct activities, assessment of the patient and establishment of care plan that is shared with the patient and caregiver, along with education. It is important that all elements are performed to be able to report this code. Other face-to-face E/M codes cannot be reported on the same date as this service to prevent any overlap with E/M codes.

99483 ***Assessment of and care planning for the patient with cognitive impairment***
The RUC reviewed the survey results from 165 practicing physicians. 91% of respondents found the vignette to be typical, and a median performance rate of 20 demonstrated the respondents were very familiar with the service. These respondents agreed with the following physician time components: pre-service time of 15 minutes, intra-service time of 50 minutes and immediate post-service time of 20 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey median work value of 3.44 is appropriate for the physician work required to perform this service. The RUC compared the surveyed code to a key reference code 99327 *Domiciliary or rest home visit for the evaluation and management of a new patient* (work RVU= 3.46, pre-service time=15 minutes, intra time= 50 minutes, and immediate post time=25 minutes) and noted that this code has identical pre and intra-service time and slightly higher post-service time justifying the slightly higher work value. The RUC also considered comparisons with CPT code 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.* (work RVU=3.17, pre-service time of 7 minutes, intra-service time of 45 minutes, and immediate post-service time of 15 minutes) and CPT code 99235 *Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.* (work RVU=3.24, pre-service time of 14 minutes, intra-service time of 50 minutes, and immediate post-service time of 19.5 minutes). **The RUC recommends a work RVU of 3.44 for CPT code 99483.**

Practice Expense:
A detailed discussion occurred where it was considered that this service is different than most in terms of PE, because it can be billed every 180 days, and the RUC took into account potential overlap with E/M services that could be billed during this time period. The clinical staff type was revised so that, rather than a RN/CORF (L051C), the standard clinical staff type of a RN/LPN/MTA (L037D) is utilized, except where the scope of practice and clinical abilities of a RN is required, and in those instances, a RN (L051A) was recommended. In the pre-service period, the RUC approved that the standard three minutes for a phone call was not adequate and determined that it should be 6 minutes to ensure that the caregiver is aware and has available all the appropriate reports and paperwork that should accompany the patient to the visit. In the service period, there is 15 minutes of clinical staff time overlapping with 15 minutes of the physian work, because both are in the exam room with the patient and the caregiver. Following that, the clinical staff and the caregiver leave the exam room while the physcian stays with the patient and completes the physical exam. During this time, the clinical staff meets separately with the the caregiver for 15 minutes to discuss the care necessary for the patient and to assess if the caregiver is capable of providing for the needs of the patient. At the conclusion of this work, the physcian and the clinical staff meet for 4 minutes to briefly discuss the care plan, and

the clinical staff proceeds to draft the care plan while the physician does other work. The physician and clinical staff then reconvene to meet with the caregiver and patient to share the plan and educate speficially on medical and medication issues for 7 minutes. Then the physician will leave, and the clinical staff meets with patient and caregiver for an additional 10 minutes. During this time, the patient and caregiver have time to ask additional questions and review the care plan again. It is typical that once the physician leaves, there are logistical questions or repeated items. Educating the patient and caregiver is complex, as the caregiver is going to need to agree to do things and ask questions; this time is necessary so as not to rush and ensure the care plan can will be carried out. In the post-service period, 9 minutes of clinical staff time was allocated for 3 phone calls, modeled after CPT code 99205. The RUC approved the direct practice expense inputs with modifications as approved by the Practice Expense Subcommittee.

Diagnostic Bone Marrow Aspiration and Biopsy (Tab 6)
David Regan, MD (ASCO); Elizabeth Blanchard, MD (ASCO); Michael Lill, MD (ASBMT); Jonathan Myles, MD (CAP)
Facilitation Committee #3

In the NPRM for 2016, CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 38221 was one of the services identified in this screen.

Prior to the January 2016 RUC meeting, the specialty societies notified the RUC of their plan to submit a code change application to the CPT Editorial Panel to revise these services. The societies indicated their plan to improve nomenclature for these codes (ie diagnostic vs therapeutic use) and to create a CPT code to replace code G0364. At the February 2016 CPT meeting, the CPT Editorial panel created one new code to replace the existing G code and revised the descriptors for CPT codes 38220 and 38221.

Compelling Evidence
The specialty societies presented compelling evidence for code 38220. They noted that the physician work and times have changed relative to the amount and types of specimens that are obtained today which are greater in number than in 1995 when 38220 was discussed at the first Five-Year review. The specialty societies noted that due to advances and greater access to immunophenotyping techniques and simultaneous refinements in cytogenetic methods and molecular diagnostics, the number of tests performed has increased, necessitating more passes to obtain additional bone marrow aspirate and material. The RUC agreed with the specialty societies that, since this procedure was originally valued, the physician work has increased as multiple passes to obtain additional bone marrow aspirate and material are now necessary. Therefore, this service would meet the compelling evidence for both technique and physician time.

The specialty societies also noted that a flawed methodology was used in the previous valuation for this service as the code has a CMS/Other designation. As the RUC has noted previously during review of other services, codes with the CMS/Other designation were never surveyed by the RUC or any other stakeholder; their physician time and work were assigned by CMS in rulemaking over 20 years ago using an unknown methodology. The RUC accepted that there is compelling evidence that both the amount of physician work and technique involved in performing 38220 has changed and that a flawed methodology was utilized when 38220 was originally valued.

38220 ***Diagnostic bone marrow; aspiration(s)***
The RUC reviewed the survey results from 121 physicians and agreed with the societies on the following physician time components: a pre-service time of 15 minutes, an intra-service time of 20 minutes and a post-service time of 12 minutes.

The RUC reviewed the survey 25th percentile work RVU of 1.20 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 1.20, the RUC compared the survey code to XXX and MPC code 95805 *Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness* (work RVU= 1.20, intra-service time of 20 minutes, total time of 50 minutes) and noted that both service involve a similar amount of physician work, have identical intra-service times and very similar total times. The RUC also reviewed 000-day global CPT code 91010 *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report;* (work RVU= 1.28, intra-service time of 20 minutes, total time of 50 minutes) and agreed that this reference code further supports a work RVU of 1.20 for the survey code. **The RUC recommends a work RVU of 1.20 for CPT code 38220.**

38221 ***Diagnostic bone marrow; biopsy(ies)***
The RUC reviewed the survey results from 120 physicians and agreed with the societies on the following physician time components: 15 minutes of pre-service time, 20 minutes of intra-service time and 15 minutes of post-service time.

The RUC reviewed the survey respondents' estimated physician work values and agreed that an appropriate value for this service is between the survey median RVU of 1.80 and survey 25th percentile value of 1.20. To determine an appropriate work value, the RUC compared the survey code to XXX code 99315 *Nursing facility discharge day management; 30 minutes or less* (work RVU=1.28, intra-service time of 20 minutes, total time of 40 minutes) and noted that reference code involves similar physician work and has identical intra-service time relative to the survey code. Therefore, the RUC recommends a direct work RVU crosswalk from code 99315 to code 38221.To further support this recommendation, the RUC compared the survey code to 000-day global code 91010 *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report;* (work RVU= 1.28, intra-time of 20 minutes, total time of 50 minutes) and noted that both services involve a similar amount of physician work and have identical intra-service and total times. **The RUC recommends a work RVU of 1.28 for CPT code 38221.**

38222 ***Diagnostic bone marrow; biopsy(ies) and aspiration(s)***
The RUC reviewed the survey results from 120 physicians and agreed with the societies on the following physician time components: 15 minutes of pre-service time, 30 minutes of intra-service time and 15 minutes of post-service time.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey respondents somewhat overvalued the work involved, with a 25th percentile RVU of 1.50. To determine an appropriate work value, the RUC compared the survey code to 000-day code 91022 *Duodenal motility (manometric) study* (work RVU= 1.44, intra-service time of 30 minutes, total time of 61 minutes) and noted that both services involve a similar amount of physician work and have identical intra-service times. Therefore, the RUC recommends a direct work RVU crosswalk from code 91022 to code 38222. To further support this recommendation, the RUC compared the survey code to XXX code 90832 *Psychotherapy, 30 minutes with patient and/or family member* (work RVU= 1.50, intra-service time 30 minutes

and total time of 45 minutes) and noted that both services have identical intra-service times and involve a similar amount of physician work. **The RUC recommends a work RVU of 1.44 for CPT code 38222.**

Global Period
At the April 2016 RUC meeting, the RUC questioned why the current global period for these procedures is XXX, while a 000-day global would seem more appropriate. The specialties concurred with the RUC that a 000-day global would be more appropriate. **The RUC recommends for CMS to convert CPT codes 38220, 38221 and 38222 to a 000-day global period. The RUC noted that the Committee's recommendations are not contingent on this global period change.** To facilitate CMS' evaluation of the global period change recommendation, this RUC recommendation includes both XXX and 000-day reference codes for each survey code.

Practice Expense
The clinical labor type was changed from the requested L051A RN to the more typical blend L037D RN/LPN/MTA with the exception of the intra-service time, as an RN typically assists the patient only with performing the procedure itself. The amount of milliliters for fixative in the supplies were also corrected. The amount of supplies included are adequate regardless and independent the number of passes and the amount of material that was obtained for each service in the family. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

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

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

<u>Chest X-Ray (Tab 7)</u>
Zeke Silva III, MD (ACR); Kurt Schoppe, MD (ACR); Daniel Wessell, MD (ACR)

In the Final Rule for 2016, CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT codes 71010 *Radiologic examination, chest; single view, frontal* and 71020 *Radiologic examination, chest, 2 views, frontal and lateral;* were identified via this screen. The specialty elected to send the entire family of chest X-ray codes to the CPT Editorial Panel to modernize the reporting of these services. The CPT Editorial panel deleted all 9 existing codes in the chest X-ray family and created 4 new codes for reporting chest X-ray.

71045 *Radiologic examination, chest; single view*
The RUC reviewed the survey results from 86 radiologists and agreed with 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 survey 25th percentile work RVU and agreed that it would be appropriate to assign the new code the same work value (work RVU= 0.18) as the deleted code 71010 *Radiologic examination, chest; single view, frontal*. The RUC noted that this

deleted code 71010 was the most commonly performed single view chest X-ray code according to 2015 Medicare claims data; 99 percent of the volume for 71045 would have previously been reported using 71010. To justify a work RVU of 0.18, the RUC compared the survey code to 2nd key reference and MPC code 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU= 0.22, intra-service time of 3 minutes, total time of 6 minutes) and noted that although both services have identical intra-service times and involve a similar intensity of work, the survey code has slightly less total time. The RUC also compared the survey code to CPT code 73501 *Radiologic examination, hip, unilateral, with pelvis when performed; 1 view* (work RVU= 0.18, intra-service time of 3 minutes and total time of 5 minutes) and noted that both services have identical physician times and involve a similar amount of physician work, further supporting a value of 0.18 for the survey code. **The RUC recommends a work RVU of 0.18 for CPT code 71045.**

71046 *Radiologic examination, chest; 2 views*
The RUC reviewed the survey results from 86 radiologists and agreed with 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 survey 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 compared the survey code to CPT code 73502 *Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views* (work RVU= 0.22, intra-service time of 4 minutes, total time of 6 minutes) and 73521 *Radiologic examination, hips, bilateral, with pelvis when performed; 2 views* (work RVU= 0.22, intra-service time of 4 minutes, total time of 6 minutes). The RUC noted that all three services have identical intra-service and total times and involve similar amounts of physician work. **The RUC recommends a work RVU of 0.22 for CPT code 71046.**

71047 *Radiologic examination, chest; 3 views*
The RUC reviewed the survey results from 86 radiologists and agreed with 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 noted that although 71047 has the same amount of survey time as 71046, the increased potential for disease and the increase in the complexity of the patient for the typical 3-view X-ray warranted a somewhat higher work RVU for 71047 relative to 71046. Also, the RUC noted that reviewing 3 views takes slightly more time than a 2 view X-ray, though the difference may only be in seconds which is a level of granularity not captured in the data.

The RUC reviewed the survey 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 compared the survey code to top key reference code 73503 *Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views* (work RVU= 0.27, intra-service time of 5 minutes, total time of 7 minutes) and noted that both services involve a similar amount of physician work and similar physician times. The RUC also reviewed CPT code 73522 *Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views* (work RVU= 0.29, intra-service time of 5 minutes, total time of 7 minutes) and noted that both services involve a similar amount of physician work and similar physician times, confirming that a work RVU of 0.27 is appropriate for the survey code. **The RUC recommends a work RVU of 0.27 for CPT code 71047.**

71048 *Radiologic examination, chest; 4 or more views*
The RUC reviewed the survey results from 86 radiologists and agreed with 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 survey 25th percentile work RVU and agreed that it would be appropriate to assign the new code the same work RVU of deleted code 71030 *Radiologic examination, chest, complete, minimum of 4 views*, 0.31. The RUC noted that the majority of projected Medicare volume for 71048 is estimated to have previously been reported using 71030. To justify a work RVU of 0.31, the RUC compared the survey code to top key reference code 72114 *Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views* (work RVU= 0.32, intra-service time of 5 minutes, total time of 8 minutes) and noted that both services have identical intra-service times and involve a similar amount of physician work. The RUC also compared the survey code to CPT code 72052 *Radiologic examination, spine, cervical; 6 or more views* (work RVU= 0.36, intra-service time of 5 minutes, total time of 8 minutes) and noted that both services have identical intra-service times while the survey code involves somewhat less physician work in the post-service period, supporting a somewhat lower valuation. **The RUC recommends a work RVU of 0.31 for CPT code 71048.**

Practice Expense
A detailed discussion was convened regarding the typical clinical labor, supplies and equipment and site of service when CPT code 71045 is performed in the non-facility setting. The vast majority of the volume for this new code would have previously been reported using deleted code 71010. For the 437,000 Medicare claims in 2014 that were reported globally, the largest provider of these claims are independent providers in nursing homes, where the largest plurality are unskilled nursing homes that are not subject to the consolidated billing rules for Medicare Part A and the X-ray provider would have to get a contract from the nursing home. The service was evaluated based on the most typical scenario which is an independent provider wheeling a portable X-ray machine into an unskilled nursing home. Due to this typical scenario, the clinical labor time for acquiring the images was reduced to 2 minutes, the clinical labor time for cleaning the room and the equipment was reduced to 1 minute, the clinical labor time for reviewing exam with the interpreting physician was deleted. Also, the X-ray equipment was changed to EF041 Portable X-ray Machine and the equipment input for the basic radiology room was eliminated.

For CPT code 71048, the clinical labor time for acquiring the images was changed to 10 minutes to make the time in line with the other services in the family based on the number of views. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

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

Abdominal X-Ray (Tab 8)
Zeke Silva III, MD (ACR); Kurt Schoppe, MD (ACR); Daniel Wessell, MD (ACR)

In the Final Rule for 2016, CMS re-ran the screen for high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010.

CPT codes 74000 *Radiologic examination, abdomen; single anteroposterior view* and 74022 *Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest* were identified via this screen. The specialty elected to submit the entire family of abdominal X-ray codes to the CPT Editorial Panel to modernize the reporting of these services. The CPT Editorial panel deleted 3 of the 4 existing codes in the abdominal X-ray family and created 3 new codes for reporting abdominal X-ray.

74018 *Radiologic examination, abdomen; 1 view*
The RUC reviewed the survey results from 76 radiologists and agreed with 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 survey 25th percentile work RVU, 0.19, and agreed that the physician work required to perform this new code is the same work as deleted code 74000 *Radiologic examination, abdomen; single anteroposterior view* (work RVU=0.18). The RUC noted that the vast majority of projected Medicare volume for 74018 is estimated to have previously been reported using 74000. To justify a work RVU of 0.18, the RUC compared the survey code to MPC code 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU= 0.22, intra-service time of 3 minutes, total time of 6 minutes) and noted that although both services have identical intra-service times and involve a similar intensity of work, the survey code has slightly less total time. The RUC also compared the survey code to 2nd key reference code 73501 *Radiologic examination, hip, unilateral, with pelvis when performed; 1 view* (work RVU= 0.18, intra-service time of 3 minutes and total time of 5 minutes) and noted that both services have identical physician times and involve a similar amount of physician work, further supporting a value of 0.18 for the survey code. **The RUC recommends a work RVU of 0.18 for CPT code 74018.**

74019 *Radiologic examination, abdomen; 2 views*
The RUC reviewed the survey results from 76 radiologists and agreed with 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 survey 25th percentile work RVU of 0.23 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.23, the RUC compared the survey code to top key reference and MPC code 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU= 0.22, intra-service time of 3 minutes, total time of 6 minutes) and noted that they survey code has more intra-service times and involves a similar intensity of physician work. The RUC also compared the survey code to 2nd key reference code 72081 *Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view* (work RVU= 0.26, intra-service time of 5 minutes, total time of 7 minutes) and noted that with less intra-service and total time, a somewhat lower work value of 0.23 is justified for the survey code. **The RUC recommends a work RVU of 0.23 for CPT code 74019.**

74021 *Radiologic examination, abdomen; 3 or more views*
The RUC reviewed the survey results from 76 radiologists and agreed with 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 noted that although 74021 has the same amount of survey time as 74019, the increased potential for disease and the increase in the complexity of the patient for the typical 3-view X-ray warranted a somewhat higher work RVU for 74021 relative to 74019. Also, the RUC noted that reviewing 3 views takes slightly more time than a

2 view X-ray, though the difference may only be in seconds which is a level of granularity not captured in the data.

The RUC reviewed the survey 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 compared the survey code to top key reference code 73503 *Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views* (work RVU= 0.27, intra-service time of 5 minutes, total time of 7 minutes) and noted that both services involve a similar amount of physician work and similar physician times. The RUC also reviewed 2nd key reference code 73522 *Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views* (work RVU= 0.29, intra-service time of 5 minutes, total time of 7 minutes) and noted that both services involve a similar amount of physician work and similar physician times, confirming that a work RVU of 0.27 is appropriate for the survey code. **The RUC recommends a work RVU of 0.27 for CPT code 74021.**

74022 ***Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest***
The RUC reviewed the survey results from 76 radiologists and agreed with 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 survey 25th percentile work RVU of 0.32 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.32, the RUC compared the survey code to top key reference code 72114 *Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views* (work RVU= 0.32, intra-service time of 5 minutes, total time of 8 minutes) and noted that both services have identical intra-service times and involve a similar amount of physician work. The RUC also compared the survey code to 2nd key reference code 72052 *Radiologic examination, spine, cervical; 6 or more views* (work RVU= 0.36, intra-service time of 5 minutes, total time of 8 minutes) and noted that both services have identical intra-service times while the survey code involves somewhat less physician work in the post-service period, supporting a somewhat lower valuation. **The RUC recommends a work RVU of 0.32 for CPT code 74022.**

Practice Expense
A discussion was convened, noting that although deleted code 74000 was identified as typically an emergent service, the corresponding new code, 74018does not typically require any pre-service clinical labor time. It was confirmed that the inclusion of SB026 gown is warranted. The amount of time for acquiring images was decreased to 6 minutes for 74019 to ensure that there is a logical progression of 3 minutes per view. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

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

<u>Pulmonary Diagnostic Tests (Tab 9)</u>
Alan Plummer, MD (ATS); Robert DeMarco, MD (CHEST)
Facilitation Committee #1

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by

specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 94620 was identified via this screen.

In January 2016, the specialty societies explained that they submitted a Code Change Application (CCA) for the February 2016 CPT Editorial Panel meeting as CPT codes 94620 and 94621 required revisions that would allow the survey respondents to better value these services. Code 94620 described two different tests commonly performed for evaluation of dyspnea, the six minute walk test as well as pre-exercise and post-exercise spirometry. These tests are entirely different and should be described with two separate codes. In addition, code 94620 described a "simple" pulmonary exercise test and code 94621 a "complex" pulmonary exercise test. The testing described in 94621 is commonly called a cardiopulmonary exercise test (CPET) and not a complex pulmonary exercise test as it is currently labeled in CPT 2016. Code 94621 includes the measurement of minute ventilation and exhaled gases in addition to heart rate, oximetry and ECG monitoring. As such, it should not be included as part of the family of less complex exercise tests. The RUC referred CPT code 94620 to the CPT Editorial Panel. In February 2016, the CPT Editorial Panel deleted code 94620, added two new codes 94617 & 94618 to report an exercise test for bronchospasm, and revised code 94621 to describe a cardiopulmonary exercise test.

The RUC discussed the survey results for CPT codes 94617, 94621and 94618 and determined that the survey respondents indicated immediate post-procedure physician time was not representative of the time required to perform this service. The RUC noted that the description of immediate post-procedure physician work described the same intensity for each of the three services but was not represented the same across all three services by the survey respondents.

The standard survey instrument did indicate that the survey respondents should capture the interpretation and report work in the intra-service time period as is typical for XXX global services, but the specialty society contends that the survey respondents did not appear to capture the physician time correctly. The RUC recommends that the specialty societies resurvey codes 94617, 94621and 94618 with the same exact survey instrument (the current standard RUC survey for imaging and tests).

The RUC recommends that CPT codes 94620, 94617, 94621 and 94618 be re-surveyed for the October 2016 RUC meeting.

Parent, Caregiver-focused Health Risk Assessment - PE Only (Tab 10)
Jennifer R. Aloff, MD (AAFP); Steven E. Krug, MD (AAP)

The CPT Editorial Panel added two new codes, 96160 *Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument* and 96161 *Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument*, to the Medicine section of CPT and deleted 99420 *Administration and interpretation of health risk assessment instrument (eg, health hazard appraisal)* from the Evaluation and Management (E/M) section.

At the January 2016 RUC meeting, the specialty societies recommended that this family of codes be surveyed for practice expense for the April 2016 RUC meeting. For their presentation in January, the specialty societies used an expert panel to determine the staff

time and medical supplies, the same process that is used for most PE recommendations. The Practice Expense Subcommittee noted that PE surveys have been utilized on occasion and it would be possible for a PE survey to be created to review these services. The specialty societies noted their concern that the PE Subcommittee's recommendation of five minutes of clinical staff time in January 2016 undervalues the services and would like the data of a PE survey in order to either verify the PE Subcommittee's recommendation or indicate that more time is appropriate. The RUC agreed that these are important services and it is critical to get the PE inputs correct.

The specialty societies developed and administered a practice expense survey for the April 2016 RUC meeting. The PE Subcommittee and the RUC reviewed the survey results from 24 pediatricians and family physicians and noted that the survey 25th percentile of 96160 is 6 minutes clinical staff time and the survey 25th percentile of 96161 is 8 minutes clinical staff time. The RUC agreed with the specialty societies that a blend of the survey 25th percentiles for both codes, for a clinical staff time of 7 minutes, appropriately accounts for the clinical staff activities required to perform each code. The specialty societies clarified that they are recommending the survey 25th percentile for each clinical staff activity except *collate and score data elements on assessment in advance of physician's exam.* For this clinical staff activity, the survey respondents reported 0 minutes for 96160 and 2 minutes for 96161. The specialty societies recommended the average between the survey 25th percentiles for this clinical labor activity, or 1 minute of clinical labor time. The breakdown of time is *explain purpose of assessment to patient/caregiver and answer questions,* 2 minutes; *remain in exam room with patient/caregiver exclusive to completion of assessment,* 2 minutes; *collate and score data elements on assessment in advance of physician's exam* 1 minutes; and *scan assessment or enter data elements and total score into electronic health record,* 2 minutes. All clinical staff activities are performed by a *Medical/Technical Assistant* (L026A). A PE Subcommittee member asked why the Beck Depression Inventory, Second Edition (BDI-II), was not recommended as a supply item as it was at the January 2016 RUC meeting, and the specialties explained that survey respondents reported using a free assessment tool, often provided as part of the electronic medical record. The specialty societies agreed that 2 sheets of *paper, laser printing (each sheet)* (SK057) to print the assessment tool is the only supply item needed for these services. **The RUC recommends the direct practice expense inputs as recommended by the specialty societies and approved by the Practice Expense Subcommittee.**

XI. CMS Request/Relativity Assessment Identified Codes

Anesthesia for Intestinal Endoscopic Procedures (Tab 11)
Marc Leib, MD (ASA)

In the Final Rule for 2016, CMS stated that the anesthesia procedure codes 00740 *Anesthesia for procedure on gastrointestinal tract using an endoscope* and 00810 *Anesthesia for procedure on lower intestine using an endoscope* are used for anesthesia furnished in conjunction with lower GI procedures. In reviewing Medicare claims data, CMS noted that a separate anesthesia service is now reported more than 50 percent of the time when several types of colonoscopy procedures are reported. Given the significant change in the relative frequency with which anesthesia codes are reported with colonoscopy services, CMS believes the base units of the anesthesia services should be reexamined. Therefore, CMS proposed to identify CPT codes 00740 and 00810 as potentially misvalued. The RUC reviewed CPT codes 00740 and 00810 in January 2016 and recommended:

1. An interim base unit of 5 for code 00740 and 00810 and notes the comparison to the RUC recommended values for moderate sedation, 991X4 and 991X6, results in a work RVU equivalent that is only slightly higher than moderate sedation service of the same number of minutes.
2. Referral to the Research Subcommittee for review of the vignettes and to develop a method on how to review the survey data to value these services. The specialty societies should revise the vignette for the typical patient receiving anesthesia for an EGD, CPT code 00740, and for a patient receiving anesthesia for a colonoscopy (45378) , CPT code 00810.
3. Resurvey 00740 and 00810 for the April 2016 RUC meeting.

In April 2016, an Ad Hoc Anesthesia Workgroup was formed to discuss the issues surrounding these services. The specialty society stated and the Workgroup agreed that CPT codes 00740 and 00810 are too broad in the range of endoscopic procedures covered under each code and should be referred to the CPT Editorial Panel September 29-October 1, 2016 meeting to request a new family of anesthesia codes to describe anesthesia for GI endoscopic procedures. The revised codes will specifically identify those patients undergoing both upper and lower gastrointestinal endoscopic procedures. **The RUC recommends CPT codes 00740 and 00810 be referred to CPT to better define these services.**

The Anesthesia Workgroup also recommended an educational presentation be provided to the RUC on the existing survey and valuation process for anesthesia services since it has not been validated or used for a survey since 2007, including a specific example of how the data from a survey are used to value an anesthesia service.

Fine Needle Aspiration (Tab 12)
Peter Manes, MD (AAO-HNS); Zeke Silva III, MD (ACR); Charles Mabry, MD (ACS)

Following publication of the 2014 Final Rule, the RUC solicited feedback from specialty societies regarding CPT codes potentially impacted by the OPPS/ASC payment cap proposal. Specialty societies looked over the list of 211 codes identified by the proposal and indicated which services they have an interest in reviewing. The RUC recommended developing practice expense (PE) inputs only for the subset of codes identified by specialty societies, grouped by specialty, at the April 2014 RUC meeting. In the 2016 Final Rule, CMS noted their concerns about implementing PE inputs without the corresponding work being reviewed. The RAW analyzed the 58 services that the RUC submitted PE recommendations for and determined that one or more of the following is true of many of the codes: frequency less than 10,000; reviewed for work within the last five years; included in the list of proposed potentially misvalued codes identified through high expenditure by specialty screen that CMS included in the proposed rule for 2016. If you apply these criteria only 6 codes remain. CPT code 10021 *Fine needle aspiration; without imaging guidance* met those criteria. CPT Code 10022 *Fine needle aspiration; with imaging guidance* was also identified under the CMS High Expenditure Procedure list.

The specialty societies provided two reasons why these codes need to be referred to the CPT Editorial Panel prior to conducting a RUC survey. First, both codes need clarifying language stating that they should be reported per lesion rather than for every pass on the same lesion. Second, CPT code 10022 is reported with 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* more than 75% of the time together and a bundled code solution will be developed. The specialty societies also requested that these two codes be moved to the 2019 CPT cycle, due to the high workload currently involving the societies. **The RUC recommends that CPT**

codes 10021 and 10022 be referred to the CPT Editorial Panel for the February 2017 meeting.

Acne Surgery (Tab 13)
Daniel M Siegel, MD (AAD); Adam Rubin, MD (AAD)

In October 2015, AMA staff re-ran the Harvard valued codes with utilization over 30,000 based on 2014 Medicare claims data and CPT code 10040 was identified.

10040 ***Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)***
The RUC reviewed the survey results from 35 practicing dermatologists and agreed on the following physician time components: pre-service evaluation time of 3 minutes, with a reduction of 4 minutes to account for the reporting of an Evaluation and Management service on the same date, pre-service positioning time of 1 minute, to position the patient to expose and stabilize the multiple lesions to be treated and pre-service scrub, dress, wait time of 1 minute for the physician to put on the mask and prepare the patient's treatment area. Finally, the RUC discussed the medical necessity for an Evaluation and Management (99212) within the 10 day global period for this code. The typical patient is a teenager who will often need to return due to the management of medication, including changing topical treatment and/or adjusting retinoid dosage. Patients also may have new legions that need to be treated within the global period. The specialty society also noted that the survey respondents indicated a 99213 office visits was typical, but the expert panel reduced the visit to a 99212 to better align with clinical appropriateness.

The RUC reviewed the specialty society's recommended work value and agreed that the survey's 25th percentile work RVU of 0.91, lower than the current work RVU is, is appropriate. To justify a work RVU of 0.91, the RUC compared the survey code to second key reference service 17111 *Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions* (work RVU= 0.97, intra time= 10 minutes) and agreed that since both these codes have identical intra-service time and comparable physician work, both services should be valued similarly. The RUC also noted that the median intra-service time of 10 minutes is a reduction of 4 minutes from the current intra time. However, the current time source is Harvard, which assigned time for this service over 25 years ago, in a process that did not rise to the robust survey requirements currently followed by the RUC. The RUC also determined that there has been no change in the intensity of this procedure. The lowering of the IWPUT to 0.0265 is a direct result of the inclusion of a full 99212 post-operative Evaluation and Management service. Previously a half-day 99212 service was included by the Harvard study, whereas the RUC and CMS no longer include fractions of post-operative office visits. **The RUC recommends a work RVU of 0.91 for CPT code 10040.**

Practice Expense:
The clinical labor time duplicative of the Evaluation and Management code that is typically performed with this service was removed. Also, 1 *pack, minimum multi-specialty visit*, SA048 was added for a total of 2, 1 for the service and one for the post-operative visit and corrected the type of scalpel used. Additionally, equipment item *mayo stand*, EF015 was added. The RUC approved the direct practice expense inputs with modifications as approved by the Practice Expense Subcommittee.

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

Muscle Flaps (Tab 14)
Mark Villa, MD (ASPS); Charles Mabry, MD (ACS)

In October 2015, CPT codes 15732 and 15734 were identified under the High Level E/M screen for services with Medicare utilization greater than 10,000 that has a 99214 included in the global period. The RAW requested that the specialty societies submit an action plan to justify the 99214 visit and review if the family of services also have a 99214 included in the global periods. The RUC noted that a 99214 office visit is included for 15732 and 15736 but not included in the other codes in this family.

15732 ***Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)***
The specialty societies explained that, as also indicated by the three previous surveys for this procedure, the new survey results indicate the typical patient will have inpatient status (72%) and the typical length of stay will be four days. As in the past, this conflicts with the Medicare utilization data that shows the primary place of service as the outpatient hospital setting. Therefore, the specialty societies determined that the code needs to be referred to the CPT Editorial Panel to better differentiate and describe the work of large flaps performed on patients with head and neck cancer who will have inpatient status. This is in contrast to smaller flaps that may be accomplished in an office or outpatient setting and to differentiate from procedures that would be best coded by the adjacent tissue transfer codes. In addition, during the discussion, CMS requested that CPT code 15731 be added to the family of codes for the subsequent RUC review. **The RUC recommends referral of CPT code 15732 to the CPT Editorial Panel. Additionally, CPT code 15731 will be added as part of the family for review.**

15734 ***Muscle, myocutaneous, or fasciocutaneous flap; trunk***
Prior to reviewing the survey data for this procedure, the RUC considered compelling evidence that the current work RVU of 19.86 may be incorrect. The specialty societies detailed two compelling evidence arguments. First, a flawed methodology was used in the previous valuation. During the last valuation at the third Five-Year Review, plastic surgery was the only specialty to conduct a survey, and only 21 responses were collected. At that time, plastic surgery represented approximately 80% of the total utilization of CPT code 15734. Currently, 2015 Medicare utilization shows plastic surgery and general surgery as equally performing this service (43% and 42%, respectively). Furthermore, accounting for other specialties similar to general surgery (colorectal, surgical oncology, vascular, etc.), who are performing the procedure for the same indications, the dominant provider has shifted. Second, the patient population and technique has changed. General surgeons are now performing this procedure to close large, complex abdominal defects that cannot be closed primarily. This is a new surgical procedure that was not performed at the time of the last review. During the previous valuation, plastic surgeons were primarily using this procedure to repair chest wall defects. Given this information, the RUC approved compelling evidence that the current work value for CPT code 15734 may be incorrect.

The RUC reviewed the survey results from 41 general and plastic surgeons and recommends the following physician time components: pre-service time of 75 minutes, intra-service time of 180 minutes and immediate post-service time of 30 minutes. The RUC agreed to add 12 minutes of positioning time above the standard package because the typical patient

undergoing a latissimus muscle flap will be positioned supine, then lateral as the procedure progresses. The typical patient undergoing a rectus abdominis flap will require additional time related to a vacuum assisted dressing in place that will need to be taken down. The RUC also recommend the following post-operative visits: four hospital visits (1 x 99233, 2 x 99232, 1 x 99231), one discharge day management service 99238, and five office visits (1 x 99214, 2 x 99213, 2 x 99212). The RUC discussed the need for a higher level Evaluation and Management service (99214) for the first post-operative visit and agreed it was appropriate. The patient has an extensive dressing (for both the flap and the donor site) that has to be taken down. The process is complex and intense due to concern about not disturbing the blood supply to the flap, as well as not disturbing the skin graft. Finally the RUC noted the increase to two 99232 hospital visits in the global period and confirmed that this visit is in fact typical and was captured, by the survey respondents, as performed in the post-operative period and not on the same day of the surgery.

The RUC reviewed the specialty societies' recommendation and agreed that the survey median work RVU of 23.00 reflects the additional intra-operative time and additional postoperative hospital work for CPT code 15734. To justify a work RVU of 23.00, the RUC compared the surveyed code to the primary key reference code 22905 *Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; 5 cm or greater* (work RVU= 21.58, intra time= 150 minutes) and determined that code 15734 is similar in time and intensity. The RUC also considered the second key reference service 27364 *Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; 5 cm or greater* (work RVU= 24.49, intra time= 180 minutes) and agreed that CPT code 15734 is more work and should be valued higher. Finally, the RUC noted that the increase in work RVUs is further substantiated by the increase in intra-service time, from 163 minutes to 180 minutes, and total time, from 524 minutes to 596 minutes. **The RUC recommends a work RVU of 23.00 for CPT code 15734.**

15736 ***Muscle, myocutaneous, or fasciocutaneous flap; upper extremity***
The RUC reviewed the survey results from 46 practicing general, plastic, and hand surgeons and recommends the following physician time components: pre-service time of 72 minutes, intra-service time of 150 minutes and immediate post-service time of 30 minutes. The RUC agreed to add 9 minutes of positioning time above the standard package to monitor and/or assist with patient positioning, including padding of bony prominences, application of thermal regulation drapes, assessing position of extremities and head and adjusting as needed, positioning the patient's arm on the hand surgery table, applying a sterile tourniquet to the proximal arm, elevating the arm and exsanguinating the arm, and inflating the pneumatic tourniquet. The RUC noted that total positioning time of 12 minutes is consistent with many other recently reviewed upper extremity procedures. The RUC also recommend the following post-operative visits: one-half discharge day management service 99238 that is consistent with outpatient facility status and five office visits (1 x 99214, 3 x 99213, 1 x 99212). The RUC discussed the need for a higher level Evaluation and Management service (99214) for the first post-operative visit and agreed it was appropriate. The patient's comfort and adherence to the postoperative regimen is discussed. The extremity edema, circulation, sensation and motor function are assessed. The splint is removed, but the arm is supported. The superficial dressing is removed. The viability of the flap is assessed. The wound is checked for any sign of infection. The non-stick dressing covering the skin graft is very carefully separated from the graft while protecting the graft with cotton swabs. A new non-stick dressing is applied to the flap. A new dressing is applied to the arm. The donor site is evaluated and redressed. Pain is assessed and adjustments to medications are made as needed. The patient care plan is reviewed with the patient and family. Communication with the referring physician is

completed. The medical record is completed. It is typical for this visit to take upwards of one hour.

The RUC reviewed the specialty societies' recommendation and agreed that the current work RVU of 17.04, which is between the survey's 25th percentile and median work values, is appropriate. The RUC agreed with the specialties that the work and total time has not changed; the intra-operative time is the same and the facility work has shifted to higher level office work. To justify a work RVU of 17.04, the RUC compared the surveyed code to the primary key reference code 24160 *Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar components* (work RVU= 18.63, intra time= 120 minutes) and agreed that while code 15736 has 30 additional minutes of intra-service time, the reference code has more post-operative visits and is a more intense procedure. Therefore, the surveyed code is valued appropriately slightly less than the key reference service. Additionally, the RUC reviewed a broad range of 090 day global outpatient procedures recently reviewed by the RUC and agreed that the current work RVU of 17.04 appropriately fits in this range. Specifically, CPT codes 49655 *Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated* (work RVU= 16.84, intra time= 150 minutes) and 42415 *Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve* (work RVU= 17.16, intra time= 150 minutes) offer appropriate brackets around the recommended value. **The RUC recommends a work RVU of 17.04 for CPT code 15736.**

15738 ***Muscle, myocutaneous, or fasciocutaneous flap; lower extremity***
The specialties presented compelling evidence of a flawed methodology yin the previous survey. The specialties indicated that the survey instrument in 1995 requested total hospital time and number of visits, but not level of visits. Then, when level of visits was necessary for the first five-year review of practice expense, a CMS contractor transformed the postoperative time into visit levels using an algorithm based on intra-service time. This resulted in all low level hospital and office visits being assigned to code 15738. The current survey indicates that the hospital and office visit work was underestimated and that increases in the value for E/M codes over the years were not correctly incorporated in the global code value for 15738. The RUC rejected this compelling evidence citing that the RUC survey has evolved over time and that an old RUC survey instrument is not compelling evidence of a flawed methodology.

The RUC reviewed the survey results from 39 plastic surgeons and recommends the following physician time components: pre-service time of 70 minutes, intra-service time of 150 minutes and immediate post-service time of 30 minutes. The RUC agreed to add 12 minutes of positioning time above the standard package to adequately position the patient with the leg extended lateral or the patient positioned prone. In addition, these patients will require a significant amount of effort to transfer from the hospital bed to the operating room bed because there is commonly a vacuum-assisted dressing in place that will need to be taken down. The RUC also recommend the following post-operative visits: four hospital visits (2 x 99232, 2 x 99231), one discharge day management service (99238), five office visits (4 x 99213, 1 x 99212).

The RUC reviewed the survey respondents' estimated physician work values and noted that the current work RVU of 19.04, slightly above the 25th percentile work RVU of 19.00 should be maintained since compelling evidence was not accepted. The RUC compared the surveyed code to the second key reference code 22905 *Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; 5 cm or greater* (work RVU= 21.58, intra time= 150 minutes) and agreed that while both services have identical intra-service time, the reference code has less

total time, but may be more intense. **The RUC recommends a work RVU of 19.04 for CPT code 15738.**

Practice Expense:
The large amounts of supplies (eg, gauze, etc. were reviewed). However, the specialties explained that the wounds are large and complex for these patients and the large quantities of supplies are appropriate. The specialties provided details of quantities required on a visit by visit basis. The RUC approved the direct practice expense inputs as submitted by the specialty without modification and reviewed and approved by the PE Subcommittee.

Mastectomy (Tab 15)
Eric Whitacre, MD (ASBrS); Charles Mabry, MD (ACS)

In October 2015, CPT code 19303 was identified by a screen in which the Medicare data from 2011-2013 indicated that it was performed less than 50% of the time in the inpatient setting, but included inpatient hospital Evaluation and Management services within the global period. This service was also identified under the High Level E/M screen for services with Medicare utilization greater than 10,000 that has a 99214 included in the global period.

19303 Mastectomy, simple, complete
The RUC reviewed the survey results from 148 general and breast surgeons and recommend the following physician time components: pre-service time of 58 minutes, intra-service time of 90 minutes and immediate post-service time of 30 minutes. The RUC agreed with the specialties and a majority of the survey respondents (87%) who indicated that the typical mastectomy patient will stay overnight or be admitted as inpatients. The RUC also agreed that the typical patient will require a E/M visit later the same day, however, because CMS does not allow reporting inpatient E/M codes for procedures that will have a facility status of outpatient, 10 minutes was added to the survey immediate post-time to reflect face to face time for a visit later on the same day, per CMS policy. The RUC also recommends the following post-operative visits in the surgical global package: one-half discharge management service (99238) (per CMS policy for codes with a facility status of outpatient), three office visits (2 x 99213 and 1 x 99214). The specialties explained that the 99214 office visit is appropriate because this procedure requires post-discharge management of a large, complex wound, including drains. At the second visit after discharge, the surgeon will take down dressings; evaluate the wound for infection; remove the drain; redress the wound; assess the extremity for edema, circulation, sensation and motor function; assess the pain score and order medication, as necessary; review pathology results and marker studies, and possible genetic analysis with the patient, family, referring physician(s), and appropriate consultants; discuss the need for postoperative adjuvant chemotherapy, post mastectomy radiation and/or hormonal therapy based on the pathology findings; discuss case with oncologist, and radiation oncologist if indicated, and prepare documents for transmission to their offices; answer patient and family questions and reinforce instructions on wound care, activity, and bathing; enter progress notes into medical record; and discuss progress with PCP. This post-surgical assessment, planning and discussion are time-intensive, with the typical visit lasting at least 30 minutes. The RUC agreed that this work is appropriately represented by 99214 for the typical patient.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the median work RVU of 15.00 accurately accounts for the physician work required for CPT code 19303. To justify a work RVU of 15.00, the RUC compared the surveyed code to key reference service 19302 *Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy); with axillary lymphadenectomy*

(work RVU= 13.99, intra time= 100 minutes) and agreed that the surveyed code is a more intense and complex surgical procedure. The specialties noted that although the CPT descriptor for 19303 states "simple", the procedure is a "total" mastectomy. Compared to lumpectomy with axillary dissection (CPT code 19302), the procedure is in a completely different tissue plane with different risks - mostly involving control of tributary blood vessels along the sternal border and the lateral thoracic artery and vein in the axilla, which can result in substantial bleeding. An additional difference between these two procedures is that patients undergoing code 19302 will almost always go home the same day, whereas the patients undergoing code 19303 will almost always stay overnight or be admitted for several days. This difference reflects increased post-operative work on the day of the procedure.

Finally, the RUC reviewed several other surgical 90-day global codes with 90 minutes of intra-service time, performed as outpatient procedures, and agreed that a work RVU of 15.00 is appropriate relative to these comparable services. Specifically, CPT codes 29915 *Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)* (work RVU= 15.00) and 58571 *Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)* (work RVU= 15.00) offer appropriate cross-references to the recommended value. **The RUC recommends a work RVU of 15.00 for CPT code 19303.**

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

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

Injection for Knee Arthrography (Tab 16)
Zeke Silva III, MD (ACR)

In October 2015, AMA staff re-ran the Harvard valued codes with utilization over 30,000 based on 2014 Medicare claims data and this service was identified. CPT code 27370 was also identified as a service on the high volume growth screen with Medicare utilization of 10,000 or more that have increased by at least 100% from 2008 through 2013 and the CMS High Expenditure Codes list in the Final Rule for 2016.

This service was previously reviewed in January 2014, in which the specialty societies noted that, at the February 2014 CPT Editorial Panel meeting, a Code Change Proposal (CCP) was submitted to address the high growth of this code. The Panel approved editorial revisions replacing the term "procedure" for "of contrast." This revision to the descriptor clarifies that the correct use of 27370 is to describe the injection of contrast into the knee joint space for arthrography only. The specialty societies noted that the high volume growth for this procedure is likely due to its being reported incorrectly as arthrocentesis or aspiration. The correct reporting of those services is CPT code 20610 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance* (work RVU= 0.79).

27370 Injection of contrast for knee arthrography
The specialty society indicated that CPT code 27370 was initially scheduled to be surveyed for the October 2016. However, this code was put on the Level of Interest (LOI) for the April 2016 RUC meeting. The specialty society still intends to survey this code for the following

meeting in October 2016. **The RUC recommends deferral to October 2016 for CPT code 27370.**

Application of Rigid Leg Cast (Tab 17)
Timothy Tillo, DPM (APMA); Pete Mangone, MD (AOFAS); William Creevy, MD (AAOS); John Heiner, MD (AAOS)

In October 2015, AMA Staff assembled a list of all services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2008 through 2013 and code 29445 was identified. In January 2016 the RAW indicated that the dominant provider has changed, there is high volume growth and it was surveyed more than 10 years ago.

29445 ***Application of rigid total contact leg cast***
The RUC reviewed the survey results from 59 practicing physicians and agreed with the following time components: pre-service time of 23 minutes, intra-service time of 25 minutes and immediate post-service time of 10 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the current work RVU of 1.78 is appropriate, which is below the survey 25th percentile (work RVU= 1.90). The RUC noted an increase in total time to 58 from current 50 minutes due to the appropriate pre-service package being used and the adjustment to include pre-service evaluation time of 13 minutes, pre-service position time of 5 minutes, and pre-service scrub, dress, and wait time of 5 minutes. The RUC discussed the intra-service time for this code to decipher if the physician is performing the application of the cast. It was determined that the cast requires precise application and it is imperative that the physician or podiatrist apply the cast, utilizing clinical staff to assist. The patient is prone with knee flexed at 90 degrees and ankle maintained in neutral position during application. Further, as the cast is applied, shaping is important to achieve total contact. It was noted that this patient population often suffer from diabetic ulcers and severe infections that put them at risk of an amputation. The management of foot ulcers requires offloading the wound. Offloading of the ulcerated area is imperative; requiring bed rest or footwear. Total contact casting for patients who are ambulatory has become the gold standard for off-loading. The RUC compared code 29445 to the primary key reference service 29450 *Application of clubfoot cast with molding or manipulation, long or short leg* (work RVU= 2.08, intra time= 20 minutes) and noted the physician work and time are comparable. **The RUC recommends a work RVU of 1.78 for CPT code 29445.**

Practice Expense:
A detailed discussion was convened that CPT code 29445 is a 0-day global code for the application of a rigid leg cast. CPT guidelines and CMS policy indicate that casting and strapping procedures include removal of cast or strapping. Therefore, 22 minutes for the physician and clinical staff to remove the cast on a subsequent date is included in the post-service period of the casting code. The RUC approved the direct practice expense inputs with minor modifications as approved by the PE Subcommittee.

Strapping Multi-Layer Compression (Tab 18)
Timothy Tillo, DPM (APMA); Matthew Sideman, MD (SVS); Charles Mabry, MD (ACS)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia

and Evaluation and Management services and services reviewed since CY 2010. CPT code 29580 *Strapping; Unna boot* was identified via this screen and 29581 *Application of multi-layer compression system; leg (below knee), including ankle and foot* was added as part of this family of services.

At the April 2016 RUC meeting, the specialty societies indicated that the vignettes were flawed. The specialty societies will be submitting revised vignettes to the Research Subcommittee for approval. Additionally, the Research Subcommittee will review an instructional note about precision in time by the specialty societies. CMS also indicated that the family should include three codes for the upper arm, CPT codes 29582, 29583, and 29584. However, the RUC found that these codes are performed by different specialties than those involved in this code group. The RUC decided CPT codes 29582, 29583, and 29584 should be placed on the LOI for the October RUC meeting, in addition to CPT codes 29580 and 29581, so that appropriate specialties could opt in to survey them. **The RUC recommends that the specialty societies revise the vignettes for CPT code 29580 and 29581 and resurvey for the October 2016 RUC meeting.**

Resection Inferior Turbinate (Tab 19)
Peter Manes, MD (AAO-HNS)

In October 2015, AMA staff re-ran the Harvard valued codes with utilization over 30,000 based on 2014 Medicare claims data. CPT code 30140 was identified and recommended to be surveyed.

30140 ***Submucous resection inferior turbinate, partial or complete, any method***
The RUC reviewed the survey responses from 166 otolaryngologists and determined that the current work RVU of 3.57, below the survey 25th percentile work RVU of 3.89, was validated. The RUC recommends 30 minutes of pre-service evaluation time, 3 minutes of pre-service positioning time, 10 minutes of pre-service scrub/dress/wait time, 20 minutes of intra-service time, 15 minutes immediate post-service time, ½ day 99238 discharge day management and two 99213 Evaluation and Management office visits. The RUC noted that the previous physician time is Harvard valued over 25 years ago and should not be used in comparison to the current survey time.

The RUC compared the surveyed code to 67914 *Repair of ectropion; suture* (work RVU= 3.75, intra-service time of 20 minutes) as it has identical intra time and requires similar physician work to perform. The RUC also referenced CPT code 33282 *Implantation of patient-activated cardiac event recorder* (work RVU = 3.50 and 25 minutes intra-service time) to support the recommended work RVU and time for 30140 as it is a relative similar service.

This service is typically performed under general anesthesia in the outpatient hospital setting. Therefore, the RUC indicated that the ½ day discharge day management service is appropriate as the patient will still be discharged. The RUC agreed that two 99213 office visits are necessary in order to perform the following work:

- Visit #1: Examine patient, evaluating the incision site and nasal cavity for crusting, hematoma or synechiae. Clear nasal cavity of crusting. Assess for any complications including scarring or continued congestion. Discuss activity restrictions and maintenance of wound site in post-operative period, including use of nasal saline. Assess the need for topical medications to improve post-operative swelling.

- Visit #2: Examine patient, evaluating the incision site and nasal cavity for crusting or synechiae. Assess scarring or continued congestion. Discuss resumption of usual activity. Assess need for further nasal saline. Assess the need for further topical medication use.

The RUC recommends a work RVU of 3.57 for CPT code 30140.

RUC Database Notation
The RUC recommends to flag CPT code 30140 as "do not use" for validation of work as this service has a negative IWPUT and should be changed from a 090 day global period to a 000-day global period.

Global Period
The RUC requests that CMS assign a 000-day global period to CPT code 30140 and it be resurveyed for October 2016.

Practice Expense
The standard 090-day direct practice expense inputs were reviewed for 30140 and the equipment minutes for *chair with headrest, exam, reclining*, EF008, *light, fiberoptic headlight w-source,* EQ170 and *suction and pressure cabinet, ENT (SMR),* EQ234 were revised to account for monitoring the patient following the procedure, and added supply item, *pack, cleaning, surgical instruments* SA043 to clean instruments. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

<u>Control Nasal Hemorrhage (Tab 20)</u>
Peter Manes, MD (AAO-HNS)

In October 2015, the PE Subcommittee analyzed the 58 services that the RUC submitted PE only recommendations for and determined that one or more of the following is true of many of the codes: frequency less than 10,000; reviewed for work within the last five years; included in the list of proposed potentially misvalued codes identified through high expenditure by specialty screen that CMS included in the proposed rule for 2016. If you apply these criteria only 6 codes remain. The codes are 10021, 30903, 88333, 88334, 95812 and 95813. Code 30903 was identified and the specialty society identified 30901, 30905 and 30906 as part of the same family.

30901 ***Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method***
The RUC reviewed the survey results from 83 otolaryngologists and determined that the current work RVU and survey median of 1.10 was validated. The RUC reviewed the pre-service time and recommends 3 minutes for evaluation, 1 minute for positioning and 5 minutes for scrub/dress/wait. This service is typically reported with an Evaluation and Management (E/M) service, therefore the RUC reduced the evaluation time by 14 minutes from the standard package. The specialty society indicated and the RUC agreed that 3 minutes for evaluation is necessary for the physician to obtain supplies and equipment (packing material and silver nitrate for cautery) and drape and gown for the patient which is not included in the E/M. The RUC agreed that 5 minutes of scrub/dress/wait time is necessary for the physician to scrub, obtain gown, shoe covers and eye shield. The RUC recommends the same intra-service time of 10 minutes and immediate post-operative time of 5 minutes.

The RUC compared CPT code 30901 (with 23 minutes total time) to the top two key reference services 31231 *Nasal endoscopy, diagnostic, unilateral or bilateral (separate*

procedure) (work RVU = 1.10 and 21 minutes total time) and 12011 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less* (work RVU = 1.07 and 24 minutes total time) and noted that the physician work, time and intensity for these are similar and valued appropriately. For additional support the RUC referenced similar services 20611 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting* (work RVU = 1.10 and 27 minutes total time) and 11980 *Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)* (work RVU = 1.10 and 27 minutes total time). **The RUC recommends a work RVU of 1.10 for CPT code 30901.**

30903 ***Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method***

The RUC reviewed the survey results from 83 otolaryngologists and determined that the current work RVU of 1.54, between the survey 25th percentile 1.30 and median 1.80, was validated. The RUC reviewed the pre-service time and recommends 8 minutes for evaluation, 1 minute for positioning and 5 minutes for scrub/dress/wait. This service is typically reported with an Evaluation and Management (E/M) service, therefore the RUC reduced the evaluation time by two minutes. The specialty society indicated and the RUC agreed that the additional 5 minutes for evaluation time compared to 30901 is necessary to prepare the patient for using the additional electrocautery equipment. Silver nitrate sticks are used for the limited cautery used in 30901, whereas for more extensive cautery (30903, 30905 and 30906), the physician uses bipolar electrocautery equipment. The RUC recommends intra-service time of 15 minutes and immediate post-operative time of 10 minutes. The RUC agreed with the specialty societies that the intra-service time is longer than 30901 to account for the additional monitoring time by the physician as this service is more noxious and is secondary to more significant bleeding. The specialty society noted that the previous intra-service time last valued in 1995 was excessive. The RUC agreed that 15 minutes of intra-service time is more appropriate in line with the intensity of work per unit of time (IWPUT) and in position relative to other comparable services. More patients receiving this service are on blood thinners and therefore have more significant bleeding; hence the service is more intense than it was previously. The increase in post-time compared to 30901 is also due to these patients with more extensive bleeding requiring more monitoring.

The RUC also noted that during the 1995 review the specialty society requested a higher work RVU of 2.50 with 30 minutes of intra-service time, which was also similar to the original Harvard intra-service time (10 minutes pre-time /28 intra-time/10 minutes post-time). In 1995 the specialty society presented that the physician work has changed due to increased risk of HIV and Hepatitis. Although this compelling evidence was not accepted to increase the work RVU at that time, the survey intra service times were approved, which may have allowed for the intra-service time to remain high at 30 minutes. The specialty society also noted that many more people are now on some form of a blood thinner, given that so many are commercially available today. This makes the epistaxis more difficult to control, and the procedure more intense which provides a rationale for the increase in intensity given the reduced intra time.

The RUC compared CPT code 30903 (with 39 minutes total time) to the top two key reference services 31237 *Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)* (work RVU = 2.60 and 48 minutes total time) and noted that the physician work and time is lower for the surveyed code and valued appropriately. For additional support the RUC referenced similar services 15271 *Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less*

wound surface area (work RVU = 1.50), 64447 *Injection, anesthetic agent; femoral nerve, single* (work RVU = 1.50) and 64493 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level* (work RVU = 1.52) all which require the same intra-service time and similar physician work to perform. **The RUC recommends a work RVU of 1.54 for CPT code 30903.**

30905 ***Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial***

The RUC reviewed the survey results from 78 otolaryngologists and determined that the current work RVU of 1.97, below the survey 25th percentile work RVU of 2.20, was validated. The RUC reviewed the pre-service time and recommends 8 minutes for evaluation, 1 minute for positioning and 5 minutes for scrub/dress/wait. This service is typically reported with an Evaluation and Management (E/M) service, therefore the RUC reduced the evaluation time by two minutes. The specialty society indicated and the RUC agreed that the additional 5 minutes for evaluation time compared to 30901 is necessary to prepare the patient for using the additional electrocautery equipment. Silver nitrate sticks are used for the limited cautery used in 30901, whereas for more extensive cautery (30903, 30905 and 30906), the physician uses bipolar electrocautery equipment. The RUC recommends intra-service time of 20 minutes and immediate post-operative time of 10 minutes. The RUC agreed with the specialty societies that the intra-service time is longer than 30903 because for 30905 access to the area is more difficult, the work is more extensive and posterior bleeds are typically arterial, therefore controlling those are more challenging and require more time. The specialty society noted that the previous intra-service time last valued in 1995 was much longer than the current time for this procedure based on the rationale that the 1995 review occurred during a time when concerns about HIV and Hepatitis were at an all-time high. Given this, significantly more time was taken by clinicians to protect against exposure and contamination during procedures where extensive bleeding occurs. Over time, and as education and precautionary measures against contracting these viruses has grown, the time needed related to those concerns has decreased which is consistent with the decreased intra-service survey times that respondents indicated in the 2016 survey data. The RUC agreed that 20 minutes of intra-service time is more appropriate in line with the intensity of work per unit of time (IWPUT) and in position relative to other comparable services. The increase in post-time compared to 30901 is also due to these patients with more extensive bleeding requiring more monitoring.

The RUC also noted that during the 1995 review the specialty society requested a much higher work RVU of 4.50 with 48 minutes of intra-service time, which was also similar to the original Harvard intra-service time (14 minutes pre-time /39 intra-time/13 minutes post-time). In 1995 specialty society presented that the physician work has changed due to increased risk of HIV and Hepatitis. Although this compelling evidence was not accepted to increase the work RVU at that time, it may have allowed for the intra-service time to remain high at 48 minutes. The specialty society also noted that many more people are now on some form of a blood thinner, given that so many are commercially available today. This makes the epistaxis more difficult to control, and the procedure more intense which provides a rationale for the increase in intensity given the reduced intra time.

The RUC compared CPT code 30905 (with 44 minutes total time) to the top two key reference services 31237 *Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)* (work RVU = 2.60 and 48 minutes total time) and noted that the physician work and time is lower for the surveyed code and valued appropriately. For additional support the RUC referenced similar services 12005 *Simple repair of superficial*

wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm (work RVU = 1.97 and 25 minutes intra-service time) and 92960 *Cardioversion, elective, electrical conversion of arrhythmia; external* (work RVU = 2.25 and 15 minutes intra-service time) which require similar time and physician work to perform. **The RUC recommends a work RVU of 1.97 for CPT code 30905.**

30906 ***Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent***

The RUC reviewed the survey results from 76 otolaryngologists and determined that the current work RVU of 2.45, below the survey 25th percentile work RVU of 2.54, was validated. The RUC reviewed the pre-service time and recommends 12 minutes for evaluation, 1 minute for positioning and 5 minutes for scrub/dress/wait. This service is typically reported with an Evaluation and Management (E/M) service, therefore the RUC reduced the evaluation time by 9 minutes. The specialty society indicated and the RUC agreed that the additional 4 minutes for evaluation time compared to 30905 is necessary to obtain supplies such as syringes, alligator forceps and suction materials to take down the nasal packs that were already inserted and failed in 30905, while the patient is actively bleeding. Silver nitrate sticks are used for the limited cautery used in 30901, whereas for more extensive cautery (30903, 30905 and 30906), the physician uses bipolar electrocautery equipment. The RUC recommends intra-service time of 30 minutes and immediate post-operative time of 15 minutes. The RUC agreed with the specialty societies that the intra-service time is longer than 30905 because for 30906 the work is more extensive for this subsequent bleed, removing previous packing and requiring more time. The specialty society noted that the previous intra-service time last valued in 1995 was excessive, consistent with the rationale of why longer intra service times were appropriate in 1995 versus the 2016 review. The RUC agreed that 30 minutes of intra-service time is more appropriate in line with the intensity of work per unit of time (IWPUT) and in position relative to other comparable services.

The RUC also noted that during the 1995 review the specialty society requested a much higher work RVU of 5.00 with 60 minutes of intra-service time, which was also similar to the original Harvard intra-service time (15 minutes pre-time /45 intra-time/14 minutes post-time). In 1995 specialty society presented that the physician work has changed due to increased risk of HIV and Hepatitis. Although this compelling evidence was not accepted to increase the work RVU at that time, the survey intra service times were approved, which may have allowed for the intra-service time to remain high at 60 minutes. The specialty society also noted that many more people are now on some form of a blood thinner, given that so many are commercially available today. This makes the epistaxis more difficult to control, and the procedure more intense which provides a rationale for the increase in intensity given the reduced intra time.

The RUC compared CPT code 30906 (with 30 minutes intra-service time) to the top two key reference services 31237 *Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)* (work RVU = 2.60 and 20 minutes intra-service time) and noted that the physician work and time is similar and slightly more intense to perform for the surveyed code. For additional support the RUC referenced similar services 12016 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm* (work RVU = 2.68 and 30 minutes intra-service time) and 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure* (work RVU = 2.78 and 30 minutes intra-service time) which require similar time and physician work to perform. **The RUC recommends a work RVU of 2.45 for CPT code 30906.**

Practice Expense
Modifications were made to the direct practice expense inputs to correct monitoring times to account for the 1:4 multi-tasking for the two anterior packing codes and the and 1:1 for the two posterior packing codes, deleted phone call duplicative to E/M and supplies and accounted for the gowning and draping of the patient due to bleeding. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Tracheostomy (Tab 21)
Peter Manes, MD (AAO-HNS); Charles Mabry, MD (ACS)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. Code 31600 was identified through this screen and codes 31601, 31603, 31605, and 31610 were added as family codes for survey.

31600 ***Tracheostomy, planned (separate procedure);***
The RUC reviewed the survey results from 66 general surgeons and otolaryngologists and determined that the survey 25th percentile work RVU of 5.56, lower than the current value, appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation, 10 minutes of pre-service positioning, 10 minutes of pre-service scrub/dress/wait, 30 minutes of intra-service time and 30 minutes of immediate post-operative time.

The RUC compared the surveyed code to the top two key reference services 32608 *Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral* (work RVU = 6.84 and intra-service time of 60 minutes) and 43210 *Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed* (work RVU = 7.75 and intra-service time of 60 minutes) and agreed that the survey respondents valued this service lower as it requires less physician work and time to perform, but is more intense and complex. Performing a tracheotomy carries the risk of serious complications including bleeding, damage to the trachea, subcutaneous emphysema, pneumothorax, and hematoma, any of which can compromise continued breathing and patient survival.

The RUC compared 31600 to MPC code 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* (work RVU 6.75 and 45 minutes intra-service time) and agreed that a work RVU of 5.56 for 31600 correctly accounts for less intra-operative time, but greater intensity and complexity, as the RUC noted that 52352 was an endoscopic outpatient procedure on an otherwise healthy individual. Finally, the RUC reviewed the relative intra-operative intensity to other recently reviewed codes with similar intensity and agreed that 31600 was relatively as intense and complex. For additional support the RUC referenced comparable services 34834 *Open brachial artery exposure to assist in the deployment of aortic or iliac endovascular prosthesis by arm incision, unilateral* (work RVU = 5.34 and 30 minutes intra-service time) and 35476 *Transluminal balloon angioplasty, percutaneous; venous* (work RVU = 5.10 and 35 minutes intra-service time. **The RUC recommends a work RVU of 5.56 for CPT code 31600.**

31601 ***Tracheostomy, planned (separate procedure); younger than 2 years***
Compelling Evidence
The specialty societies presented compelling evidence that the value for code 31601 was based on a flawed methodology. The specialty societies informed the RUC that Harvard reviewed code 31601 as a 090-day global code. In that study, the intra-operative work estimates were provided by only ten general otolaryngologists and the pre-and post-operative work were computed by algorithm. The specialty societies also noted that the 1992 Medicare Physician Payment Schedule indicated a 090-day global period for 31601 with a footnote that the work RVU was "gap-filled" by CMS. In the 1993 Medicare Physician Payment Schedule, the global period was changed to 000-day and the work RVU reduced without resurvey and without any discussion in the Federal Register text. The specialty societies further noted that, during the first five-year-review in 1995, a comment was made to CMS that the intra-operative work of 31601 was undervalued and the code was surveyed. However, in 1995, the society did not have the history of the CMS global period changes and "gap fill" changes in valuation for this low volume procedure. Therefore, the RUC concluded that the patient population and procedure had not changed since the Harvard review and the Harvard work RVU was maintained. The rejected survey data were entered into the RUC database several years later and were marked "do not use to validate for physician work" because the surveyed physician time did not correspond to the Harvard work RVU that the RUC maintained. The RUC accepted the compelling evidence of flawed methodology as presented.

The RUC reviewed the survey results from 33 otolaryngologists and determined that the median work RVU of 8.00 appropriately accounts for the work required to perform this service. The RUC recommends 40 minutes of pre-service evaluation, 10 minutes of pre-service positioning, 10 minutes of pre-service scrub/dress/wait, 45 minutes of intra-service time and 30 minutes of immediate post-operative time.

The RUC compared the surveyed code to the top two key reference services 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 and intra-service time of 68 minutes) and 43210 *Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed* (work RVU = 7.75 and intra-service time of 60 minutes) and agreed that this service is appropriately valued as it requires less time to perform but is more intense and complex. Performing a tracheotomy carries the risk of serious complications including bleeding, damage to the trachea, subcutaneous emphysema, pneumothorax, and hematoma, any of which can compromise continued breathing and survival. In addition, performing a tracheostomy in pediatric patients has added difficulty because a child's neck is anatomically different from an adult's neck in the following ways: The dome of the pleura extends into the neck and is thus vulnerable to injury. The trachea is pliable and can be difficult to palpate. The neck is short, and there is significantly less working space. The cricoid can be injured if it is not correctly identified. The RUC also determined that a work RVU of 8.00 for 31601 appropriately ranked relative to 31600, as 31601 is performed on a pediatric patient and is significantly more intense and complex and requires more physician time.

The RUC also agreed that code 31601 was more intense and complex than MPC code 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)* (work RVU = 7.50 and 60 minutes intra-service time) which includes a low intensity diagnostic endoscopy prior to a therapeutic procedure and which is an outpatient procedure on otherwise healthy patients. Finally, the RUC reviewed the relative intra-operative intensity to other recently reviewed codes with similar intensity and agreed

that 31601 was relatively as intense/complex. **The RUC recommends a work RVU of 8.00 for CPT code 31601.**

31603 ***Tracheostomy, emergency procedure; transtracheal***
Compelling Evidence
The specialty societies presented compelling evidence that the value for code 31603 was based on a flawed methodology. The specialty societies informed the RUC that Harvard obtained estimates from both otolaryngologists and thoracic surgeons as a 090-day global code, however thoracic surgeons are not a primary provider of this service (less than 2%) and general surgeons (29%) were not included in the review. In addition, prior to implementation of the 1992 Medicare Physician Payment Schedule, the global period was changed from 090-day to 000-day and the work RVU reduced without any discussion in the Federal Register text. The specialty societies further noted that, during the first five-year-review in 1995, a comment was made to CMS that the intra-operative work of 31603 was undervalued and the code was surveyed. However, in 1995, the society did not have the history of the CMS global period changes and "gap fill" changes in valuation for this low volume procedure. Therefore, the RUC concluded that the patient population and procedure had not changed since the Harvard review and the Harvard work RVU was maintained. The rejected survey data were entered into the RUC database several years later and were marked "do not use to validate for physician work" because the surveyed physician time did not correspond to the Harvard work RVU that the RUC maintained. The RUC accepted the compelling evidence of flawed methodology as presented.

The RUC reviewed the survey results from 61 general surgeons and otolaryngologists and determined that the survey 25th percentile work RVU of 6.00 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes of pre-service evaluation, 5 minutes of pre-service positioning, 10 minutes of pre-service scrub/dress/wait, 30 minutes of intra-service time and 30 minutes of immediate post-operative time.

Although both 31603 and 31600 are both intense procedures, the RUC noted code 31603 is relatively more intense than a planned tracheostomy, code 31600. The RUC compared code 31603 to the top two key reference services 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 and intra-service time of 68 minutes) and 32608 *Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral* (work RVU = 6.84 and intra-service time of 60 minutes) and agreed that 31603 requires less physician time to perform, but is more intense and complex. Performing a tracheostomy carries the risk of serious complications including bleeding, damage to the trachea, subcutaneous emphysema, pneumothorax, and hematoma, any of which can compromise continued breathing and survival. Furthermore, in this case, the airway is not secured during the performance of the procedure, increasing the intensity and complexity.

For additional support the RUC referenced comparable services 34834 *Open brachial artery exposure to assist in the deployment of aortic or iliac endovascular prosthesis by arm incision, unilateral* (work RVU = 5.34 and 30 minutes intra-service time); 36222 *elective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed* (work RVU = 5.53 and 40 minutes intra-service time) and MPC code 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or*

manipulation of calculus (ureteral catheterization is included) (work RVU 6.75 and 45 minutes intra-service time) and agreed that a work RVU of 6.00 for 31603 correctly accounted for less intra-operative time, but greater intensity and complexity, as the RUC noted that 52352 was an endoscopic outpatient procedure on an otherwise healthy individual and 36222, a percutaneous procedure, was also performed most often as outpatient and 11% in the office and did not carry the risks and intensity of 31603. Finally, the RUC reviewed the relative intra-operative intensity to other recently reviewed codes with similar intensity and agreed that 31603 was relatively as intense and complex. **The RUC recommends a work RVU of 6.00 for CPT code 31603.**

31605 ***Tracheostomy, emergency procedure; cricothyroid membrane***
Compelling Evidence
The specialty societies presented compelling evidence that the value for code 31605 was based on a flawed methodology. The specialty societies informed the RUC that Harvard obtained estimates from 10 otolaryngologists only for intraoperative time. General surgeons and other providers of the service were not included in the review. The specialties also indicated that Harvard work estimates and the proposed rule for the 1992 Medicare Physician Payment Schedule indicated code 31605 was a 000-day global code with a proposed work RVU of 5.57 (FR 06/05/91). Prior to implementation of the Final Rule for the first payment schedule, it appears that code 31605 was treated as if it were reviewed as a 090-day global code similar to codes 31601 and 31603 and then reduced to 3.77 as a 000-day global code (FR 11/25/91) without any discussion in the Federal Register text. The RUC accepted the compelling evidence of flawed methodology as presented.

The survey was sent to a random selection of 1,802 surgeons from the AAO-HNS and ACS membership database. Responses were obtained from 56 surgeons; however the median experience was zero. This was not unexpected as this procedure is rarely performed. The survey data was significantly different between respondents who had experience and respondents without experience. After significant discussion, the RUC agreed that the recommendation should be based on the summary data from the experienced providers. The RUC reviewed the survey results from the 20 respondents with experience preforming this very low volume service in the past 12 months and agreed that the survey 25th percentile work RVU of 6.45 accurately accounts for the work required to perform this procedure.

The RUC recommends 15 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, 20 minutes of intra-service time and 21 minutes of immediate post-operative time. The RUC compared the surveyed code to the top two key reference services 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 and intra-service time of 68 minutes) and 32608 *Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral* (work RVU = 6.84 and intra-service time of 60 minutes) and agreed that the intra-service work intensity of 31605 (IWPUT=0.277) is significantly more intense and complex than both of these services. The RUC noted that the intensity of 31605 is more comparable to the intensity for 31500 *Intubation, endotracheal, emergency procedure* (Feb 2016 for CY 2017 RUC recommended work RVU=3.00, intra-service time of 10 minutes and IWPUT=0.252). **The RUC recommends a work RVU of 6.45 for CPT code 31605.**

31610 ***Tracheostomy, fenestration procedure with skin flaps***
The RUC reviewed the survey results from 94 general surgeons and otolaryngologists and recommends the current work RVU of 9.38 and 40 minutes of pre-service evaluation, 10

minutes of pre-service positioning, 10 minutes of pre-service scrub/dress/wait, 45 minutes of intra-service time, 20 minutes of immediate post-operative time, 2-99231 subsequent hospital care visits, 1-99232 subsequent hospital care visit, 1-99233 subsequent hospital care visit, 1-99238 discharge day management and 3-99213 office visits. The RUC agreed that the 99232 visit is typically the first inpatient post-operative visit and is more intense and complex than the two 99231 visits because the physician is checking for significant post-op complications such as pneumothorax subcutaneous crepitus and subcutaneous emphysema. The 99231 visits are to evaluate the skin flaps for viability and make sure there is no infection. The 99233 service is typically 4-5 days after the procedure and is the most intense visit because it includes changing the tracheostomy, taking out sutures, removing the tracheostomy, inspecting the area and inserting a new tracheostomy into the stoma. Further, the RUC agreed that 3-99123 office visits are appropriate in order to examine the patient, inspect the larynx, remove the tracheostomy and examine stoma and skin flaps, replace the tracheostomy, cauterize any granulation tissue at stoma, answer patient/family questions, assess for adequacy of pain control and discuss proper maintenance of the tracheostomy including stoma care.

The RUC noted that the previous Harvard physician intra-service time of 61 minutes was computed by an algorithm. The initial Harvard review indicated the intra-operative time was 52 minutes and then finalized at 61 minutes. The RUC noted it is not valid to compare the current surveyed intra-operative time of 45 minutes to the old computed Harvard time. The specialty societies also noted that the Harvard postop visit times were transformed into low level hospital and office visits. The RUC noted that a correction of the postoperative visits to the correct levels results in a negative intensity. **The RUC determined that since this service has a negative IWPUT it should be converted to a 000-day global period and be re-surveyed.**

The RUC compared the surveyed code to the top two key reference services 41120 *Glossectomy; less than one-half tongue* (work RVU = 11.14 and intra-service time of 60 minutes) and 38542 *Dissection, deep jugular node(s)* (work RVU = 7.95 and intra-service time of 60 minutes) and recommends the current value as an interim step as there was no compelling evidence provided to consider a higher value at this time. The intra-operative work for CPT code 31610 is more intense and complex than both 41120 and 38542, both of which are outpatient procedures. The post-operative work for 31610 is significantly greater than both of the key reference services. **The RUC recommends an interim work RVU of 9.38 for CPT code 31610.**

Practice Expense:
CPT codes 31603 and 31605 were identified by the PE Subcommittee as emergent procedures and no practice expense direct inputs were requested for these two services. For CPT code 31610, the RUC recommends the 090-global direct practice expense inputs with minor modifications for additional supplies and equipment that are not standard to Evaluation and Management services.

RUC Database Flag
The RUC recommends to flag CPT codes 31605 and 31610 as “do not use” for validation of work as 31605 physician time and work recommendations are based on only the 20 survey respondents who performed this service in the past 12 months and 31610 has a negative IWPUT and should be considered for a 000-day global period.

Global Period
The RUC requests that CMS assign a 000-day global period to CPT code 31610 and it be resurveyed for October 2016 and may require CPT to create a new code to describe changing

the tracheostomy tube in the office. The RUC noted that the specialty does not need to resurvey the entire family.

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

Bronchoscopy (Tab 22)
Stephen Hoffmann, MD (ATS); Alan Plummer, MD (ATS); Steve Peters, MD (CHEST); Robert DeMarco, MD (CHEST)

In October 2015, AMA staff re-ran the screen for Harvard valued codes with utilization over 30,000 based on 2014 Medicare claims data and CPT code 31645 was identified. CPT code 31646 was identified as part of the family.

The specialty societies noted that a Code Change Application (CCA) is needed to describe the services accurately, thereby allowing for an adequate RUC survey. This CCA, attached, will be reviewed by the CPT Editorial Panel in May 2016 and a RUC survey will be conducted for presentation at the October 2016 RUC meeting. **The RUC recommends referral to the CPT Editorial Panel for CPT code 31645 and 31646.**

Selective Catheter Placement (Tab 23)
Michael Hall, MD (SIR); Jerry Niedzwiecki, MD (SIR); Curtis Anderson, MD (SIR); Zeke Silva III, MD (ACR); Kurt Schoppe, MD (ACR); Matthew Sideman, MD (SVS); Francesco Aiello, MD (SVS); Timothy Pflederer, MD (RPA)
Facilitation Committee #2

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. *CPT code 36215 also identified via the Harvard Valued – Utilization Over 30,000 screen.* CPT codes 36216, 36217 and 36218 were added as part of the family of services.

36215 ***Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family***
The RUC reviewed the survey results from 113 practicing interventional radiologists, vascular surgeons and renal physicians and recommends the following physician time components: pre-service time of 25 minutes, intra-service time of 30 minutes and immediate post-service time of 20 minutes. The RUC agreed to add two minutes of positioning time above the standard package to account for positioning the patient supine and orienting the patient, imaging equipment, and lines/catheters to allow for access to the puncture site. Additionally, 5 minutes of scrub, dress, wait time was added above the standard package to maintain a sterile operating room technique when performed in the office suite, requiring scrubbing and sterile gown, mask and gloves for the physician and clinical staff.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey respondents somewhat overvalued the work involved, with a 25th percentile work RVU of 5.25. To find an appropriate work RVU for CPT code 36215, the RUC reviewed CPT code 32550 *Insertion of indwelling tunneled pleural catheter with* cuff (work RVU= 4.17, intra time= 30 minutes) and agreed that since this reference code has identical intra-service time compared to 36215 and is an analogous procedure with a similar amount of

physician work, the work RVUs should be identical. To justify a direct physician work RVU crosswalk of 4.17, the RUC also reviewed CPT code 43233 *Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)* (work RVU= 4.17, intra-time= 28 minutes) and MPC code 52224 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy* (work RVU= 4.05, intra-time= 30 minutes) and agreed that both codes validate the recommended work RVU of 4.17. Finally, the RUC noted the decrease in intra-service time from 61 minutes to 30 minutes. The current time source is Harvard, with all the physicians' time is captured in the intra-service category, without considering the time required for pre and immediate post-service. Comparisons between the prior intensity and current intensity are inappropriate due to the lack of adequate physician time components assigned during the Harvard studies. **The RUC recommends a work RVU of 4.17 for CPT code 36215.**

36216 ***Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family***
The RUC reviewed the survey results from 87 practicing interventional radiologists and vascular surgeons and recommends the following physician time components: pre-service time of 31 minutes, intra-service time of 45 minutes and immediate post-service time of 20 minutes. The RUC agreed to add two minutes of positioning time above the standard package to account for positioning the patient supine and orienting the patient, imaging equipment, and lines/catheters to allow for access to the puncture site.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the current work RVU of 5.27, lower than the survey's 25th percentile, is appropriate for CPT code 36216. To justify a work RVU of 5.27, the RUC compared the surveyed code to the top two key reference services CPT code 36246 *Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU= 5.27, intra time= 45 minutes and code 36223 *Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed* (work RVU= 6.00, intra time= 45 minutes) and agreed that these comparable services provide appropriate comparisons to the recommended value. In addition, the RUC noted the incremental work difference between the work of placing the stent in the first order branch (code 36215) and the initial second order (code 36216) is 1.10 work RVUs with 15 additional minutes. This increment is appropriate and magnitude estimation of this increment is maintained throughout the family of services.

Finally, the RUC noted the decrease in intra-service time from 72 minutes to 45 minutes. The current time source is Harvard, all the physicians' time is captured in the intra-service category, without considering the time required for pre and immediate post-service. Comparisons between the prior intensity are inappropriate due to the lack of adequate physician time components assigned during the Harvard studies. **The RUC recommends a work RVU of 5.27 for CPT code 36216.**

36217 ***Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family***
The RUC reviewed the survey results from 87 practicing interventional radiologists and vascular surgeons and recommends the following physician time components: pre-service time of 31 minutes, intra-service time of 60 minutes and immediate post-service time of 20

minutes. The RUC agreed to add two minutes of positioning time above the standard package to account for positioning the patient supine and orienting the patient, imaging equipment, and lines/catheters to allow for access to the puncture site.

The RUC had significant discussions regarding the appropriate intra-service time for this procedure. The median survey intra-service time was 50 minutes. However, CPT code 36217 includes the work of both 36215 (intra time= 30 minutes) and 36216 (intra time= 45 minutes). Therefore, the median intra-service time of 50 minutes, only 5 minutes above 36216, is not clinically appropriate. The RUC agreed to accept the 75th intra-service time of 60 minutes in order to accurately account for the physician work of placing a catheter in the third order branch. This more accurate intra-service time, preserves the incremental, linear consistency between the work RVU and intra-service time within the family.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the current work RVU of 6.29, supported by the survey's 25th percentile work RVU of 6.30, is appropriate for CPT code 36217. To justify a work RVU of 6.29, the RUC compared the surveyed code to the top key reference service CPT code 36247 *Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU= 6.29, intra time= 60 minutes) and agreed that since both services have identical intra-service time and comparable physician work, the work RVUs should be the same. In addition, the RUC noted the incremental work difference between the work of placing the stent in the second order branch (code 36216) and the initial third order (code 36217) is 1.01 work RVUs with 15 additional minutes. This increment is appropriate and magnitude estimation of this increment is maintained throughout the family of services.

Finally, the RUC noted the decrease in intra-service time from 86 minutes to 60 minutes. The current time source is Harvard, all the physicians' time is captured in the intra-service category, without considering the time required for pre and immediate post-service. Comparisons between the prior intensity are inappropriate due to the lack of adequate physician time components assigned during the Harvard studies. **The RUC recommends a work RVU of 6.29 for CPT code 36217.**

36218 ***Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family***
The RUC reviewed the survey results from 80 practicing interventional radiologists and vascular surgeons and recommends intra-service time of 15 minutes for this add-on procedure.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the current work RVU of 1.01, lower than the survey's 25th percentile, is appropriate for CPT code 36218. To justify a work RVU of 1.01, the RUC compared the surveyed code to MPC code 64480 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level* (work RVU= 1.20, intra time= 15 minutes) and code 36148 *Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention* (work RVU= 1.00, intra time= 15 minutes) and agreed that both reference services have identical intra-service time and should be valued nearly identical to CPT code 36218. Finally, the RUC agreed that the increment of 1.01 for an additional branch with intra-service time of 15 minutes appropriately fits with the incremental hierarchy established with the base codes in this family. **The RUC recommends a work RVU of 1.01 for CPT code 36218.**

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

Global Period:
The RUC requests that CMS assign CPT codes 36215, 36216 and 36217 a 000-day global period.

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.

Therapeutic Apheresis (Tab 24)
Jonathan Myles, MD (CAP)

CPT code 36516 was identified by Centers for Medicare and Medicaid Services (CMS) as potentially misvalued in the final rule for 2016. At the April 2016 RUC meeting, Therapeutic Apheresis code 36516 was discussed. During the discussion, the Renal Physicians Association and the College of American Pathologists indicated there is a concern that the service is misplaced within the CPT coding structure and this misplacement may have resulted in recent inaccuracy of coding. Specifically, the service is an extracorporeal therapy that is more akin to dialysis services (CPT codes 90935-90999) than to surgical procedures, and the code may need to reside in the 909XX series of codes within the CPT coding structure. The two specialties plan to submit a code change proposal to CPT that will address CPT code 36516 as well as any others in the coding family that may be impacted by a change. The specialty societies will submit a CCP for the September 2016 CPT meeting to address these concerns. **The RUC refers CPT code 36516 to the CPT Editorial Panel.**

Voiding Pressure Studies (Tab 25)
James Dupree, MD (AUA); Thomas Turk, MD (AUA)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. The RUC commented that CPT code 51798 *Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging* should be removed from this screen because it has a work RVU of0.00. In the Final Rule for 2016, CMS indicated that the work and practice expense (PE) for this service should be reviewed.

The PE Subcommittee and the RUC reviewed the direct PE inputs for CPT code 51798. A member questioned one of the supply items *paper, recording, roll (per foot)* SK060 and the specialty explained that this is a print out that the machine automatically does and that it is scanned into the electronic medical record. The following modifications were made:

- Removed 1 minute from line 21 *Greet patient, provide gowning, ensure appropriate medical records are available* as it is duplicative of the Evaluation and Management service typically performed on the same day.
- Removed 2 minutes from line 23 *Provide pre-service education/obtain consent* as it is duplicative of the Evaluation and Management service typically performed on the same day.

- Remove 3 minutes from line 43 *Other Clinical Activity - specify: Enter data in EMR* as entering information into the medical record is not typically allocated clinical staff time.
- The unit for supply item *paper, recording, roll (per foot)* SK060 was changed from item to foot.
- The equipment time calculation was modified to include the entire service period for both, the *table, power* EF031 and the *ultrasound, noninvasive bladder scanner w-cart* EQ255.

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

Transurethral Electrosurgical Resection of Prostate (Tab 26)
Thomas Turk, MD (AUA); James Dupree, MD (AUA)
Facilitation Committee #3

In October 2015, CPT code 52601 was identified in which the Medicare data from 2011-2013 indicated that it was performed less than 50% of the time in the inpatient setting, yet include inpatient hospital Evaluation and Management services within the global period.

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)***
The RUC reviewed the survey results from 97 urologists for CPT code 52601 and determined that the survey 25th percentile work RVU was too high compared to the key reference services. The RUC recommends cross-walking the survey code to CPT code 29828 *Arthroscopy, shoulder, surgical; biceps tenodesis* (work RVU = 13.16, intra-service time of 75 minutes and 252 minutes total time) because these services require the same physician work and intra-service time. The RUC recommends 33 minutes of pre-service evaluation time, 8 minutes of pre-service positioning, 10 minutes of pre-service scrub/dress/wait, 75 minutes intra-service time, 45 minutes of immediate post-service time, ½ day discharge management 99238 and two 99213 office visits. The top two key reference services 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 intra-service time of 120 minutes) and 55873 *Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)* (work RVU =13.60 and intra-service time of 100 minutes) require significantly more intra-service time and more physician work. Therefore, the RUC determined the crosswalk to CPT code 29828 was appropriate.

The RUC noted that this service has shifted from the inpatient setting to primarily the outpatient hospital. The RUC confirmed that the immediate post-service time of 45 minutes appropriately accounts for the immediate care of the patient (25 minutes) as well as the post-operative care for the patient within the next 23 hours (20 minutes). As per CMS' policy for 23-hour stay hospital outpatient services, the 20 minutes is derived from the intra-service time of the post-operative hospital visit that is typically performed on the same day. The specialty society noted that approximately 65% of the survey respondents indicated that they performed a 99232 hospital visit and the RUC determined that the time should be captured in the immediate post-service time. The postoperative visit during the 23-hour stay includes conducting the post-operative pain assessment, hand irrigating the catheter, determining the

need for continued catheter traction or continuous bladder irrigation and answering any questions from the patient.
For additional support, the RUC referenced similar service 58545 *Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less*; (work RVU = 12.29, intra-service time of 75 minutes and 226 minutes total time). **The RUC recommends a work RVU of 13.16 for CPT code 52601.**

Practice Expense:
A minor modification to delete 3 minutes for a telephone call on line 49 as it is duplicative of that associated with an Evaluation and Management service was made. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

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

Colporrhaphy (Tab 27)
George A. Hill, MD (ACOG)

In October 2015, CPT code 57240 was identified in which the Medicare data from 2011-2013 indicated that it was performed less than 50% of the time in the inpatient setting, yet include inpatient hospital Evaluation and Management services within the global period.

In April 2016, the specialty society indicated they are working with CMS and its contractor NCCI on issues related to the colporrhaphy codes. NCCI instituted edits that prohibit reporting a Cystourethroscopy (CPT code 52000) with these services. The specialty society determined that the most appropriate way to address this issue is through the CPT process. The specialty will submit a CCP for the September 2016 CPT meeting to address these concerns. **The RUC recommends 57240, 57250, 57260 and 57265 be referred to the CPT Editorial Panel.**

Injection Anesthetic Agent (Tab 28)
Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA); Matthew Grierson, MD (AAPMR); Barry Smith, MD (AAPMR)
Facilitation Committee #1

In October 2015, AMA staff re-ran the Harvard valued codes with utilization over 30,000 based on 2014 Medicare claims data and this service was identified.

64418 Injection, anesthetic agent; suprascapular nerve
The RUC reviewed the survey results from 139 physicians for CPT code 64418 and determined that the survey median and 25th percentile work RVUs did not adequately account for the work required to perform this service. Therefore, the RUC recommends crosswalking code 64418 to code 20611 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting* (work RVU = 1.10 and 10 minutes intra-service time).

The RUC reviewed the pre-service time for CPT code 66418 and agreed that pre-time package 6A (Procedure with local/topical anesthesia care requiring wait time for anesthesia to take effect) is appropriate. However, the RUC did not agree with the specialties recommended pre-time inputs and determined that the pre-time needed to be decreased

further to account for overlap in time with an Evaluation and Management service that typically reported with this service. Therefore, the RUC recommends 6 minutes of evaluation time, 3 minutes of positioning time, 3 minutes of scrub dress and wait time, 10 minutes intra-service time and 10 minutes immediate post-service time. The RUC confirmed that 10 minutes of immediate post-service time is required to assess the patient for pain relief, respiratory, hemodynamic, mental orientation, and extremity vascular status changes; required as a result of the risk of intra-vascular injection or pneumothorax. The physician also assesses any impact on the patient's activities of daily living including eating, bathing, brushing teeth and hair and overhead activities. The physician performs both strength testing and functional assessments to evaluate weakness in the limb that was injected as a result of anesthetic response. The RUC noted that the majority of nerve block codes that were recently reviewed include 10 minutes of immediate post-service time.

The RUC noted that the recommended work RVU of 1.10 and 32 minutes of total time for CPT 66418 is relative compared to the top two key reference services 64450 *Injection, anesthetic agent; other peripheral nerve or branch* (work RVU = 0.75 and 20 minutes total time) and 64486 *Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)* (work RVU = 1.27 and 35 minutes of total time). The RUC noted that the recommendation is comparable to other nerve block codes 64405 *Injection, anesthetic agent; greater occipital nerve* (work RVU = 0.94 and 22 minutes total time) and 64415 *Injection, anesthetic agent; brachial plexus, single* (work RVU = 1.48 and 44 minutes total time). **The RUC recommends a work RVU of 1.10 for CPT code 64418.**

Practice Expense
One minor modification was made to correct the equipment minutes calculation. The Practice Expense Subcommittee reviewed the clinical staff time inputs to ensure that there were no duplicative times with the Evaluation and Management visit. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

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

Correction of Trichiasis (Tab 29)
David Glasser, MD (AAO); Charlie Fitzpatrick, OD (AOA)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010.

67820 *Correction of trichiasis; epilation, by forceps only*
The RUC reviewed the survey results from 59 practicing ophthalmologists and optometrists and agreed with the following physician time components: pre-service time of 4 minutes, intra-service time of 5 minutes and immediate post-service time of 2 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the appropriate value is below the 25th percentile (work RVU 0.50). The RUC compared the surveyed code to a key reference code 11900 *Injection, intralesional; up to and including 7 lesions* (work RVU= 0.52, intra time= 8 minutes) and noted that it is appropriate to value CPT code 67820 below this comparison given its increased complexity. Additionally the

RUC compared CPT code 11720 *Debridement of nail(s) by any method(s); 1 to 5* (work RVU=0.32 and intra-service time of 5 minutes) noting identical intra-time and physician work. **The RUC recommends a work RVU of 0.32 for CPT code 67820.**

Practice Expense:
The pre-service time was revised to be consistent with the times for minimal use of clinical staff time for a 000 day global service in the facility setting. The RUC approved the direct practice expense inputs with modifications as approved by the Practice Expense Subcommittee.

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

X-Ray of Ribs (Tab 30)
Zeke Silva III, MD (ACR); Kurt Schoppe, MD (ACR); Daniel Wessell, MD (ACR)

In October 2015, CPT code 71101was identified as a CMS/Other source code with 2014 Medicare utilization of 250,000 or more.

Compelling Evidence
The specialty society presented compelling evidence for code 71110. The society noted that a flawed methodology was used in the previous valuation for this service as the code has a CMS/Other designation. As the RUC has noted previously during review of other services, codes with the CMS/Other designation were never surveyed by the RUC or any other stakeholder; their physician time and work were assigned by CMS in rulemaking over 20 years ago using an unknown methodology. The RUC accepted that there is compelling evidence that 71110 was originally valued using a flawed methodology.

71100 ***Radiologic examination, ribs, unilateral; 2 views***
The RUC reviewed the survey results from 50 radiologists and agreed with 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 survey 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 compared the survey code to CPT code 73502 *Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views* (work RVU= 0.22, intra-service time of 4 minutes, total time of 6 minutes) and 73521 *Radiologic examination, hips, bilateral, with pelvis when performed; 2 views* (work RVU= 0.22, intra-service time of 4 minutes, total time of 6 minutes). The RUC noted that all three services have identical intra-service and total times and involve similar amounts of physician work. **The RUC recommends a work RVU of 0.22 for CPT code 71100.**

71101 ***Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of 3 views***
The RUC reviewed the survey results from 50 radiologists and agreed with 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 survey 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 compared the survey code to top key reference code 73503 *Radiologic examination,*

hip, unilateral, with pelvis when performed; minimum of 4 views (work RVU= 0.27, intra-service time of 5 minutes, total time of 7 minutes) and noted that both services have identical intra-service and total times and involve a similar amount of physician work. The RUC also 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 and involve a similar physician work intensity, confirming that a work RVU of 0.27 is appropriate for the survey code. **The RUC recommends a work RVU of 0.27 for CPT code 71101.**

71110 ***Radiologic examination, ribs, bilateral; 3 views***
The RUC reviewed the survey results from 50 radiologists and agreed with 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 survey 25th percentile work RVU of 0.29 and agreed that this value appropriately accounts for the physician work involved and aligns appropriately with the other codes in the x-ray of ribs code family. To justify a work RVU of 0.29, the RUC compared the survey code to 2nd key reference code 72110 *Radiologic examination, spine, lumbosacral; minimum of 4 views* (work RVU= 0.31, intra-service time of 5 minutes, total time of 8 minutes) and noted that while both services have identical total times, the survey code has more intra-service time. The RUC also compared the survey code to CPT code 73523 *Radiologic examination, hips, bilateral, with pelvis when performed; minimum of 5 views* (work RVU= 0.31, intra-service time of 6 minutes, total time of 8 minutes) and noted that both services have identical times and involve a similar amount of physician work, supporting a work RVU of 0.29 for the survey code. **The RUC recommends a work RVU of 0.29 for CPT code 71110.**

71111 ***Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views***
The RUC reviewed the survey results from 50 radiologists and agreed with following physician time components: pre-service time of 1 minute, intra-service time of 7 minutes and post-service time of 1 minute.

The RUC reviewed the survey 25th percentile work RVU and agreed that maintaining the current work RVU of 0.32 is supported. To justify a work RVU of 0.32, the RUC compared the survey code to 2nd key reference and MPC code 72114 *Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views* (work RVU= 0.32, intra-service time of 5 minutes, total time of 8 minutes) and noted that the survey code has more intra-service and total time. The RUC also compared the survey code to CPT code 72083 *Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); 4 or 5 views* (work RVU= 0.35, intra-service time of 7 minutes, total time of 9 minutes) and noted that although both codes have identical times, the survey code involves somewhat less intense physician work, supporting a somewhat lower work RVU of 0.32 for the survey code. **The RUC recommends a work RVU of 0.32 for CPT code 71111.**

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

CT Chest (Tab 31)
Zeke Silva lll, MD (ACR); Kurt Schoppe, MD (ACR)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010.

Compelling Evidence
The specialty society presented compelling evidence for code 71250. The society noted that a flawed methodology was used in the previous valuation for this service as instead of accepting the RUC recommended value of 1.16, CMS assigned a work RVU of 1.02 based on the single lowest response to the survey. The RUC agreed that using a work RVU based on the survey minimum RVU is statistically invalid and inappropriate. The RUC accepted that there is compelling evidence that 71250 was originally valued using a flawed methodology.

71250 ***Computed tomography, thorax; without contrast material***
The RUC reviewed the survey results from 76 radiologists and agreed on the following physician time components: pre-service time of 5 minutes, intra-service time of 15 minutes and post-service time of 5 minutes.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 1.19, and agreed that reaffirming the October 2009 RUC recommended work RVU of 1.16 is supported by the new survey data. The RUC also noted that this value has appropriate rank order relative to the other codes in the family. The RUC compared the survey code to MPC code 70470 *Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections* (work RVU= 1.27, intra-service time of 15 minutes, total time of 25 minutes) and noted that both services have identical intra-service and total times, whereas the survey is somewhat less intense. The RUC also compared the survey code to CPT code 78071 *Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)* (work RVU= 1.20, intra-service time of 15 minutes, total time of 25 minutes) and noted that both services have identical intra-service and total times and involve similar amounts of physician work.

As the RUC agreed that its prior recommendation for 71250 was still appropriately relative, the RUC re-affirmed the recommendations made for this code at the October 2009 RUC meeting:

> The RUC reviewed survey data from nearly 60 physicians who frequently perform this service. The specialty recommended a pre-service time of 5 minutes based on the survey results and the RUC concurred. The RUC also agreed that the surveyed intra-service of 15 minutes and immediate post service time of 5 minutes were typical for the physician work required for the service. The total time of 25 minutes is comparable to the 22 minutes of total time assumed by CMS.
>
> The RUC compared 71250 to key reference service 71260 *Computed tomography, thorax; with contrast material(s)* (work RVU = 1.24, with pre, intra, and post service times of 3, 15, and 5 minutes respectively), and noted that the survey respondents indicated that in general a CT of the thorax without contrast is a slightly less intense service than one with contrast, as reflected in slightly lower values for the intensity and complexity measures. The RUC also compared 71250 to the specialty's multi-specialty points of comparison codes 78306 *Bone and/or joint imaging; whole body*

(work RVU = 0.86, with pre, intra, and post service times of 5, 8, and 5 minutes respectively) and 74160 *Computed tomography, abdomen; with contrast material(s)* (work RVU = 1.27, with pre, intra, and post service times of 3, 15, and 5 minutes respectively).

The RUC agreed that there is significant evidence to support the current valuation, given changes in technology and the patient population. The RUC and the specialty cited the following as evidence to maintain the work relative value of 1.16 for CT of the thorax:

- Modern CT technology produces an increased amount of data to be reviewed and interpreted. Because of the improved spatial resolution and multi-planar reformation of the data, a higher level of diagnostic specificity and accuracy is expected, and the number of possible protocols to be considered in the pre-service period by the interpreting physician has increased. Many patients require prone and supine imaging with both inspiration and expiration for the evaluation of interstitial lung disease. Further, 2D reconstructions (previously separately billable using code 76375 *Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computed tomography, magnetic resonance imaging, or other tomographic modality* in 2005 with 0.16 work RVUs) were bundled into the base code in 2006 and are now being considered an inherent part of the service.

- Using multi-detector row CT scanners, modern high resolution CT protocols are able to generate contiguous 1.25 mm images through the entirety of the lungs which are also used to create coronal 2D reconstructions to more accurately assess distribution of disease. As such, these examinations now generate more than 300 images for interpretation.

- The expectation of the referring physician is now much higher in terms of defining the various subtypes of interstitial lung disease and also in evaluating whether a lung nodule merits follow up or more aggressive intervention. The incidence of smoking-related lung disease continues to increase in the Medicare population, as does the ability to characterize these diseases with the advent of high resolution multi-detector CT. Current estimates are that pulmonary emphysema and the smoking related interstitial lung diseases – centrilobular emphysema, respiratory bronchiolitis interstitial lung disease (RBILD), desquamative interstitial pneumonia (DIP), and Langerhan's cell histiocytosis (LCH) – are among the top ten causes of morbidity and mortality in the Medicare population and both morbidity and mortality from these illnesses are expected to increase by 2020.

- Because of refinements in technique and the ability to examine the entire lung, specific diagnoses of potentially reversible diseases such as RBILD and DIP can now be made and differentiated from irreversible diseases such as LCH and pulmonary fibrosis (usual interstitial pneumonia) without open lung biopsy or the need to institute potentially harmful empiric therapy without a definitive diagnosis. The extent and distribution of pulmonary centrilobular and bullous emphysema is now well characterized and critically important in both medical and surgical treatment planning.

While CT technology is changing rapidly, the adoption of newer techniques is not yet universal. The reasons for the increase in utilization of non-enhanced CT procedures are likely multi-factorial but concerns over the use of intravenous contrast and its potential nephrotoxicity in at-risk patients is felt to contribute at least in part to this increase.

Advances in CT technology have provided new indications for non-enhanced CT leading to volume growth. The most common indication for non-enhanced CT of the thorax is evaluation and follow-up of pulmonary nodules. The ability to detect small non-calcified pulmonary nodules has increased dramatically in recent years with high-resolution exam protocols. And while any of these nodules could represent small malignancies, most of the nodules are benign. The protocol for following likely benign pulmonary nodules developed by the Fleischner Society stated that pulmonary nodules should be followed with serial CT examinations for two years to assure benignity. Recent literature has prompted a re-evaluation of these guidelines by the Fleischner Society with the end result being a statement that will drastically reduce the number of follow-up examinations in low-risk patients with nodules less than 8 mm in size. These recommendations are supported by pulmonary medicine and thoracic surgery societies as well, and it is expected that the volume of these service will likely decrease in the future as these practice guidelines are established in the community.

From the survey results, comparison of similar services, rank order maintenance, and considerations regarding the rationale for the volume growth in the service, the RUC agreed that the physician work relative value should be maintained at its current value of 1.16 work RVUs, which was lower than the survey's 25% percentile of 1.20. The RUC acknowledges the growth in CT scans in the Medicare population. However, there is no evidence that this growth has led to a reduction in physician resources, as confirmed by the recent survey time data.

The RUC recommends maintaining the relative work value for CPT code 71250 of 1.16.

The RUC recommends a work RVU of 1.16 for CPT code 71250.

71260 ***Computed tomography, thorax; with contrast material(s)***
The RUC reviewed the survey results from 76 radiologists and agreed on the following physician time components: pre-service time of 5 minutes, intra-service time of 16 minutes and post-service time of 5 minutes.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 1.27, and agreed that maintaining the current work RVU of 1.24 is supported by the new survey data. The RUC compared the survey code to MPC code 73721 *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (work RVU= 1.35, intra-service time of 20 minutes, total time of 30 minutes) and noted that both services have identical intra-service and total times and involve similar physician work. **The RUC recommends a work RVU of 1.24 for CPT code 71250.**

71270 ***Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections***
The RUC reviewed the survey results from 76 radiologists and agreed on the following physician time components: pre-service time of 5 minutes, intra-service time of 20 minutes and post-service time of 5 minutes.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 1.40, and agreed that maintaining the current work RVU of 1.38 is supported by the new survey data. The RUC compared the survey code to MPC code 73721 *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (work RVU= 1.35, intra-service time of 20 minutes, total time of 30 minutes) and noted that both services have identical intra-service and total times and while the survey code involves somewhat more physician work. The RUC also compared the survey code to MPC code 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU= 1.40, intra-service time of 18 minutes, total time of 28 minutes, and noted that the survey code has slightly more intra-service and total times, supporting a work RVU of 1.38 for the survey code. **The RUC recommends a work RVU of 1.38 for CPT code 71270.**

Practice Expense
A detailed discussion was convened regarding specialty society's recommendation to include 3 minutes for the CT Technologist (L046A) to *Technologist QC's images in PACS, checking for all images, reformats, and dose page* (line 44). Often this clinical labor input requires 2 minutes of clinical staff time; however this line item does not have a standard time. An additional minute above the typical is warranted for these CT Chest codes. During the discussion, precedent was cited from the practice expense review for Mammography services and Cardiac MR services.

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

X-Ray of Wrist (Tab 32)
Zeke Silva III, MD (ACR); Kurt A. Schoppe, MD (ACR); Daniel Wessell, MD (ACR); Anne Miller, MD (ASSH); William Creevy, MD (AAOS); John Heiner, MD (AAOS)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. Code 73110 was identified in this screen and code 73100 was added as a family code.

73100 ***Radiologic examination, wrist; 2 views***
The RUC reviewed the survey results from 97 radiologists, hand surgeons and orthopaedic surgeons and agreed with 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 survey 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 compared the survey code to the primary key reference code 73600 *Radiologic examination, ankle; 2 views* (work RVU= 0.16, intra-service time of 3 minutes, total time of 5 minutes) and noted that both services have identical intra-service and total times and involve a similar amount of physician work. The RUC also compared the survey code to the

second key reference code 73060 *Radiologic examination; humerus, minimum of 2 views* (work RVU= 0.16, intra-service time of 3 minutes, total time of 5 minutes) and noted that both services have identical physician times and involve a similar amount of physician work. **The RUC recommends a work RVU of 0.16 for CPT code 73100.**

73110 *Radiologic examination, wrist; complete, minimum of 3 views*
The RUC reviewed the survey results from 97 radiologists, hand surgeons and orthopaedic surgeons and agreed with 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 survey 25th percentile work RVU of 0.17 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.17, the RUC compared the survey code to MPC code 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU= 0.22, intra-service time of 3 minutes, total time of 6 minutes) and noted that the survey code has more intra-service time and identical total time. The RUC also compared the survey code to the primary 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. **The RUC recommends a work RVU of 0.17 for CPT code 73110.**

Practice Expense
The specialty met compelling evidence that there is a change from previous code-specific practice expense to adoption of a newly applicable standard or package. The amount of time for acquiring images was increased to 8 minutes for 73110, because the CPT descriptor has a minimum of 3 views and in the typical scenario 4 views are performed. The change to 8 minutes would insure that the typical number of views for this service would follow a logical progression per view. PACS workstations are also typically present in the office-based practices of orthopaedic surgeons and hand surgeons, so the inclusion of a PACS workstation is warranted. The RUC determined that the inclusion of SB026 gown is not typical for codes 73100 or 73110 and therefore removed that supply input. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

X-Ray of Hands and Fingers (Tab 33)
Zeke Silva, III, MD (ACR); Kurt A. Schoppe, MD (ACR); Daniel Wessell, MD (ACR); Anne Miller, MD (ASSH); William Creevy, MD (AAOS); John Heiner, MD (AAOS)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. Code 73130 was identified in this screen and codes 73120 and 73140 were added as family codes.

73120 *Radiologic examination, hand; 2 views*
The RUC reviewed the survey results from 93 radiologists, hand surgeons 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 2014 Medicare claims data for this service and confirmed that diagnostic radiology is the dominant provider for global reporting and 26-modifier reporting in aggregate.

The RUC reviewed the survey 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 compared the survey code to the primary key reference code 73600 *Radiologic examination, ankle; 2 views* (work RVU= 0.16, intra-service time of 3 minutes, total time of 5 minutes) and the second key reference code 73060 *Radiologic examination; humerus, minimum of 2 views* (work RVU= 0.16, intra-service time of 3 minutes, total time of 5 minutes) and noted that the survey code includes more intra-service time and total time relative to the reference codes. **The RUC recommends a work RVU of 0.16 for CPT code 73120.**

73130 *Radiologic examination, hand; minimum of 3 views*
The RUC reviewed the survey results from 93 radiologists, hand surgeons 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 survey 25th percentile work RVU of 0.17 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.17, the RUC compared the survey code to MPC code 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU= 0.22, intra-service time of 3 minutes, total time of 6 minutes) and noted that the survey code has more intra-service time and total time. The RUC also compared the survey code to the second 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. **The RUC recommends a work RVU of 0.17 for CPT code 73130.**

73140 *Radiologic examination, finger(s), minimum of 2 views*
The specialty societies presented compelling evidence that hand surgeons were not involved the previous review of this code in 2005 and that the work and times recorded were based on flawed data. The RUC rejected compelling evidence, indicating that hand surgeons are not the dominant providers and a hand surgeon was involved in the presentation to the RUC in 2005.

The RUC reviewed the survey results from 93 radiologists, hand surgeons 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 survey data and agreed that since compelling evidence was not accepted, the existing value of 0.13 should be maintained for this service. The RUC compared the survey code to the top key reference code 73060 *Radiologic examination; humerus, minimum of 2 views* (work RVU= 0.16, intra-service time of 3 minutes, total time of 5 minutes) and the second key reference code 73600 *Radiologic examination, ankle; 2 views* (work RVU= 0.16, intra-service time of 3 minutes, total time of 5 minutes) and noted that the survey code includes more intra-service time and total time relative to the reference codes. The RUC also noted that all RUC reviewed plain film codes with one or two views were valued at 0.16, however since compelling evidence was not accepted, an increased work RVU for 73140 was not appropriate. **The RUC recommends a work RVU of 0.13 for CPT code 73140.**

Practice Expense
The specialty met compelling evidence that there is a change from previous code-specific practice expense to adoption of a newly applicable standard or package. The RUC determined that the inclusion of SB026 gown is not typical for codes 73120, 73130 or 73140 and

therefore removed that supply input. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

CT Angiography of Abdominal Arteries (Tab 34)
Zeke Silva lll, MD (ACR); Kurt Schoppe, MD (ACR)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010.

75635 ***Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing***

The RUC reviewed the survey results from 65 radiologists and agreed with the following physician time components: pre-service time of 10 minutes, intra-service time of 39 minutes and post-service time of 8 minutes. The RUC noted that, although there was a modest decrease in physician time relative to when this service was last reviewed by the RUC in 2001, the number of images has increased several fold and the detail in those image reconstructions has increased. The RUC agreed that the change in the amount and detail of these images would make the work somewhat more intense to perform.

The specialty society noted that the survey code was presented separately from other CTA codes as this service represents a different patient populations and different diagnoses. For example, the typical patient receiving a CTA of abdominal arteries has peripheral vascular disease, as opposed to CTA Abdomen and Pelvis where aortic disease or visceral disease are typical. The RUC agreed the survey code does not have any other services within the same family.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 2.45, which is somewhat higher than the existing work RVU, and agreed that the survey data supports maintaining a work RVU of 2.40 for the code. The RUC compared the survey code to key reference code 74262 *Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed* (work RVU= 2.50, intra-service time of 45 minutes, total time of 57 minutes) and noted that both services have identical total times, while the survey code involves somewhat more intense work, supporting a work RVU of 2.40 for the survey code. To further justify a work RVU of 2.40, the RUC compared the survey code to MPC code 95810 *Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU= 2.50, intra-service time of 36.5 minutes, total time of 66.5 minutes) and noted that the survey code has more intra-service time and involves somewhat more intense physician work. The RUC also compared the survey code to other CT Angiography services such as, 73706 *CT Angiography, lower extremity, with contrast, including noncontrast images, if performed, and post processing* (work RVU= 1.90) and 74174 *CT Angiography, abdomen and pelvis, with contrast, including noncontrast images, if performed, and post processing* (work RVU= 2.20) and agreed that the valuation of the survey code is appropriate relative to these other CTA services. **The RUC recommends a work RVU of 2.40 for CPT code 75635.**

Practice Expense
The clinical staff time inputs were revised to ensure that there is sufficient time for the clinical staff to obtain consent and to prepare the supplies to accommodate the angiography. Additionally, the equipment minutes were corrected for the CT room as it is used to acquire the images, but not during the post processing. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Ophthalmic Ultrasound (Tab 35)
David B. Glasser, MD (AAO)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 76512 was identified via this screen and codes 76510 and 76511 were added for review as part of this family of services.

> The specialty societies indicated a scheduling conflict for the American Society of Retina Specialists (ASRS) to be able to survey for the April 2016 RUC meeting. The RUC inquired about the delay and learned that ASRS had a meeting conflict which would have prohibited their involvement in the survey process. The RUC agreed that it was important for the appropriate specialties to be involved and that the delay would not impact the ability of the RUC to value the codes within the current cycle. Therefore, the RUC agreed that a delay in surveying for the October RUC meeting would be appropriate. **The RUC recommends delay to the October 2016 RUC meeting for CPT codes 76510, 76511, and 76512.**

Ophthalmic Biometry (Tab 36)
David B. Glasser, MD (AAO)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010.

76516 ***Ophthalmic biometry by ultrasound echography, A-scan;***
The RUC reviewed the survey results from 86 practicing ophthalmologists and agreed with the following time components: pre-service time of 2 minutes, intra-service time of 10 minutes and immediate post-service time of 2 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the appropriate value is the 25th percentile (work RVU= 0.40). The RUC compared the surveyed code to top key reference code 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg;, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVU= 0.50, intra time= 10 minutes) and noted that both services have identical intra-service time and comparable physician work. The RUC also compared to CPT code 92541 *Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording* (workRVU=0.40, intra time=10 minutes) as a recently reviewed (RUC review 2014) code with identical intra-service time. **The RUC recommends a work RVU of 0.40 for CPT code 76516.**

76519 ***Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation***
The RUC reviewed the survey results from 99 practicing ophthalmologists and agreed with the following time components: pre-service time of 2 minutes, intra-service time of 10 minutes and immediate post-service time of 10 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the appropriate value is between the median value (work RVU= 0.70) and 25th percentile (work RVU= 0.51), which aligns with maintaining the current work RVU of 0.54. The RUC compared the surveyed code to top key reference code 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg;, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVU= 0.50, intra time= 10 minutes) and noted that both services have identical intra-service time and comparable physician work. **The RUC recommends a work RVU of 0.54 for CPT code 76519.**

92136 ***Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation***
The RUC reviewed the survey results from 101 practicing ophthalmologists and agreed with the following time components: pre-service time of 2 minutes, intra-service time of 10 minutes and immediate post-service time of 10 minutes.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the appropriate value is between the median value (work RVU= 0.75) and 25th percentile (work RVU= 0.50), which aligns with maintaining the current work RVU of 0.54. The RUC compared the surveyed code to top key reference code 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg;, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVU= 0.50, intra time= 10 minutes) and noted that both services have identical intra-service time and comparable physician work. **The RUC recommends a work RVU of 0.54 for CPT code 92136.**

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

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

Radiation Therapy Planning (Tab 37)
Michael Kuettel, MD, PhD (ASTRO); Peter Orio III, DO (ASTRO)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code

77263 was identified by this criteria and CPT code 77261 and 77262 were added as part of the family of services.

77261 ***Therapeutic radiology treatment planning; simple***
The RUC reviewed the survey results from 143 practicing radiation oncologists and recommend the following physician time components: pre-service time of 3 minutes, intra-service time of 30 minutes and immediate post-service time of 3 minutes.

The RUC reviewed the survey respondents' estimated physician work RVUs and agreed that the survey's 25th percentile work RVU of 1.30, lower than the current work RVU of 1.39, is appropriate. To justify a work RVU of 1.30, the RUC compared the surveyed code to the top key reference service CPT code 77306 *Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)* (work RVU= 1.40, intra time= 30 minutes) and agreed that while the two services have comparable physician work, the reference code has more intra-service time and should be valued higher. The RUC also reviewed CPT codes 77334 *Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)* (work RVU= 1.24, intra time= 35 minutes) and 77768 *Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions* (work RVU= 1.40, intra time= 35 minutes) and agreed both services offer reasonable comparisons to the recommended value.

Finally, the RUC discussed the current CMS/Other physician time. This service was originally assigned a work value and times by CMS over 20 years ago using some unknown methodology, making it inappropriate to compare changes in total time. In addition to the existing times having been assigned using a flawed methodology, the RUC noted that only existing total time was assigned, making it not possible to compare changes in intra-service time. Accounting for appropriate time allocation, the intensity has not meaningfully changed. **The RUC recommends a work RVU of 1.30 for CPT code 77261.**

77262 ***Therapeutic radiology treatment planning; intermediate***
The RUC reviewed the survey results from 144 practicing radiation oncologists and recommend the following physician time components: pre-service time of 3 minutes, intra-service time of 45 minutes and immediate post-service time of 6 minutes.

The RUC reviewed the survey respondents' estimated physician work RVUs and agreed that the survey's 25th percentile work RVU of 2.00, lower than the current work RVU of 2.11, is appropriate. To justify a work RVU of 2.00, the RUC compared the surveyed code to the top two key reference services CPT codes77317 *Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)* (work RVU= 1.83, intra time= 50 minutes) and 77307 *Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)* (work RVU= 2.90, intra time= 80 minutes) and agreed that both these reference codes provide appropriate brackets around the recommended value. The RUC also reviewed CPT code 77770 *Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel* (work RVU= 1.95, intra time= 45 minutes) and agreed that both services have comparable physician time and work and should be valued similarly.

Finally, the RUC discussed the current CMS/Other physician time. This service was originally assigned a work value and times by CMS over 20 years ago using some unknown methodology, making it inappropriate to compare changes in total time. In addition to the existing times having been assigned using a flawed methodology, the RUC noted that only existing total time was assigned, making it not possible to compare changes in intra-service time. Accounting for appropriate time allocation, the intensity has not meaningfully changed. **The RUC recommends a work RVU of 2.00 for CPT code 77262.**

77263 ***Therapeutic radiology treatment planning; complex***
The RUC reviewed the survey results from 146 practicing radiation oncologists and recommend the following physician time components: pre-service time of 7 minutes, intra-service time of 60 minutes and immediate post-service time of 15 minutes.

The RUC reviewed the survey respondents' estimated physician work RVUs and agreed that the current work RVU of 3.14, lower than the survey's 25th percentile value, is appropriate. To justify a work RVU of 3.14, the RUC compared the surveyed code to the second key reference service 77307 *Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)* (work RVU= 2.90, intra time= 80 minutes) and agreed that while both services have analogous physician work, with similar total time, surveyed code is more intense procedure and is correctly valued higher. In addition, the RUC reviewed several recently RUC reviewed services with identical intra-service time to validate the recommended work value across a broad spectrum of services: CPT code 38241 *Hematopoietic progenitor cell (HPC); autologous transplantation* (work RVU= 3.00), 90792 *Psychiatric diagnostic evaluation with medical services* (work RVU= 3.25) and 94012 *Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age* (work RVU= 3.10).

Finally, the RUC discussed whether it is possible to compare changes in intra-service time. Unlike the other codes in this family, this service was RUC reviewed in 2005. However, the survey only collected total time and thus does not have appropriate breakouts for pre- and post-service time. Accounting for appropriate time allocation, the intensity has not meaningfully changed. **The RUC recommends a work RVU of 3.14 for CPT code 77263.**

Practice Expense:
There are no direct practice expense inputs for these services. These services represent physician work only.

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

<u>Bone Imaging (Tab 38)</u>
Gary Dillehay, MD (SNMMI); Scott Bartley, MD (ACNM); Zeke Silva III, MD (ACR); Kurt Schoppe, MD (ACR)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 78306 was identified via this screen.

During the RUC's discussion of this tab, the specialty societies noted and the RUC agreed that physician work governed by regulatory requirements happens both in the pre-service and post-service periods. The specialty societies noted that before the study is performed, the physician must review flood sources and perform tasks pertaining to receipt of the radiopharmaceutical; after the intra-service period, there are regulatory review tasks pertaining to review of surveys and disposal or return of radiopharmaceuticals.

78300 ***Bone and/or joint imaging; limited area***
The RUC reviewed the survey results from 137 physicians and agreed on the following physician time components: pre-service time of 5 minutes, intra-service time of 10 minutes and post-service time of 5 minutes. The RUC noted that the Harvard Study only measured total time for this service, so a comparison of change in intra-service time is not possible.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 0.70, and agreed that maintaining the current work RVU of 0.62 is appropriate. To further validate a work RVU of 0.62, the RUC compared the survey code to top key reference code 78226 *Hepatobiliary system imaging, including gallbladder when present;* (work RVU= 0.74, intra-service time of 10 minutes, and total time of 20 minutes) and noted that both services have identical intra-service and total times and the survey respondents rated both services as involving a similar amount of intensity and complexity. The RUC also compared the survey code to CPT code 76856 *Ultrasound, pelvic (nonobstetric), real time with image documentation; complete* (work RVU= 0.69, intra-service time of 10 minutes, total time of 20 minutes) and noted that both services have identical intra-service and total times and involve a similar amount of physician work. **The RUC recommends a work RVU of 0.62 for CPT code 78300.**

78305 ***Bone and/or joint imaging; multiple areas***
The RUC reviewed the survey results from 132 physicians and agreed on the following physician time components: pre-service time of 5 minutes, intra-service time of 10 minutes and post-service time of 5 minutes.

The RUC noted that although the survey times where identical relative to 78300, the amount of physician work of bone imaging studies for multiple areas represents more physician work relative to only a limited area. The RUC also noted that although the Harvard Study only measured total time for this service, so a comparison of change in intra-service time is not possible.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 0.85, and agreed that maintaining the current work RVU of 0.83 is appropriate. To further validate a work RVU of 0.83, the RUC compared the survey code to 70486 *Computed tomography, maxillofacial area; without contrast material* (work RVU= 0.85, intra-service time of 10 minutes, total time of 16 minutes) and noted that both services have identical intra-service time, while the survey code includes more total time. The RUC also compared the survey code to CPT code 78453 *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)* (work RVU= 1.00, intra-service time of 10 minutes, total time of 20 minutes) and noted that identical intra-service time and total times, a work RVU of 0.83 for the survey code is supported. **The RUC recommends a work RVU of 0.83 for CPT code 78305.**

78306 *Bone and/or joint imaging; whole body*
The RUC reviewed the survey results from 143 physicians and agreed on the following physician time components: pre-service time of 5 minutes, intra-service time of 10 minutes and post-service time of 5 minutes.

The RUC noted that although the survey times where identical relative to 78306, the amount of physician work of bone imaging studies for the whole body represents more work relative to only multiple areas.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 0.90, and agreed that maintaining the current work RVU of 0.86 is appropriate. To further validate a work RVU of 0.86, the RUC compared the survey code to the RUC compared the survey code to 70486 *Computed tomography, maxillofacial area; without contrast material* (work RVU= 0.85, intra-service time of 10 minutes, total time of 16 minutes) and noted that both services have identical intra-service time, while the survey code includes more total time. The RUC also compared the survey code to CPT code 78453 *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)* (work RVU= 1.00, intra-service time of 10 minutes, total time of 20 minutes) and noted that identical intra-service time and total times, a work RVU of 0.86 for the survey code is supported. **The RUC recommends a work RVU of 0.86 for CPT code 78306.**

Practice Expense
It was determined that the clinical staff perform surveys of areas used during imaging and documentation for regulatory compliance during the clinical labor post-service period after the patient has left the office and not during the post-service portion of the service period when the patient is still in the office. Making this reallocation also reduced the PACS Workstation equipment time by 3 minutes for each code. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

<u>Pathology Consultation During Surgery (Tab 39)</u>
Jonathan Myles, MD (CAP); Swati Mehrotra, MD (ASC)

Following publication of the 2014 Final Rule, the RUC solicited feedback from the specialties societies regarding CPT codes potentially impacted by the OPPS/ASC Payment Cap. Specialty societies indicated an interest in re-reviewing or validating a recent RUC review for PE only, for 58 of the 211 codes identified through the cap. The PE Subcommittee reviewed the codes identified by specialty societies, grouped by families, at the April 2014 RUC meeting and provide CMS with the recommendations as a sample subset of the codes impacted by the cap. CPT codes 88333 and 88334 were included in these recommendations. CMS chose not to implement the RUC recommendations for 2015, but has reviewed and accepted the recommendations with refinement for 2016. CMS expressed concern about the way the services were selected for review and limiting the review to PE only. The RUC understand CMS' concerns about implementing PE inputs without the corresponding work being reviewed. AMA staff analyzed the 58 services that the RUC submitted PE recommendations for and determined that one or more of the following is true of most of the codes: frequency less than 10,000; reviewed for work within the last five years; included in the list of proposed potentially misvalued codes identified through high expenditure by specialty screen that CMS included in the proposed rule for 2016. The application of this criteria, results in only 6 remaining codes. The codes are 10021, 30903, 88333, 88334, 95812 and 95813.

88333 ***Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site***
The RUC reviewed the survey results from 53 pathologists and cytopathologists and determined that it was appropriate to maintain the current work RVU of 1.20, which is supported by the survey median of 1.20. The RUC recommends 25 minutes intra-service time. The RUC compared the surveyed code to the top key reference service 88331, *Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen* (work RVU = 1.19, intra-service time of 25 minutes) and noted that both services have similar physician work and should be valued similarly. For additional support the RUC compared the surveyed code to CPT code 88120 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual* (work RVU = 1.20, intra-service time of 30 minutes) and noted that the surveyed code requires slightly less intra-service time, but is more intense to perform justifying the identical work RVUs. **The RUC recommends a work RVU of 1.20 for CPT code 88333.**

88334 ***Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 41 pathologists and cytopathologists and determined that it was appropriate to maintain the current work RVU of 0.73, which is supported by the survey 25th percentile of 0.75. The RUC recommends 20 minutes intra-service time. The RUC compared the surveyed code to the top key reference service 88332, *Pathology consultation during surgery; each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)* (work RVU = 0.59, intra-service time of 16 minutes) and noted that the surveyed code as greater intra-service time and is appropriately valued higher. For additional support the RUC compared the surveyed code to CPT code 95887 *Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)* (work RVU = 0.71, intra-service time of 20 minutes) and noted that the both services have identical intra-service time and similar intensity and should be valued similarly. Additionally the RUC discussed that 88334 is an add-on code and should have a ZZZ global period rather than a XXX global period. **The RUC recommends a work RVU of 0.73 for CPT code 88334.**

Global Period
The RUC requests that CMS assign a ZZZ global period to CPT code 88334. The RUC noted that the Committee's other recommendations are not contingent on this global period change, as this code does not include any pre-service or post-service time.

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

<u>Tumor Immunohistochemistry (Tab 40)</u>
Jonathan Myles, MD (CAP); Swati Mehrotra, MD (ASC);
Roger McLendon, MD (CAP)

In the Proposed Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT codes

88360 and 88361 were among the codes under this high expenditure screen for which CMS sought recommended values from the RUC and other interested stakeholders,

88360 ***Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; manual***
The RUC reviewed the survey results from 60 practicing pathologists and cytopathologists and recommends 23 minutes of intra-service time. The RUC then reviewed the survey respondents' estimated physician work values and noted that the survey's 25th percentile work RVU of 0.85, lower than the current work RVU of 1.10, is appropriate for this code. To justify a work value of 0.85, the RUC compared the surveyed code to the top key reference code 88342 *Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure* (work RVU= 0.70, intra time= 25 minutes) and agreed that code 88360 is a more intense procedure than code 88342; although it has slightly less intra-service time, it should be valued higher. With code 88342, the physician is only giving a positive or negative result. Whereas in code 88360 the physician must, in addition to reporting the result, also give a quantitative or semi-quantitative analysis of the number of positive cells.

To corroborate this assertion, the RUC, noting the drop in intra-service time and the change in intensity since the previous valuation, had a significant discussion regarding the rise in intensity due to a lower survey time. In 2010, practice guidelines were published by the American Society of Clinical Oncology and the College of American Pathologists regarding the reporting of estrogen and progesterone receptor results. Prior to the guidelines, there was no consensus as to what constituted a positive result. Now physicians are now required to do the following: report a percentage of positive cells, indicate whether the staining is weak, moderate or strong, check the length and type of fixation and document the status of internal and external control tissue. All of this was not required when the code was last reviewed in 2004. Given this robust set of clinical information, the RUC confirmed that the intensity has increased and the recommended value is appropriately higher than the top key reference service. **The RUC recommends a work RVU of 0.85 for CPT code 88360.**

88361 ***Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; using computer-assisted technology***
The RUC reviewed the survey results from 53 practicing pathologists and cytopathologists and recommends 25 minutes of intra-service time. The RUC then reviewed the survey respondents' estimated physician work values and noted that the survey's 25th percentile work RVU of 0.95, lower than the current work RVU of 1.18, is appropriate for this code. To justify a work value of 0.95, the RUC compared the surveyed code to the top two key reference codes 88121 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology* (work RVU= 1.00, intra time= 25 minutes) and 88342 *Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure* (work RVU= 0.70, intra time= 25 minutes) and agreed that the work involved in code 88361 is more analogous to code 88121 than code 88342. The surveyed code and code 88121 both contain similar physician work in that both use computer-assisted technology and include morphometry. The second key reference code contains neither element. Additionally, the top key reference code and the surveyed code are also more intense procedures because the findings result in direct therapeutic intervention.

In addition to discussing the issue of increased intensity for this service due to the lower survey time, which is covered in the discussion above for code 88360, the RUC also noted

that the physician work is greater for code 88361 compared to 88360, even though computer-assisted technology is involved. With the aid of the computer, the physician is able to review many more cells compared to the manual approach. Furthermore, the computer does not just produce the answers. The physician must still check the staining intensity, review fixation and ensure the technologist set the gait correctly in order to identify the correct target area. Given this information, the RUC agreed that the recommend value is appropriate relative to both the top key reference service and the other manual procedure (88360) in the family. **The RUC recommends a work RVU of 0.95 for CPT code 88361.**

Practice Expense:
The RUC approved the direct practice expense inputs with the specialty society's' modifications as approved by the Practice Expense Subcommittee.

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

Glaucoma Provocative Tests (Tab 41)
David B. Glasser, MD (AAO)

In October 2015, AMA staff re-ran the Harvard valued codes with utilization over 30,000 based on 2014 Medicare claims data and this service was identified.

The specialty societies noted that they believe the increase usage is due to incorrect coding and have submitted a Coding Change Application to the CPT Editorial Panel. The RUC noted that the review of this code for potential deletion will occur at the May 2016 CPT meeting. **The RUC recommends referral of CPT code 92140 to the CPT for deletion.**

Transthoracic Echocardiography (TTE) (Tab 42)
Richard Wright, MD (ACC); Thad Waites, MD (ACC); Michael Main, MD (ASE)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. CPT code 93306 was identified by CMS.

Compelling Evidence
The specialty societies indicated that there has been a change in technique and diffusion of technology used to perform 93306. The digital evolution and more sophisticated computers allow for additional modalities to be deployed for echocardiography. The eleven different windows for each echocardiography now comprise more information per study. The physician also performs new services such as diastolic function and spectral tracking, resulting in more images. The physician now reviews 84 video loops for a typical study. Additionally, there have been many accreditation body requirements since this service was last valued, which increases the work per study. For example, the American Society of Echocardiography has published 27 different guideline/clinical recommendations. The RUC accepts compelling evidence that the work for CPT code 93306 has changed.

93306 ***Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography***
The RUC reviewed the survey results from 172 cardiologists for CPT code 93306 and determined that the survey 25th percentile work RVU of 1.50 appropriately accounts for the physician work required to perform this service. The RUC recommends 5 minutes of pre-service evaluation time, 20 minutes of intra-service time and 5 minutes of post-service time. The RUC agreed that the intensity for this service has increased in the last 10 years because the physician reviews more images in the same amount of time and performs additional testing such as diastolic function and spectral tracking. Part of the standard of care now includes the physician calculation of left ventricular ejection fraction in many patient populations. This is all incremental physician work that is not an automated function. The RUC agreed that there may be minor efficiencies in time for this service; however the intensity in work has been compounded by the increase in technology and the number of images to review, additional testing and calculations that the physician is now conducting.

The RUC compared 93306 to top key reference service 78452 *Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection* (work RVU = 1.62 and 20 minutes intra-service time). The survey respondents indicated that 93306 is somewhat more intense/complex than 78452, however the intra-service times are identical (20 minutes). The specialty societies indicated that the higher intensity and complexity measures, likely reflect the more diverse disease processes to consider when the physician is reviewing the images. CPT code 93306 provides a non-invasive comprehensive assessment of cardiac structure and function which includes measurements performed in the course of the examination, 2-dimensional and/or M-Mode numerical data for transthoracic echocardiograms, and Doppler/color flow data. Whereas, CPT code 78452 assesses heart conditions including myocardial wall motion abnormalities with myocardial perfusion at stress and rest. The total time differences between codes 78452 and 93306 were solely based on the shorter pre- and post-service time periods, which are balanced by the difference in work RVUs.

For additional support, the RUC referenced MPC code 74176 *Computed tomography, abdomen and pelvis; without contrast material* (work RVU = 1.74 and 22 minutes intra-service) and similar service72146 *Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material* (work RVU = 1.48 and 20 minutes intra-service time). **The RUC recommends a work RVU of 1.50 for CPT code 93306.**

93307 ***Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography***
The RUC reviewed the survey results from 152 cardiologists for CPT code 93307 and determined that the current work RVU of 0.92, lower than the survey 25th percentile, appropriately accounts for the physician work required to perform this service. The RUC recommends 5 minutes of pre-service evaluation time, 15 minutes of intra-service time and 5 minutes of post-service time. The RUC noted that CPT code 93307 was last RUC reviewed in 2007; since that time there have been technological and clinical advances which allow for efficient review of additional images. The Intersocietal Accreditation Commission (IAC) standards last updated in 2015 require eleven separate imaging windows, with approximately 4-5 views per window (even without color Doppler or pulse Doppler). Quantitative evaluation of cardiac structures, such a left atrial volume, is now the expected standard. While digital

technology has afforded some improvement in intra service time, the physician no longer must passively wait as videotape advances, the volume and complexity of information to evaluate in the study has increased. The RUC agreed that this appropriately explains the increased intensity that results from maintaining the work RVU while slightly reducing the intra-service time.

The RUC compared 93307 to top key reference service 78454 *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection* (work RVU = 1.34 and 15 minutes intra-service time). The survey respondents indicated that 93307 is somewhat more intense/complex than 78454, however the intra-service times are identical (15 minutes). The specialty societies indicated that the intensity and complexity measures were higher for 93307, likely reflecting the more diverse disease processes to consider when the physician is reviewing the images. CPT code 93307 is a comprehensive cardiac study which includes measurements performed in the course of the examination, 2-dimensional and/or M-Mode numerical data for transthoracic echocardiograms and Doppler/color flow data. Whereas, CPT code 78454 is a planar imaging test to assess specific heart conditions including myocardial wall motion abnormalities with myocardial perfusion at stress and rest.

For additional support, the RUC referenced MPC codes 76805 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation* (work RVU = 0.99 and 15 minutes intra-service time) and 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08 and 15 minutes intra-service time). **The RUC recommends a work RVU of 0.92 for CPT code 93307.**

93308 ***Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study***
The RUC reviewed the survey results from 167 cardiologists for CPT code 93308 and determined that the current work RVU of 0.53, lower than the survey 25th percentile, appropriately accounts for the physician work required to perform this service. The RUC recommends 5 minutes of pre-service evaluation time, 10 minutes of intra-service time and 5 minutes immediate of post-service time. The RUC noted that CPT code 93308 was last RUC reviewed in 2011. This limited study is a problem-specific study, such a follow up for left ventricular ejection fraction in a patient undergoing chemotherapy. Once again, the array of tools now applied in this "limited" setting has advanced considerably since the last valuation. Use of contrast detailed analysis of regional ventricular function and quantitative assessment of ejection fraction are now routinely applied in "limited" echo studies, in stark contrast to the clinical standard at the time of the prior valuation. Additionally, while digital technology has afforded some improvement in intra service time, the volume and complexity of information the physician must evaluate for the study has increased. The RUC agreed that this appropriately explains the increased intensity that results from maintaining the work RVU while slightly reducing the intra-service time.

The RUC compared 93308 to top key reference service 78454 *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection* (work RVU = 1.34 and 15 minutes intra-service time). The survey respondents indicated that 93308 is somewhat more intense/complex than 78454. The specialty societies indicated that the intensity and complexity measures were higher for 93308, likely reflecting the more diverse disease processes to consider when the physician is reviewing the images. CPT code 93308 is

a cardiac study which includes measurements performed in the course of the examination, 2-dimensional and/or M-Mode numerical data for transthoracic echocardiograms and Doppler/color flow data. Whereas, CPT code 78454 is a planar imaging test to assess specific heart conditions including myocardial wall motion abnormalities with myocardial perfusion at stress and rest. CPT code 78454 requires 5 more minutes of intra-service time than 93308, which is balanced by the difference in work RVUs.

For additional support, the RUC referenced similar codes 78014 *Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)* (work RVU = 0.50 and 10 minutes intra-service time), 93882 *Duplex scan of extracranial arteries; unilateral or limited study* (work RVU = 0.50 and 10 minutes intra-service time) and 93979 *Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study* (work RVU = 0.50 and 10 minutes intra-service time). **The RUC recommends a work RVU of 0.53 for CPT code 93308.**

Practice Expense
The direct practice expense inputs were modified by reducing the clinical staff time in accordance with the two minute standard: line 21 *review prior images and report*, line 30 *prepare room, equipment*, supplies, and line 32 *Prepare and position patient/ monitor patient/ set up IV*. The Subcommittee also corrected line 71 the amount of *ultrasound transmission gel*, deleted line 73 *glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)* and replaced the vascular ultrasound room (EL016) with a general ultrasound room (EL015) thus eliminating the duplicative equipment. The RUC recommends the direct practice expense modifications as indicated by the Practice Expense Subcommittee.

Photodynamic therapy - PE Only (Tab 43)
Daniel M. Siegel, MD (AAD)

CPT code 96567 *Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (eg, lip) by activation of photosensitive drug(s), each phototherapy exposure session* was identified by Centers for Medicare and Medicaid Services (CMS) in the high expenditure services screen. The RUC recommended that this service be removed from the screen because it has a work RVU of 0.00. In the Final Rule for 2016 CMS indicated that this service should be reviewed.

In April 2001 CPT code 96567 was reviewed as new technology. The procedure involves application of a photo-sensitizing agent followed by exposure to special ultra-violet light. A survey of 39 dermatologists using this new technology indicated that there was some physician work for this XXX global period procedure. However, upon review of the survey responses, the specialty society concluded that the respondents did not accurately assess the time required by the physician for this procedure using the new technology and included a written recommendation that for the typical patient receiving this procedure, there is no physician work. The RUC agreed that the procedure, using this new technology, does not involve physician work but does involve practice expense direct inputs. Years later the service was nominated to be considered in 2005 Five-Year Review. The final Five-Year Workgroup report indicated that after extensive discussion with the RUC regarding the potential need for further CPT revisions, the RUC advised the specialty society that if physician work is part of the code then the specialty would need to submit a coding proposal to CPT to clarify the language to include physician work. At that time the specialty decided to instead withdraw the code from the Five-Year Review.

At the April 2016 RUC meeting the specialty society recommended that the service be deferred to the October 2016 RUC meeting in order for a survey of work to be conducted. The specialty explained that in reviewing the service closely, they realized that there is now physician work involved in providing this service. In order to confirm this observation, the specialty conducted an informal survey that was sent to a few dermatologists. The specialty contends that the results confirm that physicians are involved in the actual delivery of care to patients by performing tasks such as: curettage of thick lesions, real time tailoring of the PDT regimen, explaining side effects, and providing post care instructions. A RUC member questioned if any of the aforementioned services were separately billable and the specialty clarified that they are not. The specialty added that there has been no change to the service and that it is not necessary to refer to the code to the CPT Editorial Panel. A RUC member questioned why the specialty would be claiming that there is physician work now, when it was stated by the specialty that the service has not changed and in 2001 the specialty concluded that for the typical patient there is no physicians work as noted above. A RUC member suggested that there may be the need for two separate codes, one for a simple procedure that clinical staff can provide and one that is more complex and needs physician involvement. Another RUC member stated that the RUC does not have enough information to determine if the service should or should not go to CPT and ultimately that decision is up to the specialty society. The RUC member continued that this is an unusual service in that it usually is a two encounter service yet it is a single XXX global code. If they are going to survey for work the RUC advised that they go to CPT in order to separate this into two codes or at a minimum seek advice from the Research Subcommittee about how to survey for this type of service. The specialty indicated that it would submit a code change application to split code 96567 into two codes—one to describe physician work and one to describe the when the service is provided by clinical labor only. The specialty will submit a CCP for the September 2016 CPT meeting to address these concerns. **The RUC refers CPT code 96567 to the CPT Editorial Panel.**

Photochemotherapy - PE Only (Tab 44)
Daniel M. Siegel, MD (AAD)

In the Final Rule for 2016 CMS re-ran the high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since CY 2010. The RUC recommended that this service be removed from the screen because the work RVU is 0.00. In the Final Rule for 2016 CMS indicated that this service should be reviewed.

The specialty society explained that the technology for photochemotherapy has changed since this service was last reviewed in February 2001 from broadband UVB only to predominantly narrowband UVB. Patients are treated more aggressively resulting in longer treatment sessions and increased staff requirements. Moreover, due to increased energy output of bulbs, patients must be monitored more closely. The specialty also clarified that the typical patient receiving this procedure is a 47 year-old obese male patient with severe psoriasis with extensive body surface area involvement. The specialty explained that the occlusive dressings (ie impermeable sauna suit, nonlatex impermeable gloves and saran wrap) are applied over the tar. The sauna suit is listed as 0.5 units under supplies because it is used by the same patient for two separate treatment sessions. The specialty also verified that both the *phototherapy unit, hand-foot, UVA-UVB,* EQ204 and p*hototherapy unit, whole body, UVA-UVB,* EQ205 are used for the typical patient and that the *phototherapy UVB measuring device* EQ203 is only used for 2 minutes, rather than the entire service period.

The PE Subcommittee reviewed the direct PE inputs for CPT code 96910. The Subcommittee made the following modifications:

- Moved 2 minutes to *Other Clinical Activity - specify: Review physician orders and calculate dosage* from the post-service portion of the service period to pre-service portion of the service period.
- Verified that the sauna suit is used twice.
- Reduced the time to 2 minutes for equipment item *phototherapy UVB measuring device* EQ203 because it is not used for the entire service period and only requires 2 minutes of use, not directly corresponding to a line item on the spreadsheet.
- Modified the other equipment items *table, exam,* EF023 *light, exam,* EQ168, *phototherapy unit, hand-foot, UVA-UVB,* EQ204 and *phototherapy unit, whole body, UVA-UVB,* EQ205 to include the entire service period for the equipment minutes.

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

Home INR Monitoring (Tab 45)
Richard F. Wright, MD (ACC)

In October 2015, AMA Staff assembled a list of all services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2008 through 2013 and these services were identified. In April 2016, the specialty society indicated that they intend to develop Category I codes to describe home INR monitoring services for the September 2016 CPT meeting with review at the January 2017 RUC meeting. **The RUC recommends that codes G0248, G0249 and G0250 be referred to CPT to create Category I codes to describe these services.**

XII. Practice Expense Subcommittee (Tab 46)

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

- **Practice Expense Spreadsheet Update Workgroup**
  The Practice Expense (PE) Spreadsheet Update Workgroup, chaired by Doctor Ouzounian, has made substantial progress on an incremental improvement to the PE Spreadsheet. The Workgroup is categorizing all types of clinical staff activities in order to assign them a code number in the same way that supplies and equipment currently have code numbers. Assigning code numbers to clinical labor activities will better enable the PE Subcommittee to automate the PE spreadsheet, improving accuracy and reliability, as well as the ability to systematically input clinical labor activities into the CMS system. The draft spreadsheet will be circulated to specialty societies for input before we start piloting the new spreadsheet later this year.

- **Emergent Procedures Pre-Service Clinical Staff Time Review**
  The report provides the status of the work that the PE Subcommittee did at this meeting to review the pre-service clinical staff time in the facility for codes identified as emergent. AMA staff has been able to develop a method of reliably combing through the data to identify emergent procedures that is now part of the standard materials circulated for the meeting. The PE Subcommittee has come up with a new pre-service time standard for emergent procedures

in the 090 day global period of 20 minutes reduced from 60 minutes. This standard has by and large been accepted by a broad range of specialty societies for many types of codes including the 090 day global closed fracture codes listed in the report as well as a single 010 day global closed fracture code.

- **New Business**
  The PE Subcommittee discussed the CMS request that vignettes be available to the PE Subcommittee for review of PE only codes. There are currently two scenarios for PE only codes to receive vignettes. First, if a new code comes from the CPT Editorial Panel, a vignette will be included. However, these vignettes may need to be further vetted by the Research Subcommittee. Second, if a PE only code is an existing code and either has a vignette that needs to be revised or needs one created, the Research Subcommittee will review such requests.

  Additionally at the PE Subcommittee meeting during review of the single view chest X-ray code it came to the Subcommittee's attention that for five percent of the claims, which was the majority of claims in the outpatient non-facility setting, the service is provided in a nursing home. This highlights the problems that the PE Subcommittee has in determining the typical service in the non-facility setting and the typical specialty society providing the service in the non-facility setting. Moving forward AMA staff will run claims data using the five percent Medicare file to narrow down the site of service for the non-facility setting. This information will be distributed early as part of the level of interest process, so that societies will better be able to determine if they need to participate in the survey and review process. This is important because even if the specialty is a minority provider in the universe of claims, they may in fact be the dominant provider in the non-facility setting and it is critical that they are involved in developing the PE recommendations as it would primarily affect them. This data will also help inform the PE Subcommittee's review as they determine the appropriateness of the specialty society's recommended direct PE inputs in the non-facility setting, especially as it relates to whether or not Evaluation and Management services are typically reported and which specialties are dominant in the non-facility setting.

  Additionally, CMS asked that the description of clinical staff time be well articulated in the PE Summary of Recommendation document.

  The RUC approved the Practice Expense Subcommittee Report.

XIII. Relativity Assessment Workgroup (Tab 47)

- **Review of Action Plans**
  Doctor Hitzeman informed the RUC that the Relativity Assessment Workgroup review action plans for two families of codes:

  ***Continuous Glucose Monitoring* (95250 and 95251)**
  In April 2013, CPT code 95251 was identified through the High Volume Growth screen and the RUC initially recommended survey 95251 and 95250 for January 2014. These codes went through review by CPT for a couple iterations to revise and ultimately were not revised. Even though volume has stabilized, since these services were initially recommended to be surveyed in 2013 and had not been surveyed, **the Workgroup recommended to survey 95250 and 95251 for October 2016. The Workgroup also recommended that CPT code 95251 be removed from the MPC list as questions exist whether this is a well-defined service to use as an anchor reference across the physician payment schedule.**

***Physical Medicine and Rehabilitation* (97101-97799 and G0283)**

In February 2010, Physical Medicine and Rehabilitation services were first identified through the RUC's High Volume Growth Screen and subsequently by Codes Reported Together 75% of the Time and from CMS via the High Expenditure screen. Since the original identification in 2010, the organizations have maintained that the section of CPT must be updated to describe today's practice, prior to any analysis of valuation. A CPT Workgroup was formed in 2012 to address the coding issues. To date, there has not been any resolution. Therefore, the Workgroup reviewed an action plan to describing the work plan moving forward so review of these codes may occur. The specialty societies indicated which groups of codes they will be revising and when as outlined in the full Relativity Assessment Workgroup report. The review of these services will be completed by October 2017.

- **CMS/Other Source Codes – Utilization over 250,000**

  Doctor Hitzeman indicated that the Workgroup had been reviewing the remaining G-codes that were identified via the CMS/Other source codes in April 2013. Realizing that some of these are Medicare only codes, we still noted that we have surveyed G codes and these services are very high volume. After discussion, the Workgroup recommends:

Code	Recommendation
G0179 G0180	**Survey for work and review direct practice expense inputs for October 2016.**
99375 99378	**Survey for work and review direct practice expense inputs for October 2016. After review of 9937 and 99378, recommend to CMS to delete codes G0181 and G0182 as these are Category I and G codes are almost identical. Specialty society should identify any additional codes that are part of this family.**
G0438 G0439	The Workgroup questioned the validity of the current values being crosswalked to level 4 Evaluation and Management services. **Survey for work and review direct practice expense inputs for October 2016.**

- **CMS/Other Source Codes - Utilization over 100,000**

  Doctor Hitzeman indicated the Workgroup expanded the CMS/Other Source codes screen, lowering the Medicare utilization threshold from 250,000 to 100,000. **The Workgroup reviewed the list of 26 services and requested action plans to review in October 2016: 72020, 72072, 72220, 73070, 73090, 73650, 73660, 74220, 74420, 76000, 76870, 77012, 85060, 85097, G0101, G0108, G0109, G0166, G0402, G0403, G0436, G0442, G0444, G0447 and G0453.**

  For the G-codes identified, the specialty societies should specify whether the service should go back to CPT to create a Category I code or be surveyed.

  Peter K. Smith, MD reiterated that CMS and the specialty societies need to indicate what codes are part of a family of services to include in the survey process. Doctor Hitzeman indicated that we do request on the action plan and LOI forms that specialty societies indicate the family of services associated with each code identified via any relativity assessment screen.

  The RUC approved the Relativity Assessment Workgroup Report and are attached to these minutes.

XIV. Time-Intensity Workgroup (Tab 48)

Doctor Scott Collins, Workgroup Chair, provided a summary of the Time/Intensity Workgroup report:

- **Presentation by STS on Past Experience with Directly Surveying Physician Intensity**
  The Society of Thoracic Surgeons (STS) presented on the specialty's past experience with performing direct physician intensity surveys. Society of Vascular Surgeons' (SVS) is the other specialty that also has experience with performing direct intensity surveys. For direct intensity surveys, the intensity magnitude estimate asks the survey participant to estimate the average work intensity during the intra-service time of a survey code relative to average work intensities of other established codes contained in the intensity reference intensity list. The participant establishes relativity (rank order and degree of dispersion) between the code being surveyed and the intensities established for the codes in the Reference Intensity List. STS noted that the direct intensity survey methodology was validated in comparison to several Rasch analyses performed by the specialty. STS recommends for the RUC to approve this methodology for use outside of the former 5-year review process. The society also recommends that procedures be established for developing Reference Intensity Lists, so that these results can be deemed valid and utilized in a manner consistent with RUC precedents.

  The Workgroup discussed this proposal in detail and asked several questions of the STS representatives. A Workgroup member shared an idea of potentially splitting the intra-service time into several distinct subparts and for intensity to separately be measured for each of those subparts. It was noted that the methodology for evaluating anesthesia services includes some of these elements.

  Following this extensive discussion, the Workgroup thanked STS for volunteering their time and resources to prepare these materials and to present to the Workgroup. The Workgroup noted that they would continue to evaluate this presented idea along with other ideas for measuring work intensity. **Doctor Collins assured STS that there request for validation of the methodology outside of the previous 5 year review process would be maintained as an agenda item, and would be addressed at a future meeting.**

- **Discussion of New Ideas**

  - **Fly-in Meeting for Workgroup at AMA HQ:** The Time-Intensity Workgroup Chair proposed a fly-in meeting in Chicago for Workgroup. **Doctor Collins and AMA Staff will further evaluate a one or two day in-person meeting in Chicago for the Workgroup.**

  - **Intensity and Complexity (I/C) Measures**
    Doctor Collinssummarized the two main areas of concern stakeholders have expressed regarding the current intensity and complexity measures:

    1) They are hard/time-consuming to interpret.
    For each survey code, there are 18 intensity/complexity scores listed on the SOR and those scores are very small numbers that go out to the second decimal point. With the RUC reviewing ~100 codes per meeting, there is simply too much information to be able to review it all effectively.

2) Questions about the validity of the underlying data.

This stems largely from the responses tending to most commonly indicate that the survey code is somewhat more intense than the reference code. It is unclear whether this is due to a flaw in the survey design or because, for the initial selection of the key reference code, the survey respondents just tend to select reference codes that are typically somewhat less intense than the code under survey for some unknown reason.

Doctor Collins proposed to address the first issue and that the second issue be addressed at a later date. The Workgroup can attempt to revise the intensity and complexity scores without making changes to the survey instrument.

- **The Workgroup discussed the following ideas regarding the summary data for the intensity and complexity measures:**

  - **Show average responses text in summary data:** What the survey respondent is actually asked to provide is not numeric, but text choices indicating whether the survey code "much less" to "much more" intense/complex relative to the selected key reference service. The -2, -1, 0, +1 +2 scale is simply assigned to corresponding text choices behind the scenes in the raw data. If the summary data was also (or only) reported as the actual underlying text choice (i.e. if score is between 0.51 and 1.49, it could say the survey code is "somewhat more intense" than the reference code), that may make the information easier to interpret.

  - **Aggregate Score:** Prove average scores for each of three categories of "mental effort and judgment" and "psychological stress." For example, there are three I/C questions that fall under "mental effort and judgment"; those 3 summary scores could be averaged into a single score. This could also be done for the "psychological stress" category.

  - **Reordering Overall Intensity Summary score:** Although the overall I/C question is last on the actual survey, this score may be more helpful displayed first on the SOR to provide RUC members with a quick point of reference.

  The Time-Intensity Workgroup recommends for a pilot test of these three proposed ideas to be performed by all societies surveying for the October 2016 RUC meeting for every survey code. This alternate summary data would be provided as a 1 page addendum to the SOR. The Workgroup requested for AMA staff to create instructions for specialty staff on how to implement this pilot.

- **Ideas for Validation of Physician Time and Intensity**
  - **Surveying intra-service work directly:** Doctor Collins proposed the idea of surveying for intra-service physician work RVUs in addition to, or even instead of surveying total work RVU. He noted that although this does not survey directly for intensity, it does allow a direct calculation of intensity from two directly surveyed values. The Workgroup discussed this idea with some members expressing interest in exploring this idea further.

  - **Ranking surveys:** Separately from RUC survey, send out a separate survey asking respondents to simply rank a group of codes in order of their intraservice intensity and/or time and/or intraservice work. The purpose of this idea is internal validation of existing rank orders and intensities to make sure they have appropriate rank order.

Doctor Collins noted that he and AMA staff will provide a more detailed draft to share with the Workgroup at a future meeting.

- **Inserting survey code into a reference service list;** "Insert" survey code into a static reference service that is ordered by either intensity or work - this code fits between code a and b and then the respondent is asked to answer intensity questions about those two code in relationship to the new/code under review. The respondent would then be asked to compare the I/C of the survey code to the two codes it was inserted in between. Several Workgroup members expressed general interest in hearing more about this idea.

- **Review of Survey Intensity/Complexity Measures: Mean vs. Median**
  The Workgroup briefly discussed this item and there were no Workgroup members that expressed interest in switching from mean to median.

- **Discussion: Statistical Analysis of RUC Time Data**
  The Chair noted that this will be explored further by consulting an AMA Senior Economist. AMA RUC Staff will meet with an economist from the AMA Economic and Health Policy department several times prior to the October 2016 RUC meeting to discuss potential additional descriptive and analytic statistics to include in the SOR. A report of the additional ideas that come from these meetings will be presented to the Workgroup in October. An invitation will be extended for the AMA Economist to attend the October Time-Intensity Workgroup meeting to have a discussion with the workgroup.

  In addition, Doctor Collins noted that the Workgroup's recommendation to update the physician time question so survey respondents are asked to make more precise time estimates instead of rounding to the nearest 5 or 15 minute increments will be evaluated by the Research Subcommittee at this RUC meeting.

- **Discussion: Intra-service Work Per Unit of Time (IWPUT)**

  The Workgroup briefly discussed IWPUT during their brainstorming session of several ideas earlier in the meeting.

  The RUC approved the Time-Intensity Workgroup Report.

XV. Emerging CPT/RUC Issues Workgroup (Tab 49)

Doctor Raphaelson provided a summary of the Emerging CPT/RUC Issues Workgroup report:

- **An Update on CPT Editorial Panel Review of Care Collaboration/Non Face-to-Face Coding Proposals (April RUC tabs 4 & 5)**
  Doctor Ellington summarized two innovative sets of codes recently approved by the CPT Editorial Panel:

  Psychiatric Collaborative Care Management Services – three new codes were developed to capture a new practice model which involves the collaboration of a Primary Care Provider, a behavioral manager, and a Psychiatrist to provide management of psychiatric needs. These codes are being discussed by an Ad Hoc Workgroup of the Research Subcommittee to troubleshoot the survey needs for the October RUC meeting.

Cognitive Impairment Assessment and Care Plan Services – one new code was developed to capture a collaboration with an assessment and care planning for a patient with cognitive impairment. This code was surveyed and is being reviewed at this RUC meeting.

- **Physician Focused Alternative Payment Models**
  Harold Miller delivered a presentation "Tools Needed to Design and Implement Physician-Focused Payment Models." The full presentation is available on the RUC Collaboration Site in the *Handouts at the Meeting* folder.

- **Discussion/Next Steps**
  There was general discussion regarding potential coding needs related to the implementation of alternative payment models (APMs), as specified by MACRA. The CPT Editorial Panel and the RUC may need to discuss new types of codes for alternative payment models. CPT Editorial Panel members indicate that they will discuss these issues at a strategic session at the May CPT meeting.

  RUC has valued alternative models, such as medical home, and RUC is now preparing to value psychiatric care collaboration. Workgroup members agreed that an accurate relative value system will remain the basis for valuation of many future episodes of payment and for calculating payments to multiple providers engaged in an episode.

  The Workgroup passed the following motion by consent vote: To recommend that the CPT Editorial Panel discuss at their strategic session how potential codes for APMs could be developed and categorized and that the RUC is involved as appropriate in the valuation of codes similar to the work done to date.

  Members discussed the need for specialties to collaborate on a multi-disciplinary models, taking into consideration which physician would be responsible for collecting payment and dispersing payments to other involved physicians or other qualified health care professionals.

  Mr. Miller described the HHS Physician Focused Technical Advisory Committee. The proposed process may be found at (https://aspe.hhs.gov/medicare-access-and-chip-reauthorization-act-2015). The next meeting is May 4th and those wishing to attend can register online.

XVI. Administrative Subcommittee (Tab 50)

- **Review Election of Rotating Seats Submission – Tab 53**
  Doctor Waldorf informed the RUC that the Administrative Subcommittee reviewed the nominations for the internal medicine rotating seat, Timothy Laing, MD, American College of Rheumatology, and the primary care rotating seat, Julia Pillsbury, DO, American Academy of Pediatrics. The Subcommittee noted that the internal medicine rotating seat and primary care rotating seat each 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."

- **Non-Staff Representation Agreement**
  Doctor Waldorf indicated that this item has been pulled from the agenda. The non-staff representation agreement form was initiated via the CPT Editorial Panel and is still undergoing review. In May, the Panel will hold a facilitation meeting explaining why this form was created, who should complete it and answer any questions. Therefore, the RUC will

wait until the CPT Editorial Panel has this facilitation and any further edits to the document before the Administrative Subcommittee reviews.

XVII. Research Subcommittee (Tab 51)

Doctor Doug Leahy, Chair, provided a summary of the Research Subcommittee report:

- **The Subcommittee reviewed and accepted the February 2016 Research Subcommittee conference call report.** Doctor Leahy also stated that the Subcommittee would work to get Research Subcommittee calls scheduled further out in advance going forward.

- **General Survey Instrument and Memo Text Update**

  AMA Staff provided draft language for the Subcommittee to review as requested by Research Subcommittee on a December 2015 conference call. **The Research Subcommittee approved the language as follows:**

  - ***For first page of RUC Online Survey Tool:***
    "IMPORTANT: Please check CPT codes for procedures/services that you have experience performing or are familiar with. ~~Please select all of the CPT Codes that apply to you.~~ You will only be surveyed about each code that you select."

  - **For first page of Other Survey Tools** *(ones which do not have the capability to display only survey questions from selected survey codes):*
    "IMPORTANT: Please only respond to questions for survey codes that you either have experience performing or are familiar with."

  - **Updated Text for Cover Memo:**

    "You have been selected to participate in an AMA RUC survey. As you may know, the Medicare payment schedule is based on physician work, practice expense and professional liability insurance. Our society needs your help to assure relative values will be accurately and fairly presented to the Centers for Medicare and Medicaid. **Please note, you do not need to respond to the questions for all of the codes in this survey. You may not have recent experience with one or more of the procedures. We ask that you provide responses for those services about which you have direct professional knowledge and feel comfortable answering, whether or not you currently perform the service.**

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

At the December 2015 Time-Intensity Workgroup meeting, as part of a discussion on measuring physician time, several Workgroup members noted that survey results often appear that the survey respondents tend to round to the nearest 5 minute or 15 minute increment instead of providing estimates to the nearest minute. The Workgroup requested for AMA staff to draft language for the Research Subcommittee to consider at the April meeting. **Following an extensive discussion, the Subcommittee did not make a final decision on the updated text and instead, referred this issue to the Time-Intensity Workgroup for further discussion.**

- **23-hour stay outpatient surgical services with post-operative visits and New Standard Survey Template for 000-day surgical with visit**
  At the Subcommittee meeting prior to the January RUC meeting, the Subcommittee requested for AMA staff to draft instructions explaining how to implement CMS' policy related to 23-hr outpatient surgical codes with post-operative visits. The Subcommittee also requested for an alternate 000-day template to be drafted. The Subcommittee should review the below text and the draft alternate 000-day template and discuss if they should be implemented.

  23-Hour Stay Outpatient Surgical Services with Subsequent Hospital Visits Policy

  CMS labels surgical services that are typically performed in the outpatient setting and require a hospital stay of less than 24-hours as *23-hour stay outpatient services*. In the CY2011 Final Rule, CMS finalized a policy to no longer allow these codes to include bundle subsequent hospital visits (e.g. 99231-99233) into the surgical global period. Instead, the Agency permits the allocation of the intraservice portion of the typically performed subsequent hospital visit to the immediate post-service time of the procedure.

  If the survey results indicate that a 23-hour stay with a subsequent hospital visit is typical and the Medicare claims data (if available) show that the service is typically performed in the outpatient setting, then the surveying specialties may add the post-operative visit intra-service time to the immediate post-operative physician time and not list a subsequent hospital visit in the recommendation. For example, if the survey data for a 23-hour stay code includes 15 minutes of immediate post-service time and one 99232 post-operative visit (20 minutes of intra-service time), then the recommendation could include 35 minutes of immediate post-service time and no subsequent hospital visit.

  Absent Medicare claims data, the specialties may determine whether the service is outpatient via expert panel. Also, when preparing to survey a 000-day global codes which may potentially be a 23-hour stay code with a visit, please be sure to use a RUC survey template which collects site of service, hospital stay and post-op visit data. For 000-day surgical services, specialties should provide additional documentation which supports that a subsequent hospital visit is typical on the day of surgery.

  The Subcommittee reviewed the proposed instructions and alternate 000-day survey instrument *(as provided in the agenda materials)* and approved both without modification.

- **Review of Proposed Text for RUC Survey Instrument videos**
  At the October 2015 RUC meeting, as part of a review of survey process recommended from specialty societies, the Subcommittee noted that the creation of a video explaining the RUC survey process to potential survey respondents would be beneficial. AMA staff drafted three separate videos to be made: one for surgical services (000-day, 010-day, 090-day services), one for other physician services, and a third video applicable to HCPAC societies. AMA staff sent the draft scripts to a dozen specialty societies for review. Specialty societies provided many helpful edits, most of which were incorporated into an updated drafts provided to the Subcommittee for the April 2016 meeting.

The Subcommittee noted that overall these PowerPoints and scripts are appropriate and should be useful to potential survey respondents. One observer noted that a sentence stating that typical is more than 50% of the time on slide 12 should be deleted and the Subcommittee agreed. The Subcommittee also requested for AMA Staff to delete the last PowerPoint bullet on slide 4 and slide 6. In addition, the Subcommittee requested for AMA staff to replace the term "reference service(s)" on slide 14 that is easier to understand for those that are not familiar with the RUC process. **The Research Subcommittee approved the survey video scripts and PowerPoint slides with the minor modifications as described above.**

- **Initial Discussion: Survey sample numerator and denominator**
  At the last Research Subcommittee meeting, an observer questioned whether the survey response rate could be calculated in some other statistically-valid way (for example, if only those that actually opened the email could be counted). Following up on this discussion, AMA RUC staff met with AMA Senior Economist Carol Kane, PhD, from the AMA Economic and Health Policy Research team in early March. Dr. Kane explained that modifying the survey response rate denominator based on whether an individual opened an email is not a method that would be considered appropriate or that she has ever seen it used for any research studies. She did point out though that there are valid methods for calculating the survey response rate that the RUC does not currently use. Dr. Kane explained how the RUC could use a similar method as her group used to calculate the survey response rates for the AMA 2007 Physician Practice Information (PPI) survey. This method involves calculating an expected eligibility ratio for the survey pool and reducing the survey sample denominator by this expected eligibility ratio.

  Several Subcommittee members expressed general interest in this idea, while others noted that this idea would only be appropriate if the change would have a large enough impact to make the additional work needed of specialty staff worthwhile. **The Research Subcommittee requested for AMA staff to solicit a few societies test this new proposed idea. The Subcommittee will review this information at its October meeting.**

- **Review of Existing RUC and CPT Vignette Instructions**
  The Research Subcommittee reviewed the existing instructions for creating vignettes as provided by the RUC and CPT Editorial. **The Subcommittee did not propose any modifications to the existing instructions and reaffirmed the RUC's existing vignette instructions.**

- **Esophagectomy Vignette Review (43286-88, 43107, 43112, 43117)**
  The Research Subcommittee reviewed the vignettes as submitted by the specialty societies. Several Subcommittee members questioned the typicality of neoadgevent chemotherapy for 432X6-7, 43112 and 43117. The societies confirmed that neoadgevent chemotherapy is typical for these services. In addition, a Subcommittee member cited guidelines from the National Comprehensive Cancer Network (NCCN) which further supported that the inclusion of neoadgevent chemotherapy was appropriate. **The Research Subcommittee approved the vignettes as originally proposed by the specialty societies**:

  > **43286** ***Esophagectomy, total or near total, with laparoscopic mobilization of the abdominal and mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with open cervical pharyngogastrostomy or esophagogastrostomy (ie, laparoscopic transhiatal esophagectomy)***

Approved Vignette: A 72-year-old man presents with a history that includes gastroesophageal reflux, progressive dysphagia and testing that revealed a distal esophageal adenocarcinoma arising within long segment Barrett's esophagus with multifocal high-grade dysplasia. He undergoes esophageal resection and reconstruction.

43287 ***Esophagectomy, distal two-thirds, with laparoscopic mobilization of the abdominal and lower mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with separate thoracoscopic mobilization of the middle and upper mediastinal esophagus and thoracic esophagogastrostomy (ie, laparoscopic thoracoscopic esophagectomy, Ivor Lewis esophagectomy)***

Approved Vignette: A 65-year-old woman presents with one month history of progressive dysphagia. Testing revealed a distal esophagogastric junction adenocarcinoma. She received neo-adjuvant chemotherapy and radiation therapy. She now undergoes surgical resection.

43288 ***Esophagectomy, total or near total, with thoracoscopic mobilization of the upper, middle, and lower mediastinal esophagus, with separate laparoscopic proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with open cervical pharyngogastrostomy or esophagogastrostomy (ie, thoracoscopic, laparoscopic and cervical incision esophagectomy, McKeown esophagectomy, tri-incisional esophagectomy)***

Approved Vignette: A 70-year-old man presents with progressive dysphagia. Testing revealed a mid-esophageal adenocarcinoma above the level of the carina. He received neoadjuvant chemotherapy and radiation therapy. He now undergoes surgical resection.

43107 ***Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal)***

Approved Vignette: A 72-year-old man presents with a history that includes gastroesophageal reflux, progressive dysphagia, and testing that revealed a distal esophageal adenocarcinoma arising within long segment Barrett's esophagus with multifocal high-grade dysplasia. He undergoes esophageal resection and reconstruction.

43112 ***Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (ie, McKeown esophagectomy, or tri-incisional esophagectomy)***

Approved Vignette: A 70-year-old man presents with progressive dysphagia. Testing revealed a mid-esophageal adenocarcinoma above the level of the carina. He received neoadjuvant chemotherapy and radiation therapy. He now undergoes surgical resection.

43117 ***Partial esophagectomy, distal twothirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)***

Approved Vignette: A 65-year-old woman presents with one month history of progressive dysphagia. Testing revealed a distal esophagogastric junction adenocarcinoma. She received neo-adjuvant chemotherapy and radiation therapy. She now undergoes surgical resection.

- **Other Business**
  - **Psychiatric Collaborative Care Management Workgroup Reports** *(Informational Only)*
    Doctor Andreae, the Chair of the Workgroup, provided a general overview of the workgroup's report from its April 11 conference call. Doctor Andreae noted that the specialties plan to survey these services for the October 2015 RUC meeting. The Workgroup requested for the specialties to pull together a detailed plan for surveying and valuing these codes for the October RUC Meeting. The Workgroup will review and provide guidance before these items go to the Research Subcommittee for approval. The next Workgroup call will need to be scheduled for mid-May in preparation for the early June Research Subcommittee meeting. One issue that was a point of contention for the Workgroup was whether the work of the contracted psychiatrist should fall under practice expense. The Workgroup and Research Subcommittee each noted that the RUC does not have to make this determination as part of its future recommendation, instead leaving the decision to CMS. **The Research Subcommittee approved the report as submitted.**

  - **Anesthesia Workgroup Report** *(Informational Only)*
    Doctor DiSesa, chair of the Anesthesia Workgroup, provided a general overview of the workgroup's report from its April 12 conference call. The Specialty will present 6 new proposed codes to CPT for describing anesthesia for upper and lower GI endoscopy services at the October 2016 CPT meeting and plan to survey these services for the January 2017 RUC meeting. The Workgroup requested for the specialty society to proceed with taking their CPT proposal to CPT for the October 2016 CPT meeting. The Workgroup made it clear that they did not provide specifically approve the coding language or the proposed vignettes. **The Workgroup requested for the specialty to send the vignettes for these services to Research for review and approval prior to surveying these services and the Specialty agreed.**

    The Workgroup noted that it did not re-validate the individualized PIPPA work RVU methodology, but agreed that the RUC should value these services according to the present methodology, using the RUC anesthesia survey instrument and process.

    The Workgroup recommends an educational presentation be provided to the RUC on the existing survey and valuation process for anesthesia services since it has not been validated or used for a survey since 2007, including a specific example of how the data from a survey are used to value an anesthesia service.

    The Workgroup requested that anesthesia codes be included in any RAW screens.

    The Research Subcommittee approved the report, which is available in tab 51 of the agenda materials, as submitted.

- **Survey Question Proposal from RUC Member:**
  Following the Research Chair's presentation, a RUC member suggested for the Subcommittee to consider adding a survey question that would determine if the survey respondent has experience performing the survey code in the recent past, the distant past or is simply familiar with the service. The RUC member suggested that this would allow the Research Subcommittee and the RUC to assess the continued viability of allowing survey respondents to complete the survey that are only familiar with the service. **The Research Subcommittee Chair noted that the Subcommittee would evaluate this proposal at an upcoming meeting.**

  The RUC approved the Research Subcommittee Report.

XVIII. HCPAC Review Board (Tab 52)

Dr. White provided a summary of the HCPAC Review Board Report:

- **RUC Process**
  As requested at the January 2016 HCPAC meeting, the HCPAC members were provided with materials regarding the RUC process. AMA staff referenced the presentation, which is included in the meeting agenda introduction materials, to provide an overview of the RUC process for valuation of codes and the screens used to identify potentially misvalued codes. The HCPAC walked through the discussion checklist and a reference SOR to highlight where the items are found that a reviewer should verify. The HCPAC also discussed the presentation guidelines where the instances requiring compelling evidence are detailed. Finally, Dr. White mentioned that we will continue to expect all HCPAC members to review tabs that come through the process and to provide comments on the reviewer comment schedule.

- **HCPAC MPC List Review**
  The HCPAC discussed the need to review and update the HCPAC MPC list. Many of the codes on the current list have not been reviewed for a number of years and it was determined that it is beneficial during the survey process to have this list up to date. A request went out to the HCPAC specialties before this meeting to ensure each specialty evaluated their codes from the current list. The HCPAC walked through the MPC Summary of Process document noting that although codes from the HCPAC may not be able to meet all of the criteria listed, the group will aim to get codes as close to these recommendations as possible.

  The HCPAC further discussed the spreadsheet of codes performed by HCPAC providers and the highlighted recommendations from specialties for changes to the MPC list. The HCPAC reviewed that additions, retentions, and deletions have been provided by six specialties. A discussion was held about how we should handle codes going to CPT and it was mentioned that codes under revision should be monitored and that the continuous review of the list would allow for these to be addressed in a timely fashion. Additionally the Committee noted that this might initially be a larger task to update given a lot of revisions occurring in code sets but that an updated list is critical during the survey process.

  The HCPAC discussed how and when the group wishes to update the MPC list moving forward. It was decided that an initial review and vote would be conducted at the October 2016 HCPAC meeting. Additionally, the HCPAC would plan to keep the list review as a standing agenda item to review specialty recommended changes at each meeting but would opt to publish the changes from multiple meetings in a new version once a year in January of each year. Finally, the HCPAC discussed that the Chairs and AMA Staff would assign

HCPAC member reviewers to review the submitted MPC list change recommendations in preparation for the October HCPAC vote.

XIX. Rotating Seat Election (Tab 53)

- Julia Pillsbury, DO, American Academy of Pediatrics (AAP) was elected to the RUC's Primary Care rotating seat.

- Timothy Laing, MD, American College of Rheumatology (ACRh) was elected to the RUC's Internal Medicine rotating seat.

XX. Other Business (Tab 54)

- The American College of Surgeons (ACS) requested a discussion regarding the intensity value of 0.0081 that is assigned to the pre-time component of "scrub, dress, wait." Specifically, ACS believes a review of the intensity calculations could be beneficial. **The RUC approved referring this issue to the Time-Intensity Workgroup.**

- The American College of Obstetricians and Gynecologists (ACOG) requested a discussion regarding CMS trends of rejecting RUC recommendations based solely on their time analysis/methodology. The RUC agreed that intensity is just as important as time and it should be reiterated that CMS should adhere to statute, where both time and intensity are both required to be considered. **The RUC will include a discussion of this issue in a May letter to CMS to accompany the RUC recommendations.**

- Doctor Peter Smith presented a discussion about the AAD Skin Biopsy tab previously discussed at the January RUC Meeting. At that time, the issue was referred to CPT for revision and would come back to the RUC after a re-survey. An article was subsequently published which may provide a potential conflict for the re-survey process. Discussion included suggestions of 1) asking the survey respondents if they received any correspondence or information about the time and work of the codes in question; 2) looking for participants who were not originally surveyed; 3) comparing the survey findings from the previous and new survey; 4) using auxiliary data from office logs to better support the recommendation; and/or 5) not reminding those participating in the survey of the article. **The RUC decided to refer the issue to the Research Subcommittee for guidance on how to properly re-survey these codes.**

- Doctor Peter Smith discussed his preference all specialties utilize the same electronic survey system to ensure fairness, transparency and accountability throughout the process.

Compelling Evidence

- A RUC member requested review of the compelling evidence standards regarding the definition and rules.

- Another RUC member noted that when reviewing these standards, the following specific language should be added "In the case when a code is resurveyed and CMS did not accept previous recommended RUC value, compelling evidence based on flawed mechanism (CMS unilateral decision) can be used to recommend a value that is equal to the previous RUC recommended value, but additional compelling evidence would need to be presented if recommended value is higher than the previous recommended value".

- A RUC member requested that in review of the compelling evidence standards that the RUC consider more examples of compelling evidence (i.e., low (to be defined) or negative IWPUT). Low or negative IWPUT may be an indicated that a service is improperly valued and that compelling evidence that it should be reviewed. **The Administrative Subcommittee will review the RUC's compelling evidence guidelines.**

Low or Negative IWPUT

- A RUC member requested that the Relativity Assessment Workgroup review services with low or negative IWPUT as a possible screen. **This issue will be referred to the Relativity Assessment Workgroup.**

AMA/Specialty Society RVS Update Committee **Tab 46**
Practice Expense Subcommittee
April 27 & 28, 2016

Members Present: Scott Manaker, MD, PhD, FCCP (Chair), David C. Han, MD (Vice Chair), Albert Bothe, MD (CPT), Gregory L. Barkley, MD, Eileen Brewer, MD, Joel V. Brill, MD, Joseph Cleveland, MD, Neal H. Cohen, MD, Thomas P. Cooper , MD, Mollie MacCormack, MD, FAAD, Geraldine B. McGinty, MD, Margaret Neal, MD, Tye Ouzounian, MD, John A. Seibel, MD, MACE, Stephen Sentovich, MD, Lloyd S. Smith, DPM, Robert J. Stomel, DO, Donna Sweet, MD, Thomas Weida, MD, Adam Weinstein, MD

I. Practice Expense Spreadsheet Update Workgroup

The Practice Expense Spreadsheet Update Workgroup has conducted three conference calls since the last RUC meeting. The goal of the Workgroup is to finalize the spreadsheet by October in order for the PE Subcommittee to vote on the spreadsheet at the October 2016 RUC meeting.

In preparation for the February conference call, AMA staff with the assistance of specialty staff categorized the activities into:

- Blank (general or nonspecific)
- Rad/IR/RadOnc
- Pathology

CMS provided their list of clinical staff activities. Specialty staff assisted in categorizing the CMS clinical staff activities list determined that 380 clinical labor activities should be categorized as blank (general or nonspecific), 271 as Pathology and 108 as Rad/IR/RadOnc. The Pathology clinical labor activities were separated to a different spreadsheet to be reviewed at a later date. AMA staff with assistance from specialty society staff began to consolidate the general or nonspecific, radiology, interventional radiology and radiation oncology clinical labor activities. Most of the clinical labor activities fit into the standard clinical labor inputs already listed on the current general and imaging PE spreadsheets.

Specialty staff worked to batch the clinical labor activities and ended up with approximately 40 clinical labor activities. The Workgroup discussed that maybe this was too much consolidation, but ultimately determined that the 40 we have is a good start and that after review by both the Workgroup and the specialty societies we will likely expand that list, but still remain under 100 general and imaging clinical labor activities. Once Pathology clinical labor activities are consolidated that will add a significant number of inputs to the list.

The Practice Expense Spreadsheet Update Workgroup last met on April 6, 2016 via conference call. The primary purpose of the call was to review the Workgroup Members comments and suggestions regarding the consolidation of clinical labor tasks. The Workgroup also discussed that the clinical labor activities that are missing will not be clear until the specialty societies are asked for their input through a formal process that allows for appropriate time for their review and testing of recently RUC reviewed codes. The Workgroup also discussed that the clinical labor activities "rolled up" into the clinical labor activities that will be given a code number will be maintained for reference in the future and during the specialty society review we will also seek input regarding the appropriate consolidation of these activities and any revisions that need to be made. The Workgroup went through the spreadsheet line by line. The Workgroup agreed that to maintain consistency all the clinical labor tasks should begin with an active verb.

The Workgroup was not able to complete their work on this call. The Workgroup will complete this work on the next conference call scheduled for May 9th. Following the call the clinical labor activities will be sent to the specialty societies for review and input.

II. Emergent Procedures Pre-Service Clinical Staff Time Review

At the January 2016 RUC meeting the Practice Expense (PE) Subcommittee discussed a subset of emergent procedures identified by the Emergent Procedures Workgroup and referred to the PE Subcommittee for review of pre-service clinical staff time in the facility setting only. The PE Subcommittee reviewed the recommendations submitted by the specialties. For the majority of the codes under review the specialties recommended 20 minutes of pre-service clinical staff time in the facility setting. The 20 minutes is divided in the following breakdown of clinical staff time.

	Description of Clinical Activities - 090	Non-emergent standard	Emergent standard
1	Complete pre-service diagnostic and referral forms	5	5
2	Coordinate pre-service surgery services	20	7
3	Schedule space and equipment in facility	8	4
4	Provide pre-service education/obtain consent	20	0
5	Follow-up phone call and prescriptions	7	4
6	Other Clinical Activity	0	0
	TOTAL	**60**	**20**

As part of the Emergent Procedures Workgroup's review, they identified 34 services (closed treatment of fracture and CPT code 40650) that have 60 minutes of pre-service clinical staff time in the facility-only setting that involved issues beyond the emergent procedure issue. The Emergent Procedures Workgroup referred these issues to the Relativity Assessment Workgroup (RAW) to review as potentially misvalued at the January 2016 meeting. Specialty societies submitted action plans addressing the appropriateness of site of service, global period, and dominant specialty for these services. At the January 2016 RUC meeting the RAW had a robust discussion on these codes and determined that the 090 day global period is correct and an efficient bundling of the required services.

The RAW referred these 34 emergent procedure codes identified back to the PE Subcommittee for review. The PE Subcommittee reviewed the recommendations submitted by the specialties. For all 34 codes the specialties recommended application of the new emergent 090 day global pre-service clinical staff time standard for the facility setting. **The following 34 emergent procedure code recommendations were reviewed and approved by the PE Subcommittee.**

CPT Code	*CPT Descriptor*	*Global Period*	*Current clinical staff pre-service time (F)*	*Recommended clinical staff pre-service time (F)*
21820	Closed treatment of sternum fracture	090	60	20
23650	Closed treatment of shoulder dislocation, with manipulation; without anesthesia	090	60	20
24600	Treatment of closed elbow dislocation; without anesthesia	090	60	20
25675	Closed treatment of distal radioulnar dislocation with manipulation	090	60	20

26700	Closed treatment of metacarpophalangeal dislocation, single, with manipulation; without anesthesia	090	60	20
26750	Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each	090	60	20
26755	Closed treatment of distal phalangeal fracture, finger or thumb; with manipulation, each	090	60	20
26770	Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia	090	60	20
27265	Closed treatment of post hip arthroplasty dislocation; without anesthesia	090	60	20
27762	Closed treatment of medial malleolus fracture; with manipulation, with or without skin or skeletal traction	090	60	20
27818	Closed treatment of trimalleolar ankle fracture; with manipulation	090	60	20
27840	Closed treatment of ankle dislocation; without anesthesia	090	60	20
28660	Closed treatment of interphalangeal joint dislocation; without anesthesia	010	5	0
23540	Closed treatment of acromioclavicular dislocation; without manipulation	090	60	20
23625	Closed treatment of greater humeral tuberosity fracture; with manipulation	090	60	20
23655	Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia	090	60	20
23665	Closed treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with manipulation	090	60	20
24505	Closed treatment of humeral shaft fracture; with manipulation, with or without skeletal traction	090	60	20
24605	Treatment of closed elbow dislocation; requiring anesthesia	090	60	20
25565	Closed treatment of radial and ulnar shaft fractures; with manipulation	090	60	20
25605	Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation	090	60	20
27230	Closed treatment of femoral fracture, proximal end, neck; without manipulation	090	60	20
27232	Closed treatment of femoral fracture, proximal end, neck; with manipulation, with or without skeletal traction	090	60	20
27240	Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with manipulation, with or without skin or skeletal traction	090	60	20
27252	Closed treatment of hip dislocation, traumatic; requiring anesthesia	090	60	20
27266	Closed treatment of post hip arthroplasty dislocation; requiring regional or general anesthesia	090	60	20

27502	Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction	090	60	20
27510	Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation	090	60	20
27550	Closed treatment of knee dislocation; without anesthesia	090	60	20
27552	Closed treatment of knee dislocation; requiring anesthesia	090	60	20
27752	Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation, with or without skeletal traction	090	60	20
27810	Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); with manipulation	090	60	20
27825	Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; with skeletal traction and/or requiring manipulation	090	60	20
40650	Repair lip, full thickness; vermilion only	090	60	20

III. New Business

The PE Subcommittee discussed the CMS request that vignettes be available to the PE Subcommittee for review of PE only codes. There are currently two scenarios for PE only codes to receive vignettes. First, if a new code comes from the CPT Editorial Panel, a vignette will be included. However, these vignettes may need to be further vetted by the Research Subcommittee, as vignettes may need to be standardized. Second, if a PE only code is an existing code and either has a vignette that needs to be revised or needs one created, the Research Subcommittee will review such requests.

Additionally the PE Subcommittee discussed that moving forward AMA staff will run claims data to narrow down to the site of service for the non-facility setting. This data will help inform the PE Subcommittee's review as they determine the appropriateness of the specialty society's recommended direct PE inputs in the nonfacility setting, especially as it relates to whether or not Evaluation and Management services are typically reported and which specialties predominate in the nonfacility setting.

IV. Practice Expense Recommendations for CPT 2017

Tab	Title	PE Input Changes
4	Psychiatric Collaborative Care Management Services	Defer to Oct RUC Meeting
5	Cognitive Impairment Assessment and Care Plan Services	Modifications

Tab	Title	PE Input Changes
6	Diagnostic Bone Marrow Aspiration and Biopsy	Minor Modifications
7	Chest X ray	Modifications
8	Abdominal X ray	Minor Modification
9	Pulmonary Diagnostic Tests	Modifications
10	Parent, Caregiver-focused Health Risk Assessment - PE Only	Modifications
11	Anesthesia for Intestinal Endoscopic Procedures	Refer to CPT
12	Fine Needle Aspiration	Refer to CPT
13	Acne Surgery	Minor Modifications
14	Muscle Flaps	No Change
15	Mastectomy	Standard 090 Day Global No Change
16	Injection for Knee Arthrography	Defer to Oct RUC Meeting
17	Application of Rigid Leg Cast	Minor Modification
18	Strapping Multi-Layer Compression	Defer to Oct RUC Meeting
19	Resection Inferior Turbinate	Minor Modifications
20	Control Nasal Hemorrhage	Minor Modifications
21	Tracheostomy	No Change

Tab	Title	PE Input Changes
22	Bronchoscopy	Refer to CPT
23	Selective Catheter Placement	Minor Modifications
24	Therapeutic Apheresis	Refer to CPT
25	Voiding Pressure Studies	Minor Modifications
26	Transurethral Electrosurgical Resection of Prostate (TURP)	Minor Modifications
27	Colporrhaphy	Refer to CPT
28	Injection Anesthetic Agent	Minor Modifications
29	Correction of Trichiasis	Minor Modifications
30	X-Ray of Ribs	No Change
31	CT Chest	No Change
32	X-Ray of Wrist	Minor Modifications
33	X-Ray of Hands and Fingers	Minor Modifications
34	CT Angiography of Abdominal Arteries	Minor Modifications
35	Ophthalmic Ultrasound	Defer to Oct RUC Meeting
36	Ophthalmic Biometry	Minor Modifications
37	Radiation Therapy Planning	No PE Inputs

Tab	Title	PE Input Changes
38	Bone Imaging	Minor Modifications
39	Pathology Consultation During Surgery	Minor Modification
40	Tumor Immunohistochemistry	Minor Modifications
41	Glaucoma Provocative Tests	Refer to CPT
42	Transthoracic Echocardiography (TTE)	Modifications
43	Photodynamic therapy - PE Only	Defer to Oct RUC Meeting
44	Photochemotherapy - PE Only	Minor Modifications
45	Home INR Monitoring	Refer to CPT

Members: Doctors David Hitzeman (Chair), Gregory Przybylski (Vice-Chair), Ronald Burd, Jimmy Clark, William Donovan, Walt Larimore, Daniel Nagle, Dee Adams Nikjeh, PhD, CCC-SLP, Scott Oates, Guy Orangio, Marc Raphaelson, Sandra Reed, Samuel Silver, Michael Sutherland, George Williams and Robert Zwolak.

I. Review Action Plans

Continuous Glucose Monitoring **(95250 and 95251)**

In April 2013, CPT code 95251 was identified through the High Volume Growth screen and the RUC recommended surveying 95251 and 95250 for January 2014. In May 2014, the CPT Editorial Panel created two Category I codes to report continuous glucose monitoring via patient managed "real time" monitoring device and revised two Category I codes to report continuous glucose monitoring via provider managed "retrospective" monitoring device. At the September 2014 RUC meeting, the specialty requested withdrawal of CPT codes 9525X1 and 9525X2 in order to take these codes back to CPT to restructure and better define the timeframe described. The specialty society communicated with the CPT Editorial Panel to rescind codes 9525X1 and 952X2 at the October 2014 CPT meeting to allow the specialties to submit a new coding change proposal. The RUC recommended referral to the CPT Editorial Panel. However, the most recent specialty society proposed revisions were not approved by CPT and the specialty societies indicated there is new information to present to the Relativity Assessment Workgroup.

The specialty societies indicated that the growth of these services has steadied in the most recent five years and should be removed from the screen. The Workgroup noted that the 2013 Workgroup recommendation was to survey these services based on the high growth in the years examined and these services have not been reviewed in over ten years. **The Workgroup recommends to survey CPT codes 95250 and 95251 for October 2016. The Workgroup also recommends that CPT code 95251 be removed from the MPC list as questions exist whether this is a well-defined service to use as an anchor reference across the physician payment schedule.**

Physical Medicine and Rehabilitation **(97101-97799 and G0283)**

In February 2010, Physical Medicine and Rehabilitation services were first identified through the RUC's High Volume Growth Screen and subsequently by Codes Reported Together 75% of the Time and from CMS via the High Expenditure screen. Since the original identification in 2010, the organizations have maintained that the section of CPT must be updated to describe today's practice, prior to any analysis of valuation. A CPT Workgroup was formed in 2012 to address the coding issues. To date, there has not been any resolution.

The specialty societies developed an action plan to describe the work plan moving forward for the Relativity Assessment Workgroup to review at the April 2016 meeting. **The Workgroup discussed the timeline and recommends the following:**

Code Number	Description	Current Codes	Recommendation	CPT Mtg	RUC Mtg
Modalities					
NEW 1	Modality-Supervised	97010, 97012, 97014, 97016, 97018, 97024, 97026, 97028	**Refer to CPT to bundle 14 modality codes into 3 codes. If no resolution at CPT with development of new codes, specialties should plan to survey existing modality codes at the Jan 2017 RUC meeting.**	Sept 2016	Jan 2017
NEW 2	Modality-Constant Attendance	97032, 97033, 97034, 97035		Sept 2016	Jan 2017
NEW 3	Hydrotherapy	97022, 97036		Sept 2016	Jan 2017
97039	Unlisted modality (specify type and time if constant attendance)		**N/A, Unlisted code**	N/A	N/A
Therapeutic Procedures					
NEW 4	Exercise Code	97110, 97112	**Refer to CPT to bundle.**	Feb 2017	Apr 2017
97113	Aquatic therapy		**Refer to CPT to revise to reflect current practice.**	Feb 2017	Apr 2017
NEW 5	Group aquatic therapy code	NEW	**Refer to CPT to create a new code.**	Feb 2017	Apr 2017
97116	Gait Training		**Refer to CPT to revise to reflect current practice.**	Feb 2017	Apr 2017
NEW 6	Manual therapy/massage	97140, 97124	**Refer to CPT to bundle and revise.**	Feb 2017	Apr 2017
97139	Unlisted therapeutic procedure (specify)		**N/A, unlisted code**	N/A	N/A
97150	Group therapeutic activities		**Survey with this family of services**	Feb 2017	Apr 2017
97530	Therapeutic Activities		**Refer to CPT to revise to reflect current practice.**	Feb 2017	Apr 2017
97542	Wheelchair mgmt. training		**Refer to CPT to revise to reflect current practice.**	Feb 2017	Apr 2017
NEW 7	Wheelchair assessment and fitting	NEW	**Refer to CPT to create a new code.**	Feb 2017	Apr 2017
ADL/IADL Section - Name TBD					
97532	Cognitive Skills Development		**Refer to CPT to revise to reflect current practice.**	Apr 2017	Oct 2017
97533	Sensory Integration			Apr 2017	Oct 2017
97535	Self-care mgmt. training			Apr 2017	Oct 2017
97537	Community/work reintegration			Apr 2017	Oct 2017

Code Number	Description	Recommendation	CPT Mtg	RUC Mtg
Active Wound Care Management				
97597	Rmvl devital tis 20 cm/<	**Maintain recently reviewed, scheduled for re-review at RAW in Oct 2017.**	N/A	N/A
97598	Rmvl devital tis addl 20cm/<	**Maintain, scheduled for re-review at RAW in Oct 2017.**	N/A	N/A
97602	Wound(s) care non-selective	**Maintain. Bundled code, no RVUs.**	N/A	N/A
97605	Neg press wound tx </=50 cm	**Maintain, recently reviewed.**	N/A	N/A
97606	Neg press wound tx >50 cm	**Maintain, recently reviewed.**	N/A	N/A
97607	Neg press wnd tx </=50 sq cm	**Maintain, recently recommended carrier price.**	N/A	N/A
97608	Neg press wound tx >50 cm	**Maintain, recently recommended carrier price.**	N/A	N/A
97610	Low frequency non-thermal us	**Maintain, recently reviewed.**	N/A	N/A
Tests and Measures				
97750	Physical performance test	**Refer to CPT to revise to reflect current practice.**	Feb 2017	Apr 2017
97755	Assistive technology assess	**Refer to CPT to revise to reflect current practice.**	Feb 2017	Apr 2017
Orthotic/Prosthetic Management				
97760	Orthotic mgmt and training	**Survey**	N/A	Oct 2016
97761	Prosthetic training	**Survey**	N/A	Oct 2016
97762	C/o for orthotic/prosth use	**Survey**	N/A	Oct 2016
Other Procedures				
97799	Unlisted physical medicine/rehabilitation service or procedure	**N/A, unlisted code**	N/A	N/A
Electrical Stimulation Other Than Wound				
NEW 8 G0283	E-stim other than wound	**Refer to CPT to create a Category I code**	Sep 2016	Jan 2017

II. CMS/Other Source Codes – Utilization over 250,000

In April 2013, services were identified via the CMS/Other source codes. The Workgroup requested that the specialty societies submit an action plan for the January 2014 meeting. The Workgroup noted that G codes are developed for programmatic need and/or to address statutory requirements. The Workgroup noted that some of the G codes have Medicare utilization well over 1 million. The Workgroup reviewed all 10 G codes. The Workgroup recommended the following services be referred to CPT to possibly develop CPT Category I codes to define these services: G0101, G0179, G0180, G0181, G0283, G0438 and G0439. Codes G0202, G0204 and G0206 were addressed with new CPT Category I codes at the January 2016 meeting and the RUC assumes CMS will delete the corresponding G codes for CY 2017.

For October 2015, AAFP and ACP submitted a letter indicating that creating Category I codes are not necessary as the G codes (G0179, G0180, G0181, G0438 & G0439) are working as intended and the creation of Category I codes would cause redundancy and overlap. The RAW reviewed this letter to determine if these codes should remain as referred to CPT to create a Category I code so a temporary G code may no longer be necessary.

The Workgroup reviewed this action plan and determined that the RAW should review the previous 10 G-code recommendations from the CMS/Other screen and determine where all these codes are at in the CPT process before determining a precedent and recommending that these G codes be surveyed.

In January 2016 the specialty societies reiterated that the physician certification, home healthcare supervision and annual wellness visit codes, G0179, G0180, G0181, G0438 and G0439, are Medicare only services or statutorily mandated codes that are valued appropriately. The Workgroup noted that the RUC has surveyed and provided recommendations on G codes in the past. The Workgroup questioned how CMS valued these services.

In April 2016, AMA staff provided the history of what codes CMS used as a crosswalk to value these services. **The Workgroup reviewed the history of these G-codes and recommends:**

Code	Recommendation
G0179 G0180	**Survey for work and review direct practice expense inputs for October 2016.**
99375 99378	**Survey for work and review direct practice expense inputs for October 2016. After review of 9937 and 99378, recommend to CMS to delete codes G0181 and G0182 as these are Category I and G codes are almost identical. Specialty society should identify any additional codes that are part of this family.**
G0438 G0439	The Workgroup questioned the validity of the current values being crosswalked to level 4 Evaluation and Management services. **Survey for work and review direct practice expense inputs for October 2016.**

III. CMS/Other Source Codes - Utilization over 100,000

CMS/Other source codes are services which were not reviewed by the Harvard studies or the RUC and were either gap filled, most often via crosswalk by CMS or were part of a radiology fee schedule. CMS/Other source codes would not have been flagged in the Harvard only screens, therefore the RUC recommended that a list of all CMS/Other codes be developed and reviewed.

The Workgroup suggested expanding the CMS/Other Source codes screen, lowering the Medicare utilization threshold from 250,000 to 100,000. **The Workgroup reviewed the list of 26 services and requested action plans to review in October 2016: 72020, 72072, 72220, 73070, 73090, 73650, 73660, 74220, 74420, 75625, 76000, 76870, 77012, 85060, 85097, G0101, G0108, G0109, G0166, G0402, G0403, G0436, G0442, G0444, G0447and G0453.**

For the G-codes indentified, the specialty societies should specify whether the service should go back to CPT to create a Category I code or be surveyed. The Workgroup noted that for the LOI process, AMA staff will rerun the screen utilization criteria based on the most recent 2015 Medicare utilization data.

IV. Informational Items

The following documents were filed as informational items: Referrals to the CPT Editorial Panel; Referrals to the CPT Assistant Editorial Board; Potentially Misvalued Services Progress Report and CMS/Relativity Assessment Status Report.

AMA/Specialty Society RVS Update Committee **Tab 48**
Time-Intensity Workgroup
April 28, 2016

Members Present: Scott Collins, MD (Chair), Stan Stead, MD (Vice Chair), Michael Bishop, MD, James Blankenship, MD, Ronald Burd, MD, Joseph Cleveland, MD, Alan Lazaroff, MD, Charles Mabry, MD, Scott Oates, MD, Richard Rausch, PT, Robert Stomel, DO

I) Presentation by STS on Past Experience with Directly Surveying Physician Intensity

Jeff Jacobs, MD, alternate CPT advisor for the Society of Thoracic Surgeons (STS), presented on STS' past experience with performing direct physician intensity surveys for the 2005 Five-year Review and for CPT code 33533 CABG, single arterial graft in 2013. Society of Vascular Surgeons' (SVS) is the other specialty that also has experience with performing direct intensity surveys. Doctor Jacobs explained that, for direct intensity surveys, the intensity magnitude estimate asks the survey participant to estimate the average work intensity during the intra-service time of a survey code relative to average work intensities of other established codes contained in the intensity reference intensity list. The participant establishes relativity (rank order and degree of dispersion) between the code being surveyed and the intensities established for the codes in the Reference Intensity List. The survey results were presented for evaluation in exactly the same fashion as in the current magnitude estimation surveys for physician work (Minimum, 25th, Median, 75th, Maximum). Doctor Jacobs noted that the direct intensity survey methodology was validated in comparison to several Rasch analyses performed by the specialty. STS recommends for the RUC to approve this methodology for use outside of the former 5-year review process. The society also recommends that procedures be established for developing Reference Intensity Lists, so that these results can be deemed valid and utilized in a manner consistent with RUC precedents.

The Workgroup discussed this proposal and asked several questions of the STS representatives. Several workgroup members questioned whether this technique could be applied to non-surgical services and across specialties. It was noted that STS is one of the few specialties with an approved source of extant data that includes intraservice time. It was also noted that this tool is reliant on having an appropriate reference intensity list. STS noted their belief that the proposed methodology should only be used by societies that have approved extant data sources available to validate physician time; some of the Workgroup members concurred. Workgroup members also mentioned that intensity varies when different specialties perform the same procedure and at the individual level as well.

A Workgroup member noted that during the Harvard studies, Doctor Hsiao and the other researchers had a difficult time separating intensity and time and therefore decided to evaluate the physician work directly using magnitude estimation and further that Doctor Hsiao evaluated only the intraservice work period.

The Vice Chair shared an idea of potentially splitting the intra-service time into several distinct subparts and for intensity to separately be measured for each of those subparts. It was noted that the methodology for evaluating anesthesia services includes some of these elements.

Following this extensive discussion, the Workgroup thanked STS for volunteering their time and resources to prepare these materials and to present to the Workgroup. The Workgroup noted that they would continue to evaluate this presented idea along with other ideas for measuring work intensity. The chair also assured STS that there request for validation of the methodology outside of the previous 5 year review process would be maintained as an agenda item, and would be addressed at a future meeting.

II) Discussion of New Ideas

- **Fly-in Meeting for Workgroup at AMA HQ:** The Time-Intensity Workgroup Chair proposed a fly-in meeting for a brainstorming session at AMA headquarters in Chicago for Workgroup. The Chair noted that many of the topics within the purview of the Workgroup necessitate in-depth discussion which is difficult to accomplish via conference call or at the RUC meeting. AMA staff had previously informed the Chair that the AMA would be able to provide meeting space for such a meeting. Many of the Workgroup members said they would be willing to participate in such a meeting. **The Chair and AMA Staff will further evaluate a one or two day in-person meeting in Chicago for the Workgroup.**

- **Intensity and Complexity (I/C) Measures**

  The Chair summarized the two main areas of concern stakeholders have expressed regarding the current intensity and complexity measures:

  1) They are hard/time-consuming to interpret.

  For each survey code, there are 18 intensity/complexity scores listed on the SOR and those scores are very small numbers that go out to the second decimal point. To interpret these decimal numbers, review of a separate legend and reviewing the question text for each of the 9 questions is often repeatedly needed. With the RUC reviewing ~100 codes per meeting, there is simply too much information to be able to review it all effectively.

  2) Questions about the validity of the underlying data.

  This stems largely from the responses tending to most commonly indicate that the survey code is somewhat more intense than the reference code. Past analyses presented by AMA Staff to the Time-Intensity Workgroup and Research Subcommittee have illustrated that this has been the case for both the current I/C methodology and the previous I/C methodology. It is unclear whether this is due to a flaw in the survey design or because, for the initial selection of the key reference code, the survey respondents just tend to select reference codes that are typically somewhat less intense than the code under survey for some unknown reason. Separately, on occasion the comparison of the survey code to the reference code does not make sense, but it is unclear whether or not these are simply rare outliers or a trend.

The Chair proposed that the first general issue should be addressed in the medium-term and the second issue be addressed more in the long term. The Workgroup can attempt to fix the first issue without making changes to the survey instrument.

The Workgroup discussed the following ideas regarding the summary data for the intensity and complexity measures:

- **Show average responses text in summary data:** What the survey respondent is actually asked to provide is not numeric, but text choices indicating whether the survey code "much less" to "much more" intense/complex relative to the selected key reference service. The -2, -1, 0, +1 +2 scale is simply assigned to corresponding text choices behind the scenes in the raw data. If the summary data was also (or only) reported as the actual underlying text choice (ie if score is between 0.51 and 1.49, it could say the survey code is “somewhat more intense" than the reference code), that may make the information easier to interpret.

- **Aggregate Score:** Prove average scores for each of three categories of “mental effort and judgment” and “psychological stress.” For example, there are three I/C questions that fall under “mental effort and

judgement"; those 3 summary scores could be averaged into a single score. This could also be done for the "psychological stress" category.

- **Reordering Overall Intensity Summary score:** Although the overall I/C question is last on the actual survey, this score may be more helpful displayed first on the SOR to provide RUC members with a quick point of reference.

The Time-Intensity Workgroup recommends for a pilot test of these three proposed ideas to be performed by all societies surveying for the October 2016 RUC meeting for every survey code. This alternate summary data would be provided as a 1 page addendum to the SOR. The Workgroup requested for AMA staff to create instructions for specialty staff on how to implement this pilot.

Ideas for Validation of Physician Time and Intensity

- **Surveying intra-service work directly:** The Chair proposed the idea of surveying for intra-service physician work RVUs in addition to, or even instead of surveying total work RVU. He noted that reference value table could perhaps be extracted from the MPC list, using reverse building block, and/or using only XXX and ZZZ codes to start and then using the IWPUT calculator to strip pre and post minutes, when codes includes those. He noted that although this does not survey directly for intensity, it does allow a direct calculation of intensity from two directly surveyed values. The Workgroup discussed this idea with some members expressing interest in exploring this idea further.

- **Ranking surveys:** Separately from RUC survey, send out a separate survey asking respondents to simply rank a group of codes in order of their intraservice intensity and/or time and/or intraservice work. This could be applied to each specialties top 20 codes or perhaps large code families. The purpose of this idea is internal validation of existing rank orders and intensities to make sure they have appropriate rank order. One Workgroup member questioned whether this method would only be appropriate for a group of relatively similar procedures. Several Workgroup members noted that this idea is worth exploring further and could serve as an alternate validation check. **The Chair noted that he and AMA staff will mock this idea up in more detail to share with the Workgroup at a future meeting.**

- **Inserting survey code into a reference service list;** "Insert" survey code into a static reference service that is ordered by either intensity or work - this code fits between code a and b and then the respondent is asked to answer intensity questions about those two code in relationship to the new/code under review. The respondent would then be asked to compare the I/C of the survey code to the two codes it was inserted in between. Several Workgroup members expressed general interest in hearing more about this idea once more details of the idea are thought of.

III) Review of Survey Intensity/Complexity Measures: Mean vs. Median

The Workgroup briefly discussed this item and there were no Workgroup members that expressed interest in switching from mean to median.

IV) Discussion: Statistical Analysis of RUC Time Data

The Chair noted that this will be explored further by consulting an AMA Senior Economist. AMA RUC Staff will meet with an economist from the AMA Economic and Health Policy department several times prior to the October 2016 RUC meeting to discuss potential additional descriptive and analytic statistics to include in the SOR. AMA RUC Staff have sent the Senior Economist example SOR and survey data for them to review and provide feedback on potentially useful new ways to represent the data. A report of the additional ideas that come from these meetings will be presented to the Workgroup in October. An

invitation will be extended for the AMA Economist to attend the October Time-Intensity Workgroup meeting to have a discussion with the workgroup.

In addition, the Chair noted that the Workgroup's recommendation to update the physician time question so survey respondents are asked to make more precise time estimates instead of rounding to the nearest 5 or 15 minute increments will be evaluated by the Research Subcommittee at this RUC meeting.

V) Discussion: Intra-service Work Per Unit of Time (IWPUT)

The Workgroup briefly discussed IWPUT during their brainstorming session of several ideas earlier in the meeting.

AMA/Specialty Society RVS Update Committee **Tab 49**
Joint CPT and RUC Emerging Issues Workgroup
April 28, 2016

Workgroup Members in Attendance: Marc Raphaelson, MD (Chair), David Ellington, MD (Co-Chair), Jennifer Wiler, MD (Vice Chair), Daniel E. Buffington, PharmD, MBA, Gregory DeMeo, MD, Mary Foto, OTR, Peter Hollmann, MD, Kathy Krol, MD, M. Douglas Leahy, MD, Jeremy S. Musher, MD, Jordan G. Pritzker, MD, MBA, Sherry Baron-Seabrook, MD and Chris Senkowski, MD

Workgroup Charge: (1) Continue work of the former chronic care coordination workgroup to identify coding/payment solutions for non-face-to-face services, including to responding to CMS rulemaking; (2) address specific RUC related questions related to advanced payment models as they arise; and (3) work with CPT to address any CMS proposals on BETOS and other potential coding/payment issues in rulemaking.

I. Welcome and Introductions:

Doctor Raphaelson welcomed attendees to the meeting and reviewed the agenda items to be discussed. He asked specialties to actively think about what codes they would need to be able to participate in MACRA APMs in a meaningful way.

II. Update on CPT Editorial Panel Review of Care Collaboration/Non Face-to-Face Coding Proposals (April RUC tabs 4 & 5)

Doctor Ellington summarized two innovative sets of codes recently approved by the CPT Editorial Panel:

Psychiatric Collaborative Care Management Services – three new codes were developed to capture a collaboration with a Primary Care Provider, a behavioral manager, and a Psychiatrist to provide management of psychiatric needs. These codes are being discussed by an Ad Hoc Workgroup of the Research Subcommittee to troubleshoot the survey needs for the October RUC meeting. *See descriptors at end of report.*

Cognitive Impairment Assessment and Care Plan Services – one new code was developed to capture a collaboration with an assessment and care planning for a patient with cognitive impairment. This code was surveyed and is being reviewed at this RUC meeting. *See descriptor at end of report.*

III. Physician Focused Alternative Payment Models

Harold Miller delivered a presentation "Tools Needed to Design and Implement Physician-Focused Payment Models." The full presentation is available on the RUC Collaboration Site in the *Handouts at the Meeting* folder.

IV. Discussion/Next Steps

There was general discussion regarding potential coding needs related to the implementation of APMs, as specified by MACRA. The CPT Editorial Panel and the RUC may need to approve and value new types of codes for alternative payment models. CPT Editorial Panel members indicate that they will discuss these issues at a strategic session at the May CPT meeting.

RUC has valued alternative models, such as medical home, and RUC is now preparing to value psychiatric care collaboration. Workgroup members agree that an accurate relative value system will remain the basis for valuation of many future episodes of payment and for calculating payments to multiple providers engaged in an episode.

The Workgroup passed the following motion by consent vote: To recommend that the CPT Editorial Panel discuss at their strategic session how potential codes for APMs could be developed and categorized and that the RUC is involved as appropriate in the valuation of codes similar to the work done to date.

Members discussed the need for specialties to collaborate on a multi-disciplinary models, taking into consideration which physician would be responsible for collecting payment and dispersing payments to other involved physicians or other qualified health care professionals.

Mr. Miller described the HHS Physician Focused Technical Advisory Committee. The proposed process may be found at (https://aspe.hhs.gov/medicare-access-and-chip-reauthorization-act-2015). The next meeting is May 4th and those wishing to attend can register online.

Psychiatric Collaborative Care Management Services

CPT Code	CPT Descriptor
●994X1	**Initial psychiatric collaborative care management,** first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: • outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; • initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; • review by the psychiatric consultant with modifications of the plan if recommended; • entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and • provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.
●994X2	**Subsequent psychiatric collaborative care management,** first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: • tracking patient follow-up and progress using the registry, with appropriate documentation; • participation in weekly caseload consultation with the psychiatric consultant; • ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; • additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; • provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; • monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment. • Subsequent psychiatric collaborative care management

●994X3	**Initial or subsequent psychiatric collaborative care management**, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure) (Use 994X3 in conjunction with 994X1, 994X2)

Cognitive Impairment Assessment and Care Plan Services

CPT Code	CPT Descriptor
●99XX3	Assessment of and care planning for the patient with cognitive impairment, requiring an independent historian, office or other outpatient, home or domiciliary or rest home, with all of the following required elements: • Cognition-focused evaluation including a pertinent history and examination • Medical decision making of moderate or high complexity • Functional assessment (eg, Basic and Instrumental Activities of Daily Living), including decision-making capacity • Use of standardized instruments for staging of dementia (eg, Functional Assessment Staging Test [FAST], Clinical Dementia Rating [CDR]) • Medication reconciliation and review for high-risk medications • Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s) • Evaluation of safety (eg, home), including motor vehicle operation • Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks • Development, updating or revision, or review of an Advance Care Plan • Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support (Do not report 99XX3 in conjunction with E/M services [99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99366, 99367, 99368, 99487, 99489, 99490, 99495, 99496, 99497, 99498]; psychiatric diagnostic procedures [90785, 90791, 90792]; psychological testing [96103]; neuropsychological testing [96120]; brief emotional/behavioral assessment [96127]; medication therapy management services [99605, 99606, 99607])

AMA/Specialty Society RVS Update Committee **Tab 50**
Administrative Subcommittee
Via E-mail
April 2016

Members: Doctors James Waldorf (Chair), Holly Stanley (Vice Chair), Amr Abouleish, Michael Bishop, Gregory DeMeo, William Fox, James Gajewski, Michael Gerardi, Anthony Hamm, DC, Robert Kossmann, John Lanza, Swati Mehrotra, Joseph Schlecht, Eugene Sherman, and Norman Smith.

I. Review Election of Rotating Seats Submission – Tab 53

The Administrative Subcommittee reviewed the nominations for the internal medicine rotating seat, Timothy Laing, MD, American College of Rheumatology, and the primary care rotating seat, Julia Pillsbury, DO, American Academy of Pediatrics. The Subcommittee noted that the internal medicine rotating seat and primary care rotating seat each had one nominee, therefore "an election will be unnecessary in the case that there is an unchallenged seat and the seat will be awarded to the candidate by voice vote."

II. Non-Staff Representation Agreement

This item has been pulled from the agenda. This form was initiated via the CPT Editorial Panel and is still undergoing review. In May, the Panel will hold a facilitation meeting explaining why this form was created, who should complete it and answer any questions. Therefore, the RUC will wait until the CPT Editorial Panel has this facilitation and any further edits to the document before the Administrative Subcommittee reviews.

AMA/Specialty Society RVS Update Committee
Ad Hoc Psychiatric Collaborative Care Management Workgroup

***Call Minutes* - Monday, April 11, 2016 7:00-8:00pm (Central)**

I. Call Attendees:

Members: Margie Andreae, MD (Chair), Allan Anderson, MD, Jane Dillon, MD, MBA, Alan Lazaroff, MD, G. Edward Vates, MD, Thomas J. Weida, MD, and Jane White, PhD, RD.

AMA Staff: Kristina Finney, MPH (RUC), Mike Morrow, MBA (RUC), Sherry Smith, MS, CPA (RUC), and Marie Mindeman (CPT).

CMS Staff: Edith Hambrick, MD and Lindsay Baldwin

Specialty Societies: American Geriatrics Society, American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Academy of Family Physicians, and American College of Physicians.

II. Workgroup Mission:

To provide guidance to Specialties (AGS, AACAP, APA, AAFP, and ACP) who will be surveying this new code set for the October RUC meeting by:

1) considering potential challenges for surveying and collecting practice data via other methods;
2) reviewing proposals from the surveying Specialties and provide recommendation;
3) and potentially reviewing proposed vignettes.

III. Call Agenda:

a. Review of Codes:

Doctor Andreae provided an overview of the new codes (see attached descriptors, *Minutes Attachment - Psychiatric Collaborative Care Management Services*). Doctor Jeremy Musher provided additional clarification regarding the new codes and noted that valuing these codes will be different than the usual RUC standard survey process and may be potentially challenging. These codes describe the work of the primary care physician or other qualified health care professional; a behavioral health care manager (e.g., RN, social worker, psychologist) employed by the primary care physician; and a consultant psychiatrist on contract with the primary care office.

Workgroup members were provided the following references regarding the evidence base used in formulating the specific codes:

Web Resources:

http://aims.uw.edu/collaborative-care/evidence-base

http://icer-review.org/sites/default/files/u148/BHI_Final_Report_060215.pdf

https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf

http://www.cochrane.org/CD006525/DEPRESSN_collaborative-care-for-people-with-depression-and-anxiety

b. Discussion of Potential Survey Challenges:

The Workgroup discussed the survey process for these codes and what potential challenges will present as specialties survey for the October RUC Meeting. Doctor Andreae asked the group what concerns they saw with the traditional survey. It was discussed that a random survey may not be effective as most family practitioners would not have an idea of how to account for costs or time of this service. The Workgroup noted we should target physicians who have done this before under a grant or other set-up to garner better information. The Workgroup discussed they would need to survey both the primary care physicians (working with their behavioral health manager and contracted psychiatrist) and the psychiatrist to capture the information needed to value these codes. Additional discussion noted that the expense of the registry set-up, the time spent by the behavioral health manager, and the contract pricing with the psychiatrist need to be deciphered for practice expense. The Workgroup discussed surveying practice expense, as well as physician work.

c. Discussion of Primary Care Physician Contracts with Consulting Psychiatrist:

The Workgroup discussed what information we have to understand these practice models and the role between the primary care office and the consulting psychiatrist. Specialties provided that contracts are normally based on hours per month. For example, the Aims Center estimates that for approximately 65-85 patients, a primary care physician would contract with a consulting psychiatrist for 12 hours per month (http://aims.uw.edu/resource-library/collaborative-care-staffing-ratios). These codes were structured for the primary care physician to report the service on a monthly basis for each patient in the model. The psychiatrist would not separately report their service as much of their work relates to population health and it would be difficult and burdensome to allocate to a patient level for the purposes of billing. The contract model allows for the primary care physician to bill per patient while the psychiatrists are simply paid from the contract they have with the primary care office for the hours they spend consulting with the primary care physician and/or the behavioral health manager. The specialties would need to develop an altered survey that asks both the psychiatrists and primary care physician questions about time and costs. After much discussion regarding whether the psychiatrist work effort should be

included in the work value or the practice expense value for the codes, it was suggested that we should first survey and CMS can decide whether the psychiatrists' time is better captured in practice expense or physician work for this code set.

d. Discussion of Next Steps:

The Workgroup discussed next steps that this Workgroup will need to take on subsequent call(s) to review the unique survey techniques and vignettes for this code set. The Workgroup agreed that next steps will include feedback from the societies about the timing it will take them to provide vignettes and survey plans for Workgroup review. The specialties should pull together revised vignettes and a detailed plan for surveying these codes for the October RUC Meeting. The Workgroup will review and provide guidance before these items go to the Research Subcommittee for approval. The next Workgroup call will need to be scheduled for mid-May in preparation for the early June Research Subcommittee meeting.

Doctor Andreae noted that the minutes from this call would be shared with the Workgroup members for approval. A report from this call will be provided to the Research Subcommittee at the April RUC Meeting.

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2016

Psychiatric Collaborative Care Management Services - Tab 4

American Geriatrics Society
American Academy of Child and Adolescent Psychiatry
American Psychiatric Association
American Academy of Family Physicians
American College of Physicians

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Evaluation and Management				
Care Management Services				
Care management services are management, and support services provided by clinical staff under the direction of a physician or other qualified health care professional, to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services may include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis. The physician or other qualified health care professional provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living.				
A plan of care must…				
Codes 99487, 99489, 99490…				
The face-to-face and…				

E/M services may be reported…

Care management codes may…

Care management codes may be …

For Psychiatric Collaborative Care Management Services, see 994X1, 994X2, 994X3.

Chronic Care Management Services

Chronic Care management services…

#99490 Chronic care management…

Complex Chronic Care Management Services

Complex chronic care management…

Patient who require complex…

99487 Complex chronic care…

99489 each additional 30 min…

----------Coding Tip----------

Time of care management with the emergency department is reportable using 99487, 99489, 99490 but time while the patient is inpatient or admitted as observation is not.
If the physician personally performs the clinical staff activities, his or her time may be counted toward the required clinical staff time to meet the elements of the code.

Psychiatric Collaborative Care Management Services

Psychiatric collaborative care services are provided under the direction of a treating physician or other qualified health care professional (see definitions below) during a calendar month. These services are provided when a patient has a diagnosed psychiatric disorder that requires a behavioral health care assessment; establishing, implementing, revising, or monitoring a care plan; and provision of brief interventions. These services are reported by the treating physician or other qualified health care professional and include the services of the treating physician or other qualified health care professional, the behavioral health care manager (see definition below), and the psychiatric consultant (see definition below) who has contracted directly with the treating physician or other qualified health care professional, to provide consultation.

Patients directed to the behavioral health care manager typically have newly diagnosed conditions, may need help in engaging in treatment, have not responded to standard care delivered in a non-psychiatric setting, or require further assessment and engagement, prior to consideration of referral to a psychiatric care setting.

The following definitions apply to this section:

Episode of Care

Patients are treated for an episode of care, defined as beginning when the patient is directed by the treating physician to the behavioral health care manager and ending with:

- the attainment of targeted treatment goals, which typically results in the discontinuation of care management services and continuation of usual follow-up with the treating physician or other qualified healthcare professional; or
- failure to attain targeted treatment goals culminating in referral to a psychiatric care provider for ongoing treatment; or
- lack of continued engagement with no psychiatric collaborative care management services provided over a consecutive six month calendar period (break in episode).

A new episode of care starts after a break in episode of six calendar months or more.

Health Care Professionals

Treating Physician or Other Qualified Health Care Professional

The treating physician or other qualified health care professional directs the behavioral health care manager and continues to oversee the patient's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed. Evaluation and management (E/M) and other services may be reported separately by the same physician or other qualified health care professional during the same calendar month.

Behavioral Health Care Manager

The behavioral health care manager refers to clinical staff with a masters/doctoral-level education or specialized training in behavioral health who provides care management services as well as an assessment of needs, including the administration of validated rating scales, the development of a care plan, provision of brief interventions, ongoing collaboration with the treating physician, maintenance of a registry, all in consultation with a psychiatric consultant. Services are provided both face-to-face and non-face-to-face and psychiatric consultation is provided minimally on a weekly basis, typically non face-to-face.

The behavioral health care manager providing other services in the same calendar month, such as psychiatric evaluation (90791, 90792), psychotherapy (90832, 90833, 90834, 90836, 90837, 90838), psychotherapy for crisis (90839, 90840), family psychotherapy (90846, 90847), multiple family group psychotherapy (90849), group psychotherapy (90853), smoking and tobacco use cessation counseling (99406, 90407), and alcohol and/or substance abuse structured screening and brief intervention services (99408, 99409), may report these services separately. Activities for services reported separately are not included in the time applied to 994X1, 994X2, 994X3.

Psychiatric Consultant

The psychiatric consultant refers to a medical professional trained in psychiatry or behavioral health and qualified to prescribe the full range of medications. The psychiatric consultant advises and makes recommendations, as needed, for psychiatric and other medical care, including psychiatric and other medical differential diagnosis, treatment strategies regarding appropriate therapies, medication management, medical management of complications associated with treatment of psychiatric disorders, and referral for specialty services; which are communicated to the treating physician or other qualified health care professional typically through the behavioral health care manager. The psychiatric consultant does not typically see the patient nor prescribe medications, except in rare circumstances.

The psychiatric consultant may provide services in the calendar month described by other codes, such as evaluation and management (E/M) services and psychiatric evaluation (90791, 90792). These services may be reported separately by the psychiatric consultant. Activities for services reported separately are not included in the services reported using 994X1, 994X2, 994X3.

Code Selection
Do not report 994X1 and 994X2 in the same calendar month.

Table X

Type of Service	Total Duration of Collaborative Care Management Over Calendar Month	Code(s)
Initial – 70 minutes	Less than 36 minutes	Not reported separately
	36-85 minutes (36 minutes – 1 hr. 25 minutes)	994X1
Initial plus each additional increment up to 30 minutes	86-116 minutes (1 hr. 26 minutes – 1 hr. 54 minutes)	994X1 X 1 AND 994X3 X 1
Subsequent – 60 minutes	Less than 31 minutes	Not reported separately
	31-75 minutes (31 minutes – 1 hr. 15 minutes)	994X2
Subsequent plus each additional increment up to 30 minutes	76-105 minutes (1 hr. 16 minutes – 1 hr. 45 minutes)	994X2 X 1 AND 994X3 X 1

●994X1	A1	**Initial psychiatric collaborative care management,** first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: • outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; • initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; • review by the psychiatric consultant with modifications of the plan if recommended; • entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and • provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.	XXX	Specialty request deferral to Oct 2016 RUC meeting

●994X2	A2	**Subsequent psychiatric collaborative care management,** first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: • tracking patient follow-up and progress using the registry, with appropriate documentation; • participation in weekly caseload consultation with the psychiatric consultant; • ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; • additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; • provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; • monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.	XXX	Specialty request deferral to Oct 2016 RUC meeting

●994X3	A3	**Initial or subsequent psychiatric collaborative care management**, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure) (Use 994X3 in conjunction with 994X1, 994X2)	ZZZ	Specialty request deferral to Oct 2016 RUC meeting

Coding Tips

If the treating physician or other qualified health care professional personally performs behavioral health care manager activities and those activities are not used to meet criteria for a separately reported code, his or her time may be counted toward the required behavioral health care manager time to meet the elements of codes 994X1, 994X2, 994X3.

Behavioral health care manager time spent coordinating care with the emergency department may be reported using 994X1, 994X2, 994X3, but time while the patient is inpatient or admitted to observation status may not be reported using 994X1, 994X2, 994X3.

AMA/Specialty Society RVS Update Committee **Tab 51**
Ad Hoc Anesthesia Workgroup
April 12, 2016
Conference call

Members: Doctors Verdi DiSesa (Chair), Dale Blasier, Scott Collins, Peter Hollmann, Christopher Senkowski and James Waldorf

I. Background

In the Final Rule for 2016, CMS stated that the anesthesia procedure codes 00740 *Anesthesia for procedure on gastrointestinal tract using an endoscope* and 00810 *Anesthesia for procedure on lower intestine using an endoscope* are used for anesthesia furnished in conjunction with upper and lower GI procedures respectively. In reviewing Medicare claims data, CMS noted that a separate anesthesia service is now reported more than 50 percent of the time when several types of GI endoscopy procedures are reported. Given the significant change in the relative frequency with which anesthesia codes are reported with GI endoscopy services, CMS believes the base units of the anesthesia services should be reexamined. Therefore, CMS identified CPT codes 00740 and 00810 as potentially misvalued. The RUC added CPT codes 00740 and 00810 to the list of potentially misvalued services to review for the January 2016 meeting.

In January 2016, the RUC reviewed codes 00740 and 00810 and determined that the vignettes on the survey did not describe the typical patient for the procedures in which these anesthesia services were administered. The RUC recommended:

1) An interim base unit of 5 for codes 00740 and 00810 and noted the comparison to the RUC recommended values for moderate sedation, 991X4 and 991X6, results in a work RVU equivalent that is only slightly higher than moderate sedation service of the same number of minutes.
2) Referral to the Research Subcommittee for review of the vignettes and to develop a method on how to review the survey data to value these services. The specialty societies should revise the vignette for the typical patient receiving anesthesia for an EGD for 00740 and for a patient receiving anesthesia for a colonoscopy (45378) for 00810.
3) Resurvey 00740 and 00810 for the April 2016 RUC meeting.

II. American Society of Anesthesiologists (ASA) Proposal

Refer to CPT
ASA re-examined CPT code 00740 and 00810 and determined that they are too broad in the range of endoscopic procedures covered under each code and made the decision to go to the CPT Editorial Panel September 29-October 1, 2016 meeting to request a new family of anesthesia codes to describe anesthesia for GI endoscopic procedures. ASA reviewed the most recent 5% LDS file to determine the most common procedures reported with anesthesia services.

ASA believes this new family of codes provides sufficient granularity to describe typical patients undergoing routine upper endoscopic procedures and differentiate them from patients undergoing more complex upper gastrointestinal endoscopic procedures, such as ultrasound or ERCP. It will also differentiate patients undergoing screening colonoscopies from those undergoing diagnostic and/or therapeutic lower gastrointestinal endoscopic procedures.

Lastly, this family of codes will also specifically identify those patients undergoing both upper and lower gastrointestinal endoscopic procedures. This new code is necessary because under the anesthesia code conventions for reporting multiple procedures, only a single anesthesia code is reported along with the total time for all procedures. Therefore, the additional anesthesia work,

such as repositioning, responding to physiologic changes when reinserting the scope into a different location, and other non-duplicative work involved in the additional procedure is not captured.

ASA intends on submitting the following new code proposals and vignettes for the September 2016 CPT Editorial Panel meeting subsequently to be surveyed and thereafter reviewed by the RUC in January 2017:

Delete 00740 – Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum

New Code 0074X1: Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified
A 63 year-old patient with abdominal pain and persistent dyspepsia undergoes EGD. Evaluation of the upper GI track is performed and multiple biopsies are taken for histology and Helicobacter pylori (H. pylori) rapid urease test

(Same vignette as for CPT code 43239 – Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple)

New Code 0074X2: Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic ultrasound and EUS guided procedures
A 66 year-old patient with recent onset dysphagia is found to have an exophytic mass lesion in the mid-esophagus that on prior biopsy was proven to be an adenocarcinoma. Imaging studies demonstrate thickening of the mid-esophagus without evidence of distant metastases. Diagnostic esophagogastroduodenoscopy of the upper GI tract is performed, and then endoscopic ultrasound of the esophagus is performed to evaluate and stage the lesion

(Same vignette as CPT code 43237 - Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures)

New Code 0074X3: Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; Endoscopic Retrograde Cholangiopancreatography (ERCP)
A 72 year-old patient with weight loss, abdominal pain, and elevated laboratory tests (AST, ALT, amylase, alkaline phosphatase) is referred for evaluation. Biliary dilation is identified on imaging studies. A diagnostic endoscopic retrograde cholangiopancreatography (ERCP) is performed where a mass at the ampulla of Vater is identified; biopsies are obtained

(Same vignette as CPT code 43261 – Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple)

Delete Code 00810 – Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum

New Code 0081X1: Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified
A 66 year-old patient presents with diarrhea, anemia, and intermittent rectal bleeding. Colonoscopy with biopsies of a lesion is performed

(Same vignette as CPT code 45380 Colonoscopy, flexible; with biopsy, single or multiple)

New Code 0081X2: Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy
A 64 year-old patient is referred for colorectal cancer screening.

(Same vignette as CPT code 45378 - Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)) Note, 0081X2 would also be reported with HCPCS codes G0105 and G0121, which describe screening colonoscopies in the Medicare system)

New Code 0081X3: Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum
A 63 year-old patient with persistent dyspepsia, abdominal pain and intermittent rectal bleeding is referred for both an upper and lower endoscopic evaluation.

(There is no single CPT code vignette to describe the simultaneous provision of these services since each CPT procedure code would be separately reported. The most common pair of Upper and Lower GI procedures performed with anesthesia services together is 45380 and 43239. However, only this one anesthesia code would be reported.)

The Workgroup noted that the proposed code changes are sufficiently granular to appropriately describe the services and the vignettes for 0074X1-3 and 0081X1 and 0081X2 seemed appropriate as typical of these GI services. The Workgroup further suggested that the vignette for the combined procedure, 0081X3 needed refinement. **The Workgroup agreed that after the CPT Editorial panel reviews the vignettes, the specialty will submit them for review by the Research Subcommittee to confirm they are appropriate prior to survey.**

Anesthesia Survey Process
The ASA requested that the current RUC anesthesia survey instrument and process, which took years and many hundreds of RUC member hours, but has not been reviewed or used to value a code since 2007, be used to survey this family of codes for the January 2017 meeting. ASA also requested that the Workgroup reaffirm the method to determine individualized PIPPA work RVUs from the survey data. For the purposes of reviewing the codes proposed by the ASA, the Workgroup essentially affirmed for now the current method as no alternative is available. The Workgroup did articulate the opinion that the process for valuation of anesthesia codes should be reviewed and/or revised. Involvement of the RAW might be helpful in consideration of these issues.

The specialty society noted that the current survey uses magnitude estimation and compares one anesthesia code to another, same as RVUS codes and that the RUC can confirm a base unit using building block, but that is not the methodology used to build/develop recommendation.

The Workgroup agreed that the specialty society should go forward utilizing the current RUC anesthesia survey instrument and process. **The Workgroup noted that it did not re-validate the individualized PIPPA work RVU methodology, but agreed that the RUC should value these services according to the present methodology, using the RUC anesthesia survey instrument and process.**

The Workgroup recommends an educational presentation be provided to the RUC on the existing survey and valuation process for anesthesia services since it has not been validated or used for a survey since 2007, including a specific example of how the data from a survey are used to value an anesthesia service.

The Workgroup requested that anesthesia codes be included in any RAW screens.

III. Anesthesia Workgroup Going Forward

In discussing anesthesia services and how they are valued, the Workgroup members agreed that there needs to be education on the way an anesthesia base unit is recommended as well as review of the overall anesthesia methodology which was last reviewed in 2007. The Workgroup recommends the following items be addressed over multiple Anesthesia Workgroup meetings.

1. What is surveyed and how does this translate into anesthesia base units?
    a. Provide copy of anesthesia survey instrument
    b. Provide an example of base unit determination/recommendation
        i. If they use magnitude estimation to compare codes for the base value and this has not been done since 2007 perhaps all codes should be reviewed. A combined discussion with expertise of the RAW would be helpful.
    c. Develop an educational presentation on how to value/make an anesthesia base unit recommendation

2. Review a side-by-side crosswalk from the CPT code to what new anesthesia code is expected to be reported with each GI service

3. Anesthesia Methodology
    a. Review recent anesthesia methodology, 2007 Workgroup memo

AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE

Research Subcommittee Conference Call
Wednesday, February 24, 2016

Members Present: Christopher Senkowski, MD (Vice Chair), Margie Andreae, MD, Allan Anderson, MD, Amy Aronsky, DO, James Blankenship, MD, Robert Dale Blasier, MD, Scott Collins, MD, Verdi DiSesa, MD, Jane Dillon, MD, MBA, Jeffrey Edelstein, MD, Peter Hollmann, MD, Alan Lazaroff, MD, Paul Martin, DO, Stanley W. Stead, MD, MBA, G. Edward Vates, MD, Jane White, PhD, RD

Note: Research requests reviewed prior to and after the February 24th call are included in the Addenda section.

I. Specialty Society Request for Review of Proposed Vignettes

a. Colporrhaphy (57240, 57250, 57260, 57265) WITHDRAWN

American Congress of Obstetricians and Gynecologists

ACOG withdrew this request prior to the call, noting that they will instead be recommending for these services to be referred to CPT.

b. Radiation Therapy Planning (77261, 77262, 77263)

American Society for Radiation Oncology

The Research Subcommittee reviewed the below vignettes submitted by the specialty for Radiation Therapy Planning and approved them as submitted:

77261 ***Therapeutic radiology treatment planning; simple***
Approved Vignette: Patient with pain in the right femur from bone metastases presents for clinical treatment planning.

77262 ***Therapeutic radiology treatment planning; intermediate***
Approved Vignette: Patient with multiple bone metastases with pain in the hip and shoulder presents for clinical treatment planning.

77263 ***Therapeutic radiology treatment planning; complex***
Approved Vignette: Patient with locally advanced prostate cancer presents for clinical treatment planning.

c. Selective Catheter Placement (36215, 36216, 36217, 36218)

Society of Interventional Radiology
American College of Radiology
Renal Physicians Association
Society for Vascular Surgery

The Research Subcommittee reviewed the below vignettes submitted by the specialty for Selective Catheter Placement and approved them as submitted:

36215 ***Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family***

Approved Vignette: Selective catheterization of the left subclavian artery to evaluate upper extremity ischemia in a 68 year old male (e.g. claudication, ischemia distal to an AV access).

36216 ***Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family***
Approved Vignette: Selective catheterization of the right subclavian artery to evaluate for thoracic outlet syndrome in a 32 year old male with evidence of distal emboli to the hand.

36217 ***Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family***
Approved Vignette: Selective catheterization of the right brachial artery to evaluate digital ischemia in a 44 year old female (e.g. vasculitis, atherosclerosis, trauma, thromboembolism, vascular malformation).

36218 ***Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)***
Approved Vignette: Following subselective catheterization of the radial artery, the catheter is drawn back and the ulnar artery is then selectively catheterized to evaluate digital ischemia in a 44 year old female (e.g. vasculitis, atherosclerosis, trauma, thromboembolism, vascular malformation).

d. Muscle/Skin Graft (15732, 15734, 15736, 15738)
American Society of Plastic Surgeons
American College of Surgeons
American Society for Surgery of the Hand

The Research Subcommittee reviewed the proposed vignettes submitted by the specialty societies. The Subcommittee made several suggestions, including the following, and requested for the societies to resubmit the vignettes for post-call review:

- All codes should have a similar level of detail and format for stating the type of pedicled muscle flap, including a parenthetical with the type of flap.
- For code 15732, the subcommittee questioned the typicality of the original type of tumor included (dermatofibrosarcoma protuberans) and suggested for a more typical type of cancer to be used instead (ie squemocell carcinoma).
- For code 15734, some Subcommittee members expressed initial concern with having two vignettes for one code. The specialties explained that for plastic surgeons, this code covers several different types of flaps and locations on the trunk, whereas general surgery uses a fewer types of flaps as they have a different patient population (primarily abdominal wall procedures). The Research Subcommittee agreed that having two vignettes for this code is appropriate, citing a precedent from the January 2016 RUC meeting for Injection of Tendon Sheath code 20550. The Specialties noted their expectation that the amount of physician work should be very similar between both vignettes, though the survey would clarify the relative amount of work.

Following the call, the societies submitted updated vignettes and the Research Subcommittee approved the below vignettes as listed below:

15732 ***Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)***

Approved Vignette: A patient with an aggressive squamous cell carcinoma, resulting in a large defect that is too large to close with a complex repair or adjacent tissue transfer presents for closure. A pedicled muscle flap (eg, temporalis) is elevated and transposed to close the defect

15734 ***Muscle, myocutaneous, or fasciocutaneous flap; trunk***

Approved Vignette 1: A patient with a history of radiation therapy develops a large open wound of the chest with exposure of several ribs resulting in a defect that is too large to close with a complex repair or adjacent tissue transfer. The defect is reconstructed with a pedicled muscle flap (eg, latissimus).

Approved Vignette 2: A trauma patient with multiple injuries initially undergoes a damage-control laparotomy with hemorrhage control, bowel resection and temporary abdominal closure. At the time of definitive closure of the abdomen, a wide gap between the opposing fascial edges in the abdominal wall has developed. A pedicled muscle flap (eg, rectus abdominis) is elevated and transposed to close the defect

15736 ***Muscle, myocutaneous, or fasciocutaneous flap; upper extremity***

Approved Vignette: A patient sustains an avulsion injury of the antecubital fossa resulting in a soft tissue defect exposing the brachial artery and median nerve. A pedicled muscle flap (eg, brachial radialis) is elevated and transposed to provide coverage of the defect.

15738 ***Muscle, myocutaneous, or fasciocutaneous flap; lower extremity***

Approved Vignette: A patient presents with a large defect of the mid portion of the lower leg with exposed bone that is too large to close with a complex repair or adjacent tissue transfer. A pedicled muscle flap (eg, medial soleus) is elevated and transposed to provide coverage of the defect.

e. Bone Imaging (78300, 78305, 78306)

American College of Nuclear Medicine
American College of Radiology
Society of Nuclear Medicine and Molecular Imaging

The Research Subcommittee reviewed the below vignettes submitted by the specialty societies. Subcommittee members questioned if stating the specific PSA level would cause confusion for certain respondents and also requested other minor revisions. **The Research Subcommittee and the specialty societies made the following underlined and strike-through changes to the original submitted vignettes:**

78300 ***Bone and/or joint imaging; limited area***
Approved Vignette: A 67-year-old female with acute onset of pain in left knee. Radiographs do not demonstrate suspected tibial plateau insufficiency fracture. MRI contraindicated due to pacemaker. Bone scan of left knee is requested to evaluate for occult fracture.

78305 ***Bone and/or joint imaging; multiple areas***
Approved Vignette: A70-year-old male fell on step of his front porch yesterday. Pain in right wrist, right ribs, and right hip. Radiographs of suspected areas do not demonstrate any fractures. Bone scan of multiple areas requested to evaluate for radiographically occult fractures.

78306 ***Bone and/or joint imaging; whole body***
Approved Vignette: A 57-year-old male with a history of prostate carcinoma presents with an elevated PSA ~~a PSA level of 11.7 ng/mL~~ and pain in his right pelvic region. A bone scan is requested to assess the cause of the pain in his pelvis and the extent of any other foci of metastatic bone disease.

f. Wrist X-Ray (73100) WITHDRAWN
American College of Radiology

ACR withdrew this request prior to the call, noting that they will instead be using the existing vignette for 73100.

X-Ray of the Ribs (71100, 71101, 71110, 71111)
American College of Radiology

The Research Subcommittee reviewed the below vignettes submitted by the specialty for X-Ray of the Ribs and approved them as submitted:

71100 ***Radiologic examination, ribs, unilateral; 2 views***
Approved Vignette: A 65-year-old female presents with a right chest contusion after suffering a fall. Frontal and oblique views of the right rib cage are obtained.

71101 ***Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of 3 views***
Approved Vignette: A 65-year-old female presents with a right chest contusion, pleuritic chest pain and shortness of breath after suffering a fall. Frontal and oblique views of the right rib cage and a posteroanterior view of the chest are obtained.

71110 ***Radiologic examination, ribs, bilateral; 3 views***
Approved Vignette: A 45-year-old male presents with bilateral chest contusions after suffering a motor vehicle collision. Frontal view of the entire rib cage and oblique views of the right and left rib cages are obtained.

71111 ***Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views***
Approved Vignette: A 45-year-old male presents with bilateral chest contusions, pleuritic chest pain and shortness of breath after suffering a motor vehicle collision. Frontal view of the entire rib cage, oblique views of the right and left rib cages and a posteroanterior view of the chest are obtained.

CT Chest (71250, 71260 and 71270)
American College of Radiology

The Research Subcommittee reviewed the below vignettes submitted by the specialty for CT Chest. The Subcommittee questioned whether including that the patient is a smoker is necessary for 71250. The specialty clarified that following an abnormal radiologic examination, additional symptoms or risk factors should be present before deciding to order a follow-up CT (instead of simply a follow-up X-ray). **The Research Subcommittee approved the vignettes as submitted:**

71250 ***Computed tomography, thorax; without contrast material***
Approved Vignette: A 65-year-old female smoker has developed progressive dyspnea over the past six months. Chest radiograph demonstrates a basilar interstitial abnormality. A CT scan of the thorax is requested for further evaluation.

71260 ***Computed tomography, thorax; with contrast material(s)***
Approved Vignette: A 75-year-old male with a history of smoking presents with persistent cough. Chest radiographs demonstrate mediastinal widening and new interstitial opacities on the left. A contrast enhanced CT of the chest is ordered.

[Note: 3D rendering, if ordered and performed, is coded separately. Interpretation of 2D thin section coronal and/or sagittal reformatted images is included and not separately reported with 71260.)

71270 ***Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections***
Approved Vignette: A 76-year-old female presents with dyspnea and hemoptysis. Prior chest radiograph showed an abnormality suspicious for a vascular lesion. A CT scan of the thorax with and without contrast is requested for further evaluation.

CT Angiography of Abdominal Arteries (75635)
American College of Radiology

The Research Subcommittee reviewed the below vignette submitted by the specialty for CT Angiography of Abdominal Arteries and approved it as submitted:

75635 ***Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing***
Approved Vignette: A 70-year-old male is referred for further evaluation of claudication with suspected aortoiliac atherosclerotic disease. A CT angiogram with lower extremity runoff is requested.

g. Transthoracic Echocardiography (93306, 93307, 93308)

American College of Cardiology
American Society of Echocardiography

The Research Subcommittee and the specialty societies made the following underlined and strike-through changes to the original submitted vignettes:

93306 ***Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography***
Approved Vignette: A 67-year-old male with progressive exertional dyspnea and a new systolic murmur. ~~A 67-year-old male with progressive exertional dyspnea. A late peaking crescendo-decrescendo murmur is appreciated. The ECG shows left ventricular hypertrophy, and pulmonary edema is noted on the chest x-ray.~~

93307 ***Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography***
Approved Vignette: A 67 year old man presents to a cardiology office complaining of recent chest discomfort ~~chest discomfort at rest~~. His EKG is abnormal. Echocardiography is performed to exclude regional wall motion abnormalities.

93308 ***Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study***
Approved Vignette (no change from 2011): A 54-year-old female with metastatic breast cancer presents after percutaneous drainage of a malignant pericardial effusion. A limited echocardiogram is performed to assess the re-accumulation of pericardial fluid.

II. Specialty Society Request for Review of Proposed Vignettes and Reference Service Lists

a. Transurethral Electrosurgical Resection of Prostate (TURP) (52601)

American Urological Association

The Research Subcommittee reviewed the below vignettes submitted by the specialty societies. The Subcommittee asked if also having a transrectal ultrasound was typical and the specialty said it was not. The size of the prostate gland was also questioned for using TURP. The specialty clarified that TURP is typically used for a medium-sized prostate.
The Research Subcommittee and the specialty societies made the following underlined and strike-through changes to the original submitted vignettes:

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)***
Approved Vignette: A 78-year-old male presents with urinary retention and wears a urinary catheter. He has failed alpha-blocker and 5-alpha reductase

inhibitor therapy. Digital rectal exam reveals a **65** ~~**70**~~ gram prostate. The patient elects to have a TURP.

The specialty requested for the Research Subcommittee to review a proposed Reference Service List (RSL). **The Subcommittee reviewed the RSL and requested for the specialty societies to consider replacing codes that where last reviewed by the RUC more than 7 years ago if possible.**

b. Control Nasal Hemorrhage (30901, 30903, 30905, 30906)
American Academy of Otolaryngology - Head and Neck Surgery

The Research Subcommittee reviewed the below vignettes submitted by the specialty for Control Nasal Hemorrhage and approved them as submitted:

30901 ***Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method***
Approved Vignette: A 75 year old male presents with intermittent unilateral epistaxis. A bleeding source on the anterior septum is identified and controlled with limited cautery and/or packing

30903 ***Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method***
Approved Vignette: A 75 year old male presents with persistent, brisk unilateral epistaxis. A bleeding source on the anterior septum is identified, requiring extensive cautery and/or packing to control.

30905 ***Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial***
Approved Vignette: A 75 year old male presents with posterior epistaxis. Control of nasal hemorrhage, posterior, with posterior nasal packs and/or cautery is performed.

30906 ***Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent***
Approved Vignette: A 75 year old male presents with recurrent posterior epistaxis, having undergone prior treatment of posterior nasal hemorrhage. Control of nasal hemorrhage, posterior, with posterior nasal packs and/or cautery is performed.

The specialty requested for the Research Subcommittee to review a proposed Reference Service List (RSL). **The Subcommittee reviewed the RSL and requested for the specialty societies to consider replacing code 31600 with a more recently reviewed code if an appropriate one is available.**

Tracheostomy (31600, 31601, 31603, 31605, 31610) ***(RSL Review request retracted)***
American Academy of Otolaryngology - Head and Neck Surgery
American College of Surgeons

AAO-HNS and ACS withdrew the request for reference service list review prior to the call. **The Research Subcommittee reviewed the below vignettes submitted by the specialties for Tracheostomy and approved them as submitted:**

> **31600** ***Tracheostomy, planned (separate procedure);***
> ***Approved Vignette:*** A 65 year old male with pneumonia and chronic obstructive pulmonary disease is unable to be extubated after prolonged intubation. A planned tracheostomy is performed.
>
> **31601** ***Tracheostomy, planned (separate procedure); younger than 2 years***
> ***Approved Vignette:*** An 18 month old male with subglottic stenosis is unable to be extubated after prolonged intubation. A planned tracheostomy is performed.
>
> **31603** ***Tracheostomy, emergency procedure; transtracheal***
> ***Approved Vignette:*** A 57 year old male presents with significant airway obstruction from a large laryngeal tumor. There is concern for impending airway obstruction. An emergency tracheostomy trans tracheal is performed.
>
> **31605** ***Tracheostomy, emergency procedure; cricothyroid membrane***
> ***Approved Vignette:*** A 45 year old female develops angioedema with swelling of the larynx and airway obstruction. Intubation is unsuccessful. An emergency tracheostomy through the cricothyroid membrane is performed.
>
> **31610** ***Tracheostomy, fenestration procedure with skin flaps***
> ***Approved Vignette:*** A 60 year old male with progressive ALS is intubated and unable to be extubated. A long term tracheostomy is needed. A tracheostomy, fenestration procedure with skin flaps is performed.

Resection Inferior Turbinate (30140)

American Academy of Otolaryngology - Head and Neck Surgery

The Research Subcommittee reviewed the below vignette submitted by the specialty for Resection Inferior Turbinate and approved them as submitted:

> **30140** ***Submucous resection inferior turbinate, partial or complete, any method***
> ***Approved Vignette:*** A 42 year old female presents with right nasal obstruction due to a hypertrophied inferior turbinate that is refractory to medical therapy. A submucous resection of the right inferior turbinate is performed.

The specialty requested for the Research Subcommittee to review a proposed Reference Service List (RSL). The Subcommittee reviewed the RSL and requested for the specialty societies to only include reference codes that have the same global as the survey code (090-day global). It was also noted that since the survey code has 3 post-operative visits, the inclusion of 010-day reference codes is not appropriate. The Specialty noted that since the survey code is a 090-day global with a very low work RVU (3.57 RVUs), finding appropriate comparator codes is challenging. Some of the Subcommittee members suggested for the Specialty to consider subcutaneous codes from other parts of the body for RSL.

The Specialty resubmitted the RSL for post-call review. The updated RSL included only 090-day reference codes and also added codes 23075, 24075 and 21040. **The Subcommittee reviewers confirmed that the updated RSL complied with all Research Subcommittee requests.**

III. Specialty Society Request for Review of Proposed Vignettes and Modified Survey Instrument

a. Pathology Consultation During Surgery (88333, 88334)

The Research Subcommittee and the specialty societies made the following underlined and strike-through changes to the original submitted vignettes:

88333 ***Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep) initial site***
Approved Vignette: A 65 year old male with a peribronchial mass undergoes a **needle** biopsy and an immediate evaluation is requested. Touch preps of the **specimen** ~~**needle biopsy**~~ are made.

88334 ***Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep) each additional site (List separately in addition to code for primary procedure)***
Approved Vignette: **A 67 year old female with a 1 cm lung mass undergoes biopsy of a right lung lesion in which needle cores are procured from two areas of the tumor. These are received in a single specimen container on saline moistened gauze. Immediate evaluation is requested and touch preps of one needle core are made and are not diagnostic. Touch preps are then made from the second needle core and separately interpreted.** ~~A biopsy of a right lung lesion is performed immediately after a previous biopsy is determined to be inadequate for diagnosis in a 67 year old woman with a 1 cm lung mass. Immediate evaluation is requested and touch preps of the biopsy are made.~~

(Note: This is an add-on code for the additional physician work related to the second needle core only. The physician work related to the first needle core would be reported separately with the primary code 88333.)

CAP also requested approval of a modified survey instrument to be intra-service time only and also to revise the definition of physician intra-service work. The Research Subcommittee noted that there is a strong precedent for the request for modification of the survey instrument, as the Subcommittee has previously approved this request before from this Specialty for several other similar Pathology Services. It was noted that Pathologists perform all of the work during the intra-service period. **The Research Subcommittee approved the proposed changes to the survey instrument work description and physician intra-service time without modification. The modified intra-service work definition is as follows:**

Approved Intra-service work period definition:
Any physician work performed between the initial receipt and final sign out of the specimen. This would include examination and interpretation of the

specimen; comparison to previous study reports; identification of clinically meaningful findings; consultation and communication with other professionals regarding the specimen; any review of literature or research during examination of the specimen; dictation, preparation and finalization of the report.

Tumor Immunohisto-chemistry (88360, 88361)
College of American Pathologists
American Society of Cytopathology

The Research Subcommittee reviewed the below vignettes submitted by the specialty for Tumor Immunohisto-chemistry and approved them as submitted:

88360 ***Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; manual***
Approved Vignette: A 54 year female has invasive ductal carcinoma of the breast diagnosed on needle biopsy. Estrogen receptor stained slides from the patient's specimen, along with reference positive and negative samples, are examined to determine if the staining process is interpretable. The estrogen receptor stain is positive and a semiquantitative or quantitative interpretation is manually performed.

88361 ***Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; using computer-assisted technology***
Approved Vignette: A 54 year female has invasive ductal carcinoma of the breast diagnosed on needle biopsy. Estrogen receptor stained slides from the patient's specimen, along with reference positive and negative samples, are examined to determine if the staining process is interpretable. The estrogen receptor stain is positive and a semiquantitative or quantitative interpretation is performed using a computer assisted methodology.

IV. Specialty Society Request for Review of Proposed Practice Expense Survey Instrument

a. Parent, Caregiver-focused Health Risk Assessment (961X0, 961X1)
Reviewers: Scott Collins, MD, Stanley W. Stead, MD, MBA
American Academy of Family Physicians
American Academy of Pediatrics

The AAFP and AAP presented direct practice expense (PE) inputs to the RUC PE Subcommittee during its January 2016 meeting based on expert panel recommendations. While the RUC approved direct PE input recommendations based on deliberations of the PE Subcommittee, the societies requested permission to conduct a PE survey to test those recommendations and either validate or refine them based on the survey results.

The Research Subcommittee discussed the proposed PE survey template in detail. It was noted that the specialties already incorporated recommended changes from AMA staff

prior to submitting the draft template to the Research Subcommittee. **The Research Subcommittee approved the PE survey template as submitted.**

V. Initial Discussion of Potential Methods to Survey New Codes for Psychiatric Collaborative Care Management Services

AMA staff provided an overview of the new CPT codes for Psychiatric Collaborative Care Management Services and clarified that the surveying specialties have indicated their plan to survey these services for the October 2016 RUC meeting.

One of the main challenges is that for this care model, the psychiatric consultant is on a retainer with the practice and does not see the patient (which is instead done by the primary care physician). Identifying primary care practices that already have a contract with a psychiatric consultant (so the societies know who to sample) and also figuring out how to collect data on the typical amount of work done by the psych consultant per patient will be two hurdles to overcome. Also, determining typical practice costs for contracting a psychiatric consultant and how many patients are seen by the primary care physician may also be logistically challenging. A Research Subcommittee member noted that this new care model is based on an evidence model so there should be statistics available on the average number of patients that were managed by the psychiatrist.

The Research Subcommittee agreed to form the ad-hoc Psychiatric Collaborative Care Management Services Workgroup which would report to the Subcommittee. The mission of the Workgroup will be 1) to consider potential challenges for surveying and collecting practice data via other methods for this new care model, 2) to review proposals from the surveying Specialties and provide recommendation, and 3) to potentially review proposed vignettes. AMA staff will coordinate the formation of this new workgroup and work on scheduling the workgroup's first concern call for before the April RUC meeting.

VI. Discussion of Letter for Anesthesia for Intestinal Endoscopic Procedures

At the January 2016 RUC meeting, the RUC reviewed Anesthesia codes 00740 and 00810 *Anesthesia for Intestinal Endoscopic Procedures*. The RUC expressed concern with the vignettes used to survey these services and also recognized certain characteristics of anesthesia services that make their review unique.

Three important points that the RUC emphasized regarding anesthesia services are:

1) Anesthesia codes are not like the other codes in the RBRVS, the RUC cannot crosswalk from one anesthesia code to another because each anesthesia code may represent the anesthesia work for 40-100 different procedures.
2) The Post-Induction Period Procedure Anesthesia (PIPPA) intensity is the single differential measure for comparison of all anesthesia base codes. The correlation between the procedure and the anesthesia service is not strict.
3) Time is calculated outside of the base unit and cannot be used as a comparator in the same way that the RUC uses intra-service time.

At that meeting, the RUC requested for the specialty to resurvey these services for the April 2016 RUC meeting.

On the Research Subcommittee call, AMA staff noted that the specialty had recently clarified that they will request for these services to be referred to CPT to consider splitting them between screening and diagnostic procedures.

The Research Subcommittee agreed to form the ad-hoc Anesthesia Workgroup which would report to the Subcommittee. The mission of the Workgroup will be to develop a method for the RUC to review the survey data and make recommendations for Anesthesia services (with assistance from the Specialty). The Workgroup will also review proposed vignettes. AMA staff will coordinate the formation of this new workgroup and work on scheduling the workgroup's first conference call for before the April RUC meeting.

ADDENDUM A: Requests Reviewed before February 24 Call

I. Specialty Society Request for Review of Proposed Vignettes

a. Ophthalmic Biometry (76516, 76519, 92136)
American Academy of Ophthalmology

The Research Subcommittee reviewed the below vignettes submitted by the specialty for Ophthalmic Biometry and approved them as submitted:

76516 ***Ophthalmic biometry by ultrasound echography, A-scan;***
Approved Vignette: A 79-year old male with a visually significant cataract has his axial length measured with ultrasound.

76519 ***Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation***
Approved Vignette: A 75-year-old female with a visually significant cataract in the right eye undergoes ultrasonic biometry and intraocular lens calculations.

92136 ***Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation***
Approved Vignette: A 75-year-old male with a visually significant cataract in the right eye undergoes optical biometry and intraocular lens calculations.

ADDENDUM B: Post-call Requests

I. Specialty Society Request for Review of Proposed Vignettes

a. Injection Anesthetic Agent (64418)
American Academy of Pain Medicine
American Academy of Physical Medicine & Rehabilitation
American Society of Anesthesiologists

The Research Subcommittee and the specialty societies made the following underlined and strike-through changes to the original submitted vignettes:

64418 ***Injection, anesthetic agent; suprascapular nerve***
Approved Vignette: A 52-year-old woman with ~~**chronic shoulder pain related to**~~ a frozen shoulder ~~**is referred for physical therapy. She**~~ is unable to tolerate physical therapy due to pain**.** **She** ~~and~~ is referred for a suprascapular nerve block to provide pain relief so that she can undergo physical therapy.

AMA/Specialty Society RVS Update Committee **Tab 51**
Research Subcommittee
April 28, 2016

Members: M. Douglas Leahy, MD (Chair), Christopher Senkowski, MD (Vice Chair), Margie Andreae, MD, Amy Aronsky, DO, Allan Anderson, MD, James Blankenship, MD, Robert Dale Blasier, MD, Scott Collins, MD, Verdi DiSesa, MD, Jane Dillon, MD, MBA, Jeffrey Edelstein, MD, Peter Hollmann, MD, Alan Lazaroff, MD, Paul Martin, DO, G. Edward Vates, MD, Jane White, PhD, RD, Jennifer Wiler, MD

I. Research Subcommittee February 24, 2016 Conference Call Meeting Report

The Research Subcommittee report from the February 2016 conference call included in Tab 51 of the April 2016 agenda materials was approved.

II. General Survey Instrument and Memo Text Update

At the previous Research Subcommittee meeting in December 2015, the Subcommittee requested for AMA staff to draft updated survey memo and survey instrument language to indicate that the potential survey respondent should only complete surveys for services where they have either experience performing the service or where they are familiar with the service.

AMA Staff provided draft language for the Subcommittee to review at the April meeting. The Vice Chair proposed revisions to the draft language which the Subcommittee approved. **The Research Subcommittee approved the language as follows:**

For first page of RUC Online Survey Tool:

> **IMPORTANT: Please check CPT codes for procedures/services that you have experience performing or are familiar with. ~~Please select all of the CPT Codes that apply to you.~~ You will only be surveyed about each code that you select."**

For first page of Other Survey Tools *(ones which do not have the capability to display only survey questions from selected survey codes):*

> **IMPORTANT: Please only respond to questions for survey codes that you either have experience performing or are familiar with.**

Updated Text for Cover Memo:

> You have been selected to participate in an AMA RUC survey. As you may know, the Medicare payment schedule is based on physician work, practice expense and professional liability insurance. Our society needs your help to assure relative values will be accurately and fairly presented to the Centers for Medicare and Medicaid. **Please note, you do not need to respond to the questions for all of the codes in this survey. You may not have recent experience with one or more of the procedures. We ask that you provide responses for those services about which you have direct professional knowledge and feel comfortable answering, whether or not you currently perform the service.**
>
> REMINDER: This survey is to be completed independently without coaching or assistance, with the exception of clarification from specialty society staff. If you are inappropriately contacted regarding this survey, please notify specialty society staff immediately."

At the December 2015 Time-Intensity Workgroup meeting, as part of a discussion on measuring physician time, several Workgroup members noted that survey results often appear that the survey respondents tend to round to the nearest 5 minute or 15 minute increment instead of providing estimates to the nearest minute. The Workgroup requested for AMA staff to draft language for the Research Subcommittee to consider at the April meeting, which is as follows:

Initial Draft Text for Question 2, Physician time:

Question 2	**How much of your own time is required per patient treated for each of the following steps in patient care related to this procedure? Indicate your time for the survey code(s) ~~on the front cover.~~ (in minutes) in each box below. *Please refer to the above pre-service, intra-service and post-service period definitions and be as specific as possible.* ~~*(Refer to definitions.)*~~**

Several Subcommittee members noted that language requesting for the survey respondent "not to round" and to be "as precise as possible" should also be incorporated in the proposed text. The Vice Chair and another Subcommittee member each proposed alternate versions. **Following an extensive discussion, the Subcommittee did not make a final decision on the updated text and instead, referred this issue to the Time-Intensity Workgroup for further discussion.**

III. 23-hour stay outpatient surgical services with post-operative visits and New Standard Survey Template for 000-day surgical with visit *(note: will not replace existing 000-day template)*

At the Subcommittee meeting prior to the January RUC meeting, the Subcommittee requested for AMA staff to draft instructions explaining how to implement CMS' policy related to 23-hr outpatient surgical codes with post-operative visits. The Subcommittee also requested for an alternate 000-day template to be drafted. The Subcommittee should review the below text and the draft alternate 000-day template and discuss if they should be implemented.

23-Hour Stay Outpatient Surgical Services with Subsequent Hospital Visits Policy

CMS labels surgical services that are typically performed in the outpatient setting and require a hospital stay of less than 24-hours as *23-hour stay outpatient services*. In the CY2011 Final Rule, CMS finalized a policy to no longer allow these codes to include bundle subsequent hospital visits (eg 99231-99233) into the surgical global period. Instead, the Agency permits the allocation of the intraservice portion of the typically performed subsequent hospital visit to the immediate post-service time of the procedure.

If the survey results indicate that a 23-hour stay with a subsequent hospital visit is typical and the Medicare claims data (if available) show that the service is typically performed in the outpatient setting, then the surveying specialties may add the post-operative visit intra-service time to the immediate post-operative physician time and not list a subsequent hospital visit in the recommendation. For example, if the survey data for a 23-hour stay code includes 15 minutes of immediate post-service time and one 99232 post-operative visit (20 minutes of intra-service time), then the recommendation could include 35 minutes of immediate post-service time and no subsequent hospital visit.

Absent Medicare claims data, the specialties may determine whether the service is outpatient via expert panel. Also, when preparing to survey a 000-day global codes which may potentially be a 23-hour stay code with a visit, please be sure to use a RUC survey template which collects site of service, hospital stay and post-op visit data. For 000-day surgical services, specialties should

provide additional documentation which supports that a subsequent hospital visit is typical on the day of surgery.

The Subcommittee reviewed the proposed instructions and alternate 000-day survey instrument *(as provided in the agenda materials)* and approved both without modification.

IV. Review of Proposed Text for RUC Survey Instrument videos

At the October 2015 RUC meeting, as part of a review of survey process recommended from specialty societies, the Subcommittee noted that the creation of a video explaining the RUC survey process to potential survey respondents would be beneficial. AMA staff drafted an initial script and powerpoint for the Subcommittee to discuss at its December meeting. During the Subcommittee's review, members suggested for three separate videos to be made: one for surgical services (000-day, 010-day, 090-day services), one for other physician services, and a third video applicable to HCPAC societies. AMA staff made these modifications and sent the draft scripts to a dozen specialty societies for review. Specialty societies provided many helpful edits, most of which were incorporated into an updated drafts provided to the Subcommittee for the April 2016 meeting.

The Subcommittee noted that overall these powerpoints and scripts are appropriate and should be useful to potential survey respondents. One observer noted that a sentence stating that typical is more than 50% of the time on slide 12 should be deleted and the Subcommittee agreed. The Subcommittee also requested for AMA Staff to delete the last powerpoint bullet on slide 4 and slide 6. In addition, the Subcommittee requested for AMA staff to replace the term "reference service(s)" on slide 14 that is easier to understand for those that are not familiar with the RUC process.

One Subcommittee member pointed out that the examples of XXX intra-service definitions did not include non-face to face coordination of care codes or hospital E/M codes. The Subcommittee decided not to make this change at this time.

The Research Subcommittee approved the survey video scripts and powerpoint slides with the minor modifications as described above.

V. Initial Discussion: Survey sample numerator and denominator

At the last Research Subcommittee meeting on RUC policy (conference call December 2015), an observer noted that the survey sample denominator, and therefore the response rate, is currently calculated by how many individuals the emails were sent out to. They questioned whether the survey response rate could be calculated in some other statistically-valid way (for example, if only those that actually opened the email could be counted).

Following up on this discussion, AMA RUC staff met with AMA Senior Economist Carol Kane, PhD, from the AMA Economic and Health Policy Research team in early March. Dr. Kane explained that modifying the survey response rate denominator based on whether an individual opened an email is not a method that would be considered appropriate or that she has ever seen it used for any research studies. She did point out though that there are valid methods for calculating the survey response rate that the RUC does not currently use. Dr. Kane explained how her group calculated the survey response rates for the AMA 2007 Physician Practice Information (PPI) survey.

For the PPI survey, the survey sample denominator was reduced to account for learned information about physician ineligibility for that survey. In the context of the RUC survey, the eligible percentage would be the number of physicians who were found eligible (were familiar with the service and did not have a conflict) divided by the number of eligible physicians *plus* the number that were found to be ineligible. The survey sample denominator would be reduced by this expected eligibility ratio. Dr. Kane confirmed that it would be appropriate to apply this new method to the RUC survey process. In addition, Dr. Kane

stated that it would also be appropriate to report two response rates using this eligibility-adjusted denominator. The numerator of the first would include only those (eligible) respondents who completed the entire survey. The numerator of the second would include all physicians who were found eligible regardless of whether they completed the entire survey, or only part of it.

Several Subcommittee members expressed interest in this idea, while others noted that this idea would only be appropriate if the change would have a large enough impact to make the additional work needed of specialty staff worthwhile. **The Research Subcommittee requested for AMA staff to solicit a few societies test this new proposed idea. The Subcommittee will review this information at its October meeting.**

VI. Review of Existing RUC and CPT Vignette Instructions

The Research Subcommittee reviewed the existing instructions for creating vignettes as provided by the RUC and CPT Editorial. **The Subcommittee did not propose any modifications to the existing instructions and reaffirmed the RUC's existing vignette instructions.**

As part of the discussion, AMA Staff noted that the principle role of the Research Subcommittee is to confirm that there is nothing either leading or inaccurate in the typical patients being proposed by specialty societies.

VII. Esophagectomy Vignette Review (432X5-7, 43107, 43112, 43117)

Society of Thoracic Surgeons
American College of Surgeons
Society of American Gastrointestinal Endoscopic Surgeons

The Research Subcommittee reviewed the vignettes as submitted by the specialty societies. Several Subcommittee members questioned the typicality of neoadgevent chemotherapy for 432X6-7, 43112 and 43117. The societies confirmed that neoadgevent chemotherapy is typical for these services. In addition, a Subcommittee member cited guidelines from the National Comprehensive Cancer Network (NCCN) which further supported that the inclusion of neoadgevent chemotherapy was appropriate. **The Research Subcommittee approved the vignettes as originally proposed by the specialty societies**:

432X5 ***Esophagectomy, total or near total, with laparoscopic mobilization of the abdominal and mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with open cervical pharyngogastrostomy or esophagogastrostomy (ie, laparoscopic transhiatal esophagectomy)***

Approved Vignette: A 72-year-old man presents with a history that includes gastroesophageal reflux, progressive dysphagia and testing that revealed a distal esophageal adenocarcinoma arising within long segment Barrett's esophagus with multifocal high-grade dysplasia. He undergoes esophageal resection and reconstruction.

432X6 ***Esophagectomy, distal two-thirds, with laparoscopic mobilization of the abdominal and lower mediastinal esophagus and proximal gastrectomy, with laparoscopic pyloric drainage procedure if performed, with separate thoracoscopic mobilization of the middle and upper mediastinal esophagus and thoracic esophagogastrostomy (ie, laparoscopic thoracoscopic esophagectomy, Ivor Lewis esophagectomy)***

Approved Vignette: A 65-year-old woman presents with one month history of progressive dysphagia. Testing revealed a distal esophagogastric junction adenocarcinoma. She received neo-adjuvant chemotherapy and radiation therapy. She now undergoes surgical resection.

432X7 ***Esophagectomy, total or near total, with thoracoscopic mobilization of the upper, middle, and lower mediastinal esophagus, with separate laparoscopic proximal gastrectomy,***

with laparoscopic pyloric drainage procedure if performed, with open cervical pharyngogastrostomy or esophagogastrostomy (ie, thoracoscopic, laparoscopic and cervical incision esophagectomy, McKeown esophagectomy, tri-incisional esophagectomy)

Approved Vignette: A 70-year-old man presents with progressive dysphagia. Testing revealed a mid-esophageal adenocarcinoma above the level of the carina. He received neoadjuvant chemotherapy and radiation therapy. He now undergoes surgical resection.

43107 ***Total or near total esophagectomy, without thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (transhiatal)***

Approved Vignette: A 72-year-old man presents with a history that includes gastroesophageal reflux, progressive dysphagia, and testing that revealed a distal esophageal adenocarcinoma arising within long segment Barrett's esophagus with multifocal high-grade dysplasia. He undergoes esophageal resection and reconstruction.

43112 ***Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (ie, McKeown esophagectomy, or tri-incisional esophagectomy)***

Approved Vignette: A 70-year-old man presents with progressive dysphagia. Testing revealed a mid-esophageal adenocarcinoma above the level of the carina. He received neoadjuvant chemotherapy and radiation therapy. He now undergoes surgical resection.

43117 ***Partial esophagectomy, distal twothirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without pyloroplasty (Ivor Lewis)***

Approved Vignette: A 65-year-old woman presents with one month history of progressive dysphagia. Testing revealed a distal esophagogastric junction adenocarcinoma. She received neo-adjuvant chemotherapy and radiation therapy. She now undergoes surgical resection.

VIII. Other Business

Psychiatric Collaborative Care Management Workgroup Reports *(Informational Only)*

Doctor Andreae, the Chair of the Workgroup, provided a general overview of the workgroup's report from its April 11 conference call. Doctor Andreae noted that the specialties plan to survey these services for the October 2015 RUC meeting. The Workgroup requested for the specialties to pull together a detailed plan for surveying and valuing these codes for the October RUC Meeting. The Workgroup will review and provide guidance before these items go to the Research Subcommittee for approval. The next Workgroup call will need to be scheduled for mid-May in preparation for the early June Research Subcommittee meeting. One issue that was a point of contention for the Workgroup was whether the work of the contracted psychiatrist should fall under practice expense. The Workgroup and Research Subcommittee each noted that the RUC does not have to make this determination as part of its future recommendation, instead leaving the decision to CMS. **The Research Subcommittee approved the report, which is available in tab 51 of the agenda materials, as submitted.**

Anesthesia Workgroup Report *(Informational Only)*

Doctor DiSesa, chair of the Anesthesia Workgroup, provided a general overview of the workgroup's report from its April 12 conference call. The Specialty will present 6 new proposed codes to CPT for describing anesthesia for upper and lower GI endoscopy services at the October 2016 CPT meeting and plan to survey these services for the January 2017 RUC meeting. The Workgroup requested for the Specialty to proceed with taking their CPT proposal to CPT for the October 2016 CPT meeting. The Workgroup made it clear that they did not provide specifically approve the coding language or the proposed vignettes. **The Workgroup requested for the specialty to send the vignettes for these services to Research for review and approval prior to surveying these services and the Specialty agreed.**

The Workgroup noted that it did not re-validate the individualized PIPPA work RVU methodology, but agreed that the RUC should value these services according to the present methodology, using the RUC anesthesia survey instrument and process.

The Workgroup recommends an educational presentation be provided to the RUC on the existing survey and valuation process for anesthesia services since it has not been validated or used for a survey since 2007, including a specific example of how the data from a survey are used to value an anesthesia service.

The Workgroup requested that anesthesia codes be included in any RAW screens.

The Research Subcommittee approved the report, which is available in tab 51 of the agenda materials, as submitted.

AMA/Specialty Society RVS Update Committee **Tab 52**
Health Care Professionals Advisory Committee Review Board
Friday, April 29, 2016, 7:00-8:00am (central)

Members in Attendance: Michael Bishop, MD (Chair), Jane White, PhD, RD, ADA (Co-Chair), Dee Adams Nikjeh, PhD, CCC-SLP (Alt. Co-Chair), Margie Andreae, MD, Charles Fitzpatrick, OD, Mary Foto, OTR, Anthony Hamm, DC, Peter Hollmann, MD, Leisha Eiten, AuD, Randy Phelps, PhD, Richard Rausch, PT, Timothy Tillo, DPM, and Doris Tomer, LCSW.

I. Introductions and CMS Update

Doctor Bishop and Dr. White welcomed the HCPAC members and reviewed the agenda. Doctor Edith Hambrick from CMS attended the HCPAC meeting and provided a brief CMS update.

II. HCPAC Member Discussion

RUC Process

As requested at the January 2016 HCPAC meeting, the HCPAC members were provided with materials regarding the RUC process. AMA staff referenced the presentation, which is included in the meeting agenda introduction materials, to provide an overview of the RUC process for valuation of codes and the screens used to identify potentially misvalued codes. The group walked through the discussion checklist and a reference SOR to highlight where the items are found that a reviewer should verify. The group also discussed the presentation guidelines where the instances requiring compelling evidence are detailed. Finally, Dr. White mentioned that we will continue to expect all HCPAC members to review tabs that come through the process and to provide comments on the reviewer comment schedule.

HCPAC MPC List Review

The HCPAC discussed the need to review and update the HCPAC MPC list. Many of the codes on the current list have not been reviewed for a number of years and it was determined that it is beneficial during the survey process to have this list up to date. A request went out to the HCPAC specialties before this meeting to ensure each specialty evaluated their codes from the current list. The group walked through the MPC Summary of Process document noting that although codes from the HCPAC may not be able to meet all of the criteria listed, the group will aim to get codes as close to these recommendations as possible.

The HCPAC further discussed the spreadsheet of codes performed by HCPAC providers and the highlighted recommendations from specialties for changes to the MPC list. The group reviewed that additions, retentions, and deletions have been provided by six specialties. A discussion was held about how we should handle codes going to CPT and it was mentioned that codes under revision should be monitored and that the continuous review of the list would allow for these to be addressed in a timely fashion. Additionally the group noted that this might initially be a larger task to update given a lot of revisions occurring in code sets but that an updated list is critical during the survey process.

The HCPAC discussed how and when the group wishes to update this list moving forward. It was decided that an initial review and vote would be conducted at the October 2016 HCPAC meeting. Additionally, the HCPAC would plan to keep the MPC list review as a standing agenda item to review specialty recommended changes at each meeting but would opt to publish the changes from multiple meetings in a new version once a year in January of each year. Finally, the group discussed that the Chairs and AMA Staff would assign HCPAC member reviewers to review the submitted MPC list change recommendations in preparation for the October HCPAC vote.

III. Other Issues

HCPAC members did not have any other items for discussion at this time and the meeting was adjourned.

AMA/Specialty Society RVS Update Committee **Tab 6**
Facilitation Committee #3
Diagnostic Bone Marrow Aspiration and Biopsy

Facilitation Committee Members: Alan Lazaroff, MD (Chair), Walter Larimore, MD, Geraldine McGinty, MD, Guy Orangio, MD, Joseph Schlecht, DO, Chris Senkowski, MD, Karin Swartz, MD, James Waldorf , MD

The Facilitation Committee had a detailed discussion with the specialty societies about the aspects of these three procedure codes, including the physician work and time involved, as well as the practice expense. The Facilitation Committee questioned why the current global for these procedures is XXX, while a 000-day global would seem more appropriate. The societies concurred with the Committee that a 000-day global would be more appropriate. **The Facilitation Committee recommends for the RUC to recommend to CMS that three codes be converted to the 000-day global period, although the Committee's below RVU and time recommendations are not contingent on this change.**

The Workgroup also noted that the intra-service description of work on the SOR should be modified, noting that all work that happens prior to when the physician makes the initial incision should be relocated to the pre-service description of work.

38220 Diagnostic bone marrow; aspirations(s)
The Committee reviewed the survey results from 121 physicians and agreed with the societies on the following physician time components: a pre-service time of 15 minutes, an intra-service time of 20 minutes and a post-service time of 12 minutes, the same times as originally recommended.

The Facilitation Committee considered recommendations forwarded from the full RUC. Following a discussion with the societies, the Committee agreed that the 25th percentile work RVU of 1.20 is appropriate. The Committee noted that the RUC had passed compelling evidence for this service. The Committee also noted that, since this procedure was originally valued, the physician work has increased as multiple passes and more tests are needed relative to when this code was originally valued, supporting a higher work RVU. Also, the societies confirmed that an E/M services is not typically performed on the same day.

The Committee compared the survey code to XXX and MPC code 95805 *Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness* (work RVU= 1.20, intra-service time of 20 minutes, total time of 50 minutes) and noted that both service involve a similar amount of physician work, have identical intra-service times and very similar total times. The Committee also reviewed 000-day code 91010 *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report;* (work RVU= 1.28, intra-service time of 20 minutes, total time of 50 minutes) and agreed the reference service further supports a work RVU of 1.20 for the survey code.

The Facilitation Committee recommends a work RVU of 1.20, a pre-service time of 15 minutes, an intra-service time of 20 minutes and a post-service time of 12 minutes.

38221 Diagnostic bone marrow; biopsy(ies)

The Committee reviewed the survey results from 120 physicians and agreed with the societies on the following physician time components: 15 minutes of pre-service time, 20 minutes of intra-service time and 15 minutes of post-service time, the same times as originally recommended.

The Facilitation Committee considered recommendations forwarded from the full RUC. The Committee expressed discomfort with the original recommended RVU of 1.37. To find an appropriate work RVU, the Committee reviewed XXX code 99315 *Nursing facility discharge day management; 30 minutes or less* (work RVU=1.28, intra-service time of 20 minutes, total time of 40 minutes) and noted that reference code involves similar physician work and has identical intra-service time relative to the survey code; therefore this service would be an appropriate crosswalk. To confirm a work RVU crosswalk of 1.28, the RUC reviewed 000-day global code 91010 *Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report;* (work RVU= 1.28, intra-time of 20 minutes, total time of 50 minutes) and noted that both services involve very similar work and have identical intra-service and total times.

The societies noted and the Committee agreed that this code involves more intense physician work relative to the 38220 and has slightly more total time. 38221 also involves a larger needle and more local anesthesia.

The Facilitation Committee recommends a work RVU of 1.28 (direct work RVU crosswalk to 99315), a pre-service time of 15 minutes, an intra-service time of 20 minutes and a post-service time of 15 minutes.

382X3 Diagnostic bone marrow; biopsy(ies) and aspiration(s)

The Committee reviewed the survey results from 120 physicians and agreed with the societies on the following physician time components: 15 minutes of pre-service time, 30 minutes of intra-service time and 15 minutes of post-service time, the same times as originally recommended.

The Facilitation Committee considered recommendations forwarded from the full RUC. The Committee expressed discomfort with the original recommended RVU of 1.50. To find an appropriate work RVU, the Committee reviewed 000-day code 91022 *Duodenal motility (manometric) study* (work RVU= 1.44, intra-service time of 30 minutes, total time of 61 minutes) and noted that both services involve a similar amount of physician work and have identical intra-service times; therefore this service would be an appropriate crosswalk for the survey code. To confirm a work RVU crosswalk of 1.44, the Committee reviewed XXX code 90832 *Psychotherapy, 30 minutes with patient and/or family member* (work RVU= 1.50, intra-service time 30 minutes and total time of 45 minutes) and agreed that the work RVU of 1.44 is supported.

The Facilitation Committee recommends a work RVU of 1.44 (direct work RVU crosswalk to 91022), a pre-service time of 15 minutes, an intra-service time of 30 minutes and a post-service time of 15 minutes.

Practice Expense

The Committee discussed the practice expense for these three services and agreed with the PE inputs as approved by the Practice Expense subcommittee

AMA/Specialty Society RVS Update Committee **Tab 09**
Pulmonary Diagnostic Tests (946X2, 94621, & 946X3)
Facilitation Committee #1

Members: Margaret Neal, MD (Chair), Scott Collins, MD, Thomas Cooper, MD, James Gajewski, MD, Michael Gerardi, MD, David Hitzeman, DO, Robert Kossmann, MD and George Williams, MD.

946X2 Exercise test for bronchospasm, including pre- and post-spirometry and pulse oximetry

94621 Cardiopulmonary exercise testing,including measurements of minute ventilation, CO2 production, O2 uptake, and electrocardiographic recordings (Do not report 94621 in conjunction with 94250, 94680, 94681 and 94690)(Do not report 946X2, 946X3, 94621 in conjunction with 94760, 94761)

946X3 Pulmonary stress testing (eg, 6-minute walk test), including measurement of heart rate, oximetry and oxygen titration, when performed (94620 has been deleted. To report pulmonary stress testing, use 946X3)

The Facilitation Committee discussed the survey results for CPT codes 946X2, 94621and 946X3 and determined that the survey respondents indicated immediate post-operative physician time was not representative of the time required to perform this service. The Committee noted that the description of immediate post-operative physician work described the same intensity for each of the three services but was not represented the same across all three services by the survey respondents.

The standard survey instrument did indicate that the survey respondents should capture the interpretation and report work in the intra-service time period as is typical for XXX global services, but the specialty society contends that the survey respondents did not appear to capture the physician time correctly. **The Facilitation Committee recommends resurveying 946X2, 94621and 946X3 with the same exact survey instrument (the current standard RUC survey for imaging and tests).**

AMA/Specialty Society RVS Update Committee **Tab 23**
Selective Catheter Placement
Facilitation Committee #2

Members Present: Doctors Gregory Przybylski, (Chair); Margie Andreae; Dale Blasier; Ronald Burd; Gregory DeMeo; Verdi DiSesa; Marc Raphaelson; George Williams; and Jane White, PhD, RD, FADA

36215 Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family

The Facilitation Committee discussed with the specialty societies about the RUC's concerns with the initial presented work RVU of 4.67, the current work value. The committee members again noted that the current value of 4.67 was too high compared to the median intra-service time of 30 minutes and did not achieve an appropriate incremental difference between the work of placing the catheter in the first order branch and placing a catheter in the second order branch.

The Facilitation committee reviewed CPT code 32550 *Insertion of indwelling tunneled pleural catheter with* cuff (work RVU= 4.17, intra time= 30 minutes) and agreed that since this reference code has identical intra-service time compared to 36215 and is an analogous procedure performed by the same specialty, the work RVUs should be identical. The Facilitation Committee also reviewed CPT code 43233 *Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)* (work RVU= 4.17, intra-time= 28 minutes) and MPC code 52224 *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy* (work RVU= 4.05, intra-time= 30 minutes) and agreed that both codes validate the recommended work RVU of 4.17. **The Facilitation committee recommends a work RVU of 4.17, a direct crosswalk to CPT code 32550, for CPT code 36215.**

36216 Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family

The Facilitation committee reviewed CPT code 36216 and noted that the RUC had not discussed this code previously. The Committee agreed with the specialty societies' recommendation of 5.27 work RVUs, the current work value. The committee noted that this recommendation is an increment of 1.10 work RVUs and 15 minutes over base code 36215. The committee also noted that this recommendation is identical to the top key reference service 36246 *Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU= 5.27, intra time=45 minutes). **The Facilitation committee recommends a work RVU of 5.27 for CPT code 36216.**

36217 Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family

The Facilitation committee reviewed CPT code 36217 and noted that the specialty societies' recommended work RVU of 6.29, the current work value, is appropriate. It maintains an appropriate work value increment of 1.02 between 36216 and 36217. However, the committee discussed an inconsistency with the intra-service time compared to the other codes in the family. CPT code 36217 includes the work of both 36215 (intra time= 30 minutes) and 36216 (intra time= 45 minutes). Therefore, the median intra-service time of 50 minutes, only 5 minutes above 36216, is not clinically appropriate. The committee agreed to accept the 75th intra-service time of 60 minutes in order to accurately account for the physician work of placing a catheter in the third order branch. This more accurate intra-service time, preserves the

incremental, linear consistency between the work RVU and intra-service time within the family. The committee compared the surveyed code to the top key reference service 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 agreed that both codes should be valued identically. **The Facilitation Committee recommends a work RVU of 6.29 for CPT code 36217.**

36218 Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)

The Facilitation committee reviewed CPT code 36218 and agreed with the specialty societies' recommendation of 1.01 work RVUs, the current work RVU, with intra-service time of 15 minutes. The committee agreed that the increment of 1.01 for an additional branch with intra-service time of 15 minutes appropriately fits with the incremental hierarchy established with the base codes in this family. **The Facilitation Committee recommends a work RVU of 1.01 for CPT code 36218.**

Practice Expense:
The Facilitation committee discussed the minor modifications as made by the Practice Expense subcommittee and had no further additions/subtractions.

AMA/Specialty Society RVS Update Committee **Tab 26**
Transurethreal Electrosurgical Resection of Prostate (52601)
Facilitation Committee #3

Members: Doctors Alan Lazaroff (Chair), Michael Bishop, Eugene Sherman, Jane Dillon, Walter Larimore, Paul Martin, Christopher Senkowski and James Waldorf.

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)

The Facilitation Committee reviewed CPT code 52601 and determined that the survey 25th percentile work RVU was too high. The Committee recommends crosswalking to CPT code 29828 *Arthroscopy, shoulder, surgical; biceps tenodesis* (work RVU = 13.16 and same intra service time of 75 minutes and 252 total time). **The Committee recommends a work RVU of 13.16 for CPT code 52601.**

Eval	Positioning	SDW	Intra	Immed Post	99238	99213	Work RVU
33	8	10	75	45	0.5	2	13.16

Practice Expense:
The Facilitation Committee noted that 3 minutes for telephone call on line 49 should be deleted as it is duplicative of that associated with an Evaluation and Management service.

AMA/Specialty Society RVS Update Committee **Tab 28**
Injection Anesthetic Agent (64418)
Facilitation Committee #1

Members: Margaret Neal, MD (Chair), Scott Collins, MD, Thomas Cooper, MD, James Gajewski, MD, Michael Gerardi, MD, David Hitzeman, DO, Robert Kossmann, MD, Jonathan Myles, MD, Dee Adams Nikjeh, PhD, CCP-SLP and George Williams, MD.

64418 Injection, anesthetic agent; suprascapular nerve
The Facilitation Committee reviewed the survey results for CPT code 64418 and determined that the pre-time needed to be decreased further than what the specialty society recommended because this service is typically reported with an Evaluation and Management service. Therefore, the Committee recommends 6 minutes of evaluation time, 3 minutes positioning time, 3 minutes scrub dress and wait time 10 minutes intra-service time and 10 minutes immediate post-service time. The Committee confirmed that 10 minutes of immediate post-service time is required to assess for complication, confirm that anesthesia is achieved and confirm that the arm is able to be moved/manipulated prior to the patient receiving physical therapy. The Committee noted that the majority of nerve block codes that were recently reviewed include 10 minutes of immediate post-service time.

The Committee determined that the survey median and 25th percentile work RVUs did not adequately account for the work required to perform this service. Therefore, the Committee recommends crosswalking code 64418 to code 20611 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting* (work RVU = 1.10 and 5 minutes evaluation, 2 minutes positioning, 5 minutes SDW, 10 minutes intra-service and 5 minutes immediate post time). **The Committee recommends a work RVU of 1.10 for CPT code 64418.**

64418 Recommendation

Eval	Positioning	SDW	Intra Service	Immediate Post	Work RVU
6	**3**	**3**	**10**	**10**	**1.10**