|  |  |
| --- | --- |
| 11-0258 AMA electronic-chgo_lh | Coding Change Application  Category II CPT Code(s) – Performance Measurement  American Medical Association, Current Procedural Terminology (CPT®) |

**Application Submission Requirements**

All CPT Code Change applications are reviewed and evaluated by AMA staff, the CPT/HCPAC Advisory Committee, and the CPT Editorial Panel. Strict conformance with the following is required for review of a code change application:

* Submission of a complete application, including all necessary supporting documents;
* Adherence to all posted deadlines;
* Cooperation with requests from AMA staff and/or Editorial Panel members for clarification and information; and
* Compliance with [CPT Statement on Lobbying](https://www.ama-assn.org/practice-management/statement-lobbying). (press “Ctrl” key and click link)

**Application Review Links** (Press “Ctrl” key and click link)

* [Applicant’s Name](#applicant)
* [Question 1](#question1)
* [Descriptor](#descriptor)
* [Typical Patient Description](#typicalpatient)

**Category II Specific Requirements**

**Criteria for Submitting CPT Category II Code Proposals**

* Definition or purpose of the measure is consistent with its intended use (quality improvement and accountability, or solely quality improvement)
* Aspect of care measured is substantially influenced by physician work (or work of other practitioner or entity for which the code may be relevant)
* Reduces data collection burden on physicians (or other health practitioner or entity), reflects the work they perform, and is useful in physicians’ practice
* Significant
  + Affects a large segment of health care community
  + Tied to health outcomes
  + Addresses clinical conditions of high prevalence, high costs, high risks
* Evidence-based
  + Agreed upon
  + Definable
  + Measurable
* Risk adjustment specifications and instructions for all outcome measures submitted or compelling evidence as to why risk adjustment is not relevant
* Sufficiently detailed to make it useful for multiple purposes
* Facilitates reporting of performance measure(s)
* Inclusion of select patient history, testing (eg, glycohemoglobin), other process measures, cognitive or procedure services within CPT, or physiologic measures (eg, blood pressure) to support performance measurements
* Performance measure development process includes
  + Nationally recognized expert panel
  + Multidisciplinary
  + Vetting process

## Definitions

**Evidence-based practice** is the integration of best research evidence with clinical expertise and patient values.

**Best research evidence** refers to clinically relevant research, often from the basic health and medical sciences, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination); the power of prognostic markers; and the efficacy and safety of therapeutic rehabilitative and preventive regimens.

**Clinical expertise** means the ability to use clinical skills and past experience to rapidly identify each patient’s unique health state and diagnosis, individual risks and benefits of potential interventions, and personal values and expectations.

**Patient values** refers to the unique preferences, concerns and expectations that each patient brings to a clinical encounter and that must be integrated into clinical decisions if they are to serve the patient.

American Medical Association  
Department of CPT Editorial Research and Development  
330 N. Wabash Ave., Suite 39300  
Chicago, Illinois 60611-5885  
or email [ccappsubmit@Z.ama-assn.org](mailto:ccappsubmit@Z.ama-assn.org)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 11-0258 AMA electronic-chgo_lh | |  | | | | | |
| *Cover Sheet for CPT® Coding Change Application* | | | | | | | |
| It is recommended that Applicants consult with national medical specialties and other qualified healthcare professional organizations that will typically provide the proposed procedure(s)/service(s) requested in this application to obtain comments on the type of work. With recognition of scheduling needs of the specialty societies, when assistance from a specialty society will be sought, it is highly recommended that the Applicant plan for enough time for scheduling such discussions in advance of the application deadline to avoid violation of the AMA Statement on Lobbying. Interested national specialty organizations may have deadlines prior to the CPT application submission deadline to allow for application review and comment. | | | | | | | |
| **Date:** |  | | | | | |  |
| **Change Requested by:** | | | | | | | |
| **Name(s):** |  | | | | | |  |
| **Organization:** |  | | | | | |
| **Address:** |  | | | | | |
| **City:** |  | | **State:** |  | **Zip Code:** |  |
| **Telephone:** |  | | | | | |
| **Email:** |  | | | | | |
|  | | | | | | |

***Please include this cover sheet with your application.***

[Top ↑](#top)

|  |
| --- |
| Notice of Potential Review by Interested Parties  An “Interested Party” is an individual or entity that may have a legitimate interest or may potentially be impacted by the CPT Editorial Panel’s decision related to this application, as determined by the AMA. If recognized by the AMA, an Interested Party may request review of your application in advance of the CPT Editorial Panel meeting. You will be notified of the identity of any Interested Party recognized by the AMA with respect to this application. The application fields indicated below (including supporting documentation) will be provided to an Interested Party. Fields not identified below will not be shared with Interested Parties.   * Applicant (both the individual’s and organization’s identity) * All information in sections 3 and 4 (FDA, HDE, rationale, code descriptor additions/deletions/revisions) * Current Code Justification * Site of Service * Diagnosis/Condition for treatment * Prevalence of Disease * Specialties and Sub-Specialties that perform the Service * Clinical Vignette/Description of patient * Description of Procedure * Submitted Literature and other supporting documentation   **I, the Applicant, acknowledge and agree.** |

|  |
| --- |
| CPT Confidentiality Agreement In consideration of the permission granted to me to participate in the CPT code development process, including submission of this code change application and participation on or attendance at meetings of the CPT Editorial Panel (“Panel”), the CPT Advisory Committee, the Health Care Professionals Advisory Committee, the CPT Assistant Editorial Board, and ad hoc and/or standing workgroups and committees established by the Panel (each a “Meeting” and collectively “Meetings”), I, the Applicant, agree to the following:   1. I will maintain as confidential any and all materials and information that I obtain in connection with my participation in the CPT code development process, attendance at or participation in any Meeting, including but not limited to the following information, which shall collectively be considered “Confidential Information” and proprietary to the AMA:    * Meeting materials that are made available by the AMA, including agendas and code change applications;    * CPT codes and modifiers, text descriptors, cross references, and guideline language that have not yet been published by the AMA in any form, including in print or online, as well as content scheduled for publication in the CPT Assistant or other AMA coding publications or products (“Publication”); and    * any information disclosed or discussed at a Meeting, and the identity and affiliation of the individual who provided the information.   The foregoing information shall be considered Confidential Information regardless of the format or forum by which it is provided to or obtained by the undersigned including but not limited to oral, electronic or print media.   1. I will use Confidential Information only in connection with my participation in the code development process and the Meeting. I will not disclose, distribute or publish Confidential Information to any individual or entity in any manner whatsoever, and I will not publish or authorize anyone else to publish Confidential Information in any Web posting, social media, article, newsletter, press release, publication, or other communication; provided, however, when participating in the code development process and Meeting as an authorized representative of or on behalf of a company, society or other legal entity, I, as an individual, understand that I am permitted to disseminate Confidential Information to appropriate individuals in that organization, for internal use within such organization solely in connection with such organization’s coding activities. Further, I understand that I am permitted to disclose non-Confidential Information. 2. I will not use audio or video recording or photographic device in any manner during a Meeting to record or to copy Confidential Information. I will not remove any notices of copyright, trademark, confidentiality or other conditions on materials obtained by me or take any other action to circumvent the purpose and intent of this Confidentiality Agreement. 3. I acknowledge that the Panel can modify or eliminate a CPT code or the language or guidelines associated with a code at any time up to the date of final Publication of the CPT code set. Panel actions are not final until distribution of the CPT code set (on or before August 31 of each year). I acknowledge that the early release of Panel actions and any related information can cause significant disruption and confusion for physicians, patients, payers and third parties and could cause irreparable injury to the AMA and others. I understand however, that I am permitted to disclose and publish the limited information contained in the Summary of Panel Action document that is posted to the [AMA public website](https://www.ama-assn.org/about/cpt-editorial-panel/summary-panel-actions) within 30 days of each Panel meeting. I understand that, prior to AMA Publication, any information that I publish beyond that contained in the Summary of Panel Action document will be considered a violation of this Confidentiality Agreement. 4. I understand that Confidential Information does not include information that (a) is already in my possession not as a result of any breach of confidentiality by myself or any third-party, (b) is publicly available other than through breach of these or other confidentiality obligations, (c) is received by me from a third-party if such third-party was authorized to release the information and is not in breach of any confidentiality obligations, or (d) is subject to Publication or other disclosure by the AMA. 5. Violators of this Agreement may be barred from future Meetings or otherwise sanctioned. 6. This Confidentiality Agreement is not exclusive, and other confidentiality or non-use requirements, such as those imposed by the RVS Update Committee, and other actions and remedies, including third-party remedies and the AMA’s right to seek injunctive relief, may apply to the information that I have access to as the result of my participation in the code development process and Meeting. 7. I, the Applicant, agree that the terms of this Confidentiality Agreement are binding on me, individually, and on the company, society or other legal entity on behalf of which I am an authorized representative. I understand that the AMA is materially relying on this representation and certification.   **I, the Applicant, acknowledge and agree.** |

|  |
| --- |
| This form plays a vital role in maintaining and increasing the efficiency of the CPT process. It can be used to submit a coding change application for Category II CPT codes. [For Category I, III, or Pathology and Molecular Pathology codes, please utilize the appropriate application form](https://www.ama-assn.org/practice-management/application-forms). As you fill out the form, please consider which category of code change you are requesting. For more information and code criteria for the code categories, please see the [Code Change Application Instructions](http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/applying-cpt-codes/request-form-instructions.page). For other forms, see the [AMA CPT website](http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/applying-cpt-codes.page).  (Press “Ctrl” key and click link)  When requesting a new code, the entire form should be completed. When submitting a request for multiple new codes, a response should be provided for each new code. The Applicant may need to create additional lines and pages as needed. Refer to the [Code Change Application Instructions](http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/applying-cpt-codes/request-form-instructions.page) if necessary. Once the application is completed, submit the form electronically to the AMA. (See information on submitting applications on the last page for [instructions on uploading](#submit) applications, literature supplements and other documents.)  **You may withdraw your application up until the time that the CPT Editorial Panel takes up the agenda item at a CPT Editorial Panel meeting. At that time, the application falls under the authority of the Editorial Panel and may not be withdrawn. If the CPT Editorial Panel determines that additional information or evaluation is warranted, consideration of your application may be tabled until later during that meeting or postponed until time certain (a specific future CPT meeting) or to time uncertain.** |

[return](#descriptor)

|  |
| --- |
| **Specific Criteria Regarding the Measure**  **The following information is intended to help identify the important factors regarding the development process for measure for which the code(s) is(are) being developed.**  Note: For specific information regarding developing the code descriptor, code location within the Category II code section, and the Alphabetical Clinical Topics Listing for the measure “snapshot” and code listing(s) (including the title of the Clinical Topic [or listing of the measure-code within an existing clinical topic], and the listing of the specific measure title), see the [**Specific Information for Development of the Category II code**](#SpecifcCritReCodeDevel)section.  In developing new and revised performance measurement codes, requests for Category II codes are considered from:   * Measurements that were developed and tested by a national organization; * Evidenced-based measurements with established ties to health outcomes; * Measurements that address clinical conditions of high prevalence, high risk or high cost; * Well established measurements that are currently being used by large segments of the health care industry across the country;   In addition, the following criteria apply:   * Definition or purpose of the measure is consistent with its intended use (quality improvement and accountability, or solely quality improvement) * Aspect of care measured is substantially influenced by physician work (or work of other practitioner or entity for which the code may be relevant) * Reduces data collection burden on physicians (or other health practitioner or entity), reflects the work they perform, and is useful in physicians’ practice * Significant   + Affects a large segment of health care community   + Tied to health outcomes   + Addresses clinical conditions of high prevalence, high costs, high risks * Evidence-based   + Agreed upon   + Definable   + Measurable * Risk adjustment specifications and instructions for all outcome measures submitted or compelling evidence as to why risk adjustment is not relevant * Sufficiently detailed to make it useful for multiple purposes * Facilitates reporting of performance measure(s) * Inclusion of select patient history, testing (e.g., glycohemoglobin), other process measures, cognitive or procedure services within CPT, or physiologic measures (eg, blood pressure) to support performance measurements * Performance measure development process includes   + Nationally recognized expert panel   + Multidisciplinary   + Vetting process   **Note:** These codes are not referred to the RUC for valuation because no RVUs are assigned to them. Since some of the Category II codes are services embedded within E/M codes, the aggregate service is already valued.  **The measure from which the changes (ie, codes, Alphabetical Clinical Topics Listing, and Category II Codes Section) are being made SHOULD BE PROVIDED AS PART OF THE APPLICATION. The application is considered incomplete without submission of the measures from which the changes are to be derived.**  **Development of the Alphabetical Clinical Topics Listing (found on the AMA website at** [**https://www.ama-assn.org/sites/default/files/media-browser/public/cpt/cpt-cat2-codes-alpha-listing-clinical-topics\_0.pdf**](https://www.ama-assn.org/sites/default/files/media-browser/public/cpt/cpt-cat2-codes-alpha-listing-clinical-topics_0.pdf)**)**  This is an alphabetical listing of clinical conditions and topics with which the measures and codes are associated. It provides an overview of the performance measures, a listing of CPT Category II codes that may be used with each measure, as well as any applicable reporting instructions.  To view the entire Alphabetical Clinical Topics Listing (Alphabetical Listing), see the AMA website. [(CPT Category II Codes Alphabetical Clinical Topics Listing (PDF)](https://www.ama-assn.org/sites/default/files/media-browser/public/cpt/cpt-cat2-codes-alpha-listing-clinical-topics_0.pdf)  The following questions are intended to assist in identifying the components that will be used to develop the listing that will be included in the Alphabetical Clinical Topics Listing. |

| 1. ***The definition or purpose of the measure is consistent with its intended use.*** | | |
| --- | --- | --- |
| ***A-1****.* **Identify the type of measure that is being used to develop each code(s). Choose from the following (select one category to define the purpose of your measure – *[*e*g, PCPI Measure Designation: Type of measure.]*). If this application requests codes for multiple measure types, complete a separate application for each measure type:**  **Composite Codes**  Composite codes combine several measures grouped within a single code descriptor to facilitate reporting for a clinical condition when all components are met. If only some of the components are met or if services are provided in addition to those included in the composite code, they may be reported individually using the corresponding CPT Category II codes for those services.  **Patient Management**  Patient management codes describe utilization measures or measures of patient care provided for specific clinical purposes (eg, prenatal care, pre- and post-surgical care).  **Patient History**  Patient history codes describe measures for select aspects of patient history or review of systems.  **Physical Examination**  Physical examination codes describe aspects of physical examination or clinical assessment.  **Diagnostic/Screening Processes or Results**  Diagnostic/screening processes or results codes describe results of tests ordered (clinical laboratory tests, radiological or other procedural examinations, and conclusions of medical decision-making).  **Therapeutic, Preventive, or Other Interventions**  Therapeutic, preventive, or other interventions codes describe pharmacologic, procedural, or behavioral therapies, including preventive services such as patient education and counseling.  **Follow-up or Other Outcomes**  Follow-up or other outcomes codes describe review and communication of test results to patients, patient satisfaction or experience with care, patient functional status, and patient morbidity and mortality.  **Patient Safety**  Patient safety codes that describe patient safety practices.  **Structural Measures**  Structural measures codes are used to identify measures that address the setting or system of the delivered care. These codes also address aspects of the capabilities of the organization or health care professional providing the care. | | |
| ***A-2. Provide the measure: List information for the measure here.***   * + - * 1. Enter Clinical condition here (Clinical Topic – Use the topic listing identified in A-8)   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * + - * 1. Enter the measure title here   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * + - * 1. Enter a brief description of the measure   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * + - * 1. Enter numerator statement from measure   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * + - * 1. Enter denominator statement from measure   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * + - * 1. Enter any relevant exclusions for this measure (medical, patient, or system)   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * + - * 1. Enter any reporting instructions needed for providing the service   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **The following includes an example language from an Alphabetical Clinical Topics Listing:** | | |
| ***Atrial Fibrillation and Atrial Flutter (AFIB)*** | | |
| ***Chronic Anticoagulation Therapy1***  *Whether or not the patient aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation or atrial flutter at high risk for thromboembolism was prescribed warfarin during the 12 month reporting period*  ***Numerator:*** *Patients who were prescribed warfarin during the 12 month reporting period*  ***Denominator:*** *All patients aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation or atrial flutter at high risk for thromboembolism*  ***Definitions of Risk***  *Patients are identified by ACC/AHA/ESC 2006 guidelines at low risk for thromboembolism if there are none of the following factors: prior stroke or TIA, age ≥ 75 years, hypertension, diabetes mellitus, and heart failure or impaired left ventricular systolic function.*  *Patients are identified by ACC/AHA/ESC 2006 guidelines at intermediate risk for thromboembolism if there is one of the following factors: age ≥ 75 years, hypertension, diabetes mellitus, and heart failure or impaired left ventricular systolic function.*  *Patients are identified by ACC/AHA/ESC 2006 guidelines at high risk for thromboembolism if there is a prior stroke or TIA* ***OR*** *two or more of the following factors: age ≥ 75 years, hypertension, diabetes mellitus, and heart failure or impaired left ventricular systolic function.*  ***Exclusion(s):*** *Documentation of medical reasons (eg, patients with transient or reversible causes of atrial fibrillation [eg, pneumonia or hyperthyroidism], postoperative patients, patients who are pregnant, allergy to warfarin, risk of bleeding)* ***OR*** *patient reason(s) (eg, economic, social, and/or religious impediments, noncompliance or other reason for refusal to take warfarin) for not prescribing warfarin*  ***Percentage*** *of patients aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation or atrial flutter at high risk for thromboembolism who were prescribed warfarin during the 12 month reporting period*  ***Reporting Instructions:*** *Report 3550F or 3551F or 3552F for each patient aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation or atrial flutter. If the patient is classified as high risk for thromboembolism and warfarin therapy is prescribed, also report 4012F.*  *For the patient with appropriate exclusion criteria, report 4012F with modifier 1P or 2P.* | *4012F*  ***Denominator***  ***Codes***  *3550F*  *3551F*  *3552F* | *Warfarin therapy prescribed*  *Low risk for thromboembolism*  *Intermediate risk for thromboembolism*  *High risk for thromboembolism* |
| ***A-3****.* ***Rationale for development of a code from the measure:*** *Provide a rationale to describe how this measure will improve quality, accountability, better patient outcomes, etc.* | | |
| ***A-4. If the measure contains data elements useful for multiple purposes, describe the data elements.*** | | |

|  |
| --- |
| **Instructions for development of code descriptor and selection of code placement within the Category II Code Section** |
| ***A-5. Using the language that identifies the measure description, specify the new code(s) descriptor(s):***  **Instruction for Requesting a new Category II Code (addition of a code):**  Category II codes are listed within a particular subsection that most accurately represent the tracking of the clinician interaction with the patient (eg, **Patient History**, **Patient Management**, and **Physical Examination**).  Use the information provided in response to A-1 to identify the section that the code will be listed within. Include the code and descriptor using language that identifies the measure description.  **Example**:  **Category II**  **Physical Examination**  *2010F* *Vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed (CAP)1 (EM)5*  ●200XF New code languageNew footnote# (New Acronym)  ***Category II***  **[Enter Existing Sub-Section Title here]**  **[Enter existing code(s) for placement]**  **●[Enter new code number and descriptor listing]** |
| **A-6 *Using the language that identifies the measure description, specify the deleted code(s) descriptor(s):***  **Instruction for Requesting a Category II Code deletion:**  *Display the code selected for deletion and specify the recommended cross-reference (ie, how is the deleted service now to be coded?) Include the conventional technique of strike-outs for deletions. An example is listed for additional guidance.*  **Example**:  **Category II**  **Physical Examination**  *2002F Clinical signs of volume overload (excess) assessed1 (HF)*  ~~2003F Auscultation of the heart performed~~~~1~~  (Code 2003F has been deleted. For performance measurement coding information regarding Heart Failure, see the Heart Failure Clinical Topic listing in ~~Appendix H~~the Alphabetical Clinical Topics Listing)  ***Category II***  **[Enter Existing Sub-Section Title here (Response to question A-1)]**  **[Enter existing code(s) to show placement]**  **▲[Enter existing code listing with ~~strike-through~~ over the code and descriptor language to show the deletion]** |
| ***A-7. Using the language that identifies the measure description, specify the revised, code(s) descriptor(s):***  ***For each code requested, describe any specific code(s) that with modification might serve as a tracking code.***  **Instruction for Requesting a Revised Category II Code:**  ***Specify the recommended terminology (code descriptor) for the proposed revised code. Use the conventional techniques of strike-outs for deletions and underlining for additions/revisions. Also, indicate the revision(s) in context with the current code descriptor (list the complete family of codes related to your request).***  **EXAMPLE:**  **Therapeutic, Preventive or Other Interventions**  *4006F Beta-blocker therapy, prescribed1 (HF, CAD)*  ▲4009F Angiotensin converting enzyme (ACE) inhibitor or Angiotensin Receptor Blocker (ARB) therapy, recommended prescribed1 (HF, CAD)  ***Category II***  **[Enter Existing Sub-Section Title here]**  **[Enter existing code(s) for placement]**  **▲[Enter existing code number and descriptor listing with revisions here (use ~~strike-through~~ for desired deleted text and underline desired additional text]** |
| ***A-8. Provide the Clinical Topic/condition/disease that this service is intended to address. This will be used to identify the Alphabetical Clinical Topics Listing that will be included for measure (this should be completed for each measure unless the measure may be included within a single topic).***  **Choose a topic in which the measure listing and code will be placed within the Alphabetical Listing.**   |  |  | | --- | --- | | **Acute Bronchitis (A-BRONCH)**  **Acute Otitis Externa/Otitis Media with Effusion (AOE/OME)**  **Amyotrophic Lateral Sclerosis (ALS)**  **Anesthesiology/Critical Care (CRIT)**  **Annual monitoring (AM)**  **Asthma**  **Atrial Fibrillation and Atrial Flutter (AFIB)**  **Back Pain (BkP)**  **Care for Older Adults (COA)**  **Chronic Kidney Disease (CKD)**  **Chronic Obstructive Pulmonary Disease (COPD)**  **Chronic Stable Coronary Artery Disease (CAD)**  **Chronic Wound Care (CWC)**  **Community-Acquired Bacterial Pneumonia (CAP)**  **Coronary Artery Bypass Graft (CAGB)**  **Dementia (DEM)**  **Diabetes (DM)**  **Distal Symmetric Polyneuropathy (DSP)**  **Emergency Medicine (EM)**  **End Stage Renal Disease (ESRD)**  **Endoscopy and Polyp Surveillance (End/Polyp)**  **Epilepsy (EPI)** | **Eye Care (EC)**  **Gastroesophageal Reflux Disease (GERD)**  **Geriatrics (GER)**  **Heart Failure (HF)**  **Hematology (HEM)**  **Hepatitis C (HEP C)**  **HIV/AIDS (HIV)**  **Hypertension**  **Inflammatory Bowel Disease (IBD)**  **Lung Cancer/Esophageal Cancer (Lung/Esop Cx)**  **Major Depressive Disorder (MDD)**  **Major Depressive Disorder-Child and Adolescent (MDD ADOL)**  **Melanoma (ML)**  **Nuclear Medicine (NUC\_MED)**  **Oncology (ONC)**  **Osteoarthritis (Adult) (OA)**  **Osteoporosis (OP)**  **Palliative/Endof Life Care (Pall Cr)**  **Parkinson’s Disease (Prkns)**  **Pathology (PATH)**  **Pediatric Acute Gastroenteritis (PAG)**  **Pediatric End Stage Renal Disease (P-ESRD)**  **Pediatric Pharyngitis (PHAR)** | |
| |  |  | | --- | --- | | **Perioperative Care 2 (PERI 2)**  **Prenatal Care (Pre-Cr)**  **Prenatal-Postpartum Care (Prenatal)**  **Preventive Care & Screening (PV)**  **Prostate Cancer (PRCA)**  **Radiology (RAD)**  **Rheumatoid Arthritis (RA)**  **Screening Colonoscopy Adenoma Detection Rate (SCADR)**  **Stroke and Stroke Rehabilitation (STR)**  **Substance Use Disorders (SUD)**  **Upper Respiratory Infection in Children (URI)** | **Non-Measure Claims Based Reporting:**   * + - * **Abdominal Aortic Aneurysm Repair**       * **Carotid Intervention** |   ***A-9.* List the clinical topic/disease/condition and the code that should be included within it.**  **If a new topic should be designated, include the name of the new topic and the acronym that will be used here.**  **Existing Topic name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Codes to be included:**  **New Topic name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Codes to be included:** |

| 1. ***The performance measure development process includes a nationally recognized expert panel with multidisciplinary representation and appropriate vetting.*** |
| --- |
| ***B-1. Identify below the nationally recognized expert panel that developed the measure.***  Footnotes  *1Physician Consortium for Performance Improvement, www.physicianconsortium.org*  *2National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®),* [*www.ncqa.org*](http://www.ncqa.org)  *3The Joint Commission (TJC), ORYX Initiative Performance Measures,* [*www.jointcommission.org/performancemeasurement.aspx*](http://www.jointcommission.org/performancemeasurement.aspx)  *4National Diabetes Quality Improvement Alliance (NDQIA),* [*www.nationaldiabetesalliance.org*](http://www.nationaldiabetesalliance.org)  *5Joint measure from The Physician Consortium for Performance Improvement,* [*www.physicianconsortium.org*](http://www.physicianconsortium.org) *and National Committee on Quality Assurance (NCQA),* [*www.ncqa.org*](http://www.ncqa.org)  *6The Society of Thoracic Surgeons,* [*http://www.sts.org*](http://www.sts.org) *, National Quality Forum,* [*http://www.qualityforum.org*](http://www.qualityforum.org)  *7Ingenix,* [*www.ingenix.com*](http://www.ingenix.com)  *8American Academy of Neurology,* [*www.aan.com/go/practice/quality/measurements*](http://www.aan.com/go/practice/quality/measurements) *Or* [*quality@aan.com*](mailto:quality@aan.com)  *9College of American Pathologists (CAP),* [*www.cap.org/apps/docs/advocacy/pathology\_performance\_measurement.pdf*](http://www.cap.org/apps/docs/advocacy/pathology_performance_measurement.pdf)  *10American Gastroenterological Association (AGA),* [*www.gastro.org\quality*](http://www.gastro.org\quality)  *11American Society of Anesthesiologists,* [*www.asahq.org*](http://www.asahq.org)  *12American College of Gastroenterology (ACG),* [*www.gi.org*](http://www.gi.org)*; American Gastroenterological Association (AGA),* [*www.gastro.org*](http://www.gastro.org)*; and American Society for Gastrointestinal Endoscopy (ASGE),* [*www.asge.org*](http://www.asge.org) |
| ***If not represented above, provide name and any relevant information regarding the source of their authority for measure development (i.e., web site location where the measure may be found)***  **13[Enter new society or name of measure developer here]** |
| ***B-2. Describe the multidisciplinary review process used to achieve consensus on the measure among all constituents of the respective organizations, including internal and public comment processes.*** |

| ***C. The performance measure for which a tracking code is sought is not currently coded using existing code sets designated under HIPAA (eg, CPT Category I, ICD-9-CM, or HCPCS codes).*** |
| --- |
| *Describe how the testing for validity and feasibility for the measure was accomplished.* |

| 1. ***The performance measure development process includes a nationally recognized expert panel with multidisciplinary representation and appropriate vetting.*** |
| --- |
| ***D. Describe any specific code(s) that with modification might serve as a tracking code.***  *See A-8* |

| ***E. The aspect of care measured is substantially influenced by physician work (or work of other practitioner or entity for which the code may be relevant*** |
| --- |
| ***E-1. Identify the clinician (eg, specialty/subspecialty or qualified health care professional described by the new codes) for whom the code is relevant ~~and why~~.*** |
| ***E-2****.* ***Describe the services of the physician or QHP required to complete/affect the performance of the measure. Use the service(s) described in the measures Supporting Guideline[s]).*** |

| ***F. The measure upon which this code is based is significant*** |
| --- |
| ***F-1. Describe the relationship of the measure to the desired outcome (eg, PCPI: Measure Importance – Relationship to desired outcome)*** |
| ***F-2****.* ***Describe how the measure addresses clinical conditions of high prevalence, high costs, high risks?*** |

| ***G. The measure is evidence-based.*** |
| --- |
| ***G-1****.* ***Describe the evidence-base from which this measure was derived.*** |
| ***G-2. Describe the evidence-based process used for development of the measure.*** |

| ***H. Risk adjustment instructions and specifications for outcome measures/ evidence of irrelevancy of risk adjustment.*** |
| --- |
| ***H. Identify the patient for whom the measure would ordinarily apply but due to appropriate reasons (i.e., medical, patient, or system reasons) should be EXCLUDED from measurement (i.e., exclusions 1P, 2P, 3P).*** |

**Statement of Compliance with the CPT Conflict of Interest Policy**

For convenience, key elements of the Conflict of Interest Policy applicable to each Applicant in his or her individual capacity and each Presenter are summarized below. Note that an application Preparer is a Presenter. The Conflict of Interest Policy in its entirety is controlling (please refer to the [Conflict of Interest Policy](https://www.ama-assn.org/system/files/2018-10/cpt-conflict-of-interest.pdf) for additional information):

1. ***General Rule Regarding Interests.*** Each code change application Applicant and each Applicant-designee making a presentation to the Panel about a code change application (**“Presenter”**), shall disclose all Interests held by the Applicant or Presenter and his or her Immediate Family Members.
   1. ***Written Disclosures of Interests by Applicant and Each Presenter.*** Written disclosures of all Interests must be made by each Applicant on a Statement of Compliance at the time of submission of the code change application. Written disclosures of all Interests must be made by each Presenter on a Statement of Compliance prior to the meeting of the Panel at which a Presenter will present his or her code change application.
   2. ***Oral Disclosure of Interests by Applicant and Each Presenter.*** Oral disclosure of Interests that are directly related to a code change application that is pending before the Panel is required by an Applicant and Presenter prior to addressing the Panel about that application.
   3. ***Impact of an Interest.*** Following written disclosure of all Interests of an Applicant or Presenter, or his or her Immediate Family Member, and oral disclosure of Interests that are directly related to a code change application that is pending before the Panel, the impacted individual is not restricted in any way in performing his or her role as an Applicant or Presenter.
2. ***Key Definitions.***
   1. ***“Interest(s)”*** means the following activities of or roles held by an Applicant and Presenter or his or her Immediate Family Member (unless otherwise noted):
      1. *Employment* – The Applicant or Presenter’s current employer, job title, description of role (in brief) and whether the employer is the applicant on the code change application that is pending before the Panel. This disclosure requirement does not apply to Immediate Family Members.
      2. *Receipt of Value* – The Applicant or Presenter, or his or her Immediate Family Member, received any Value within the prior 24 months or anticipates receiving any Value in the next 24 months. The Value is separated into three categories:
         1. *Corporate* – The Applicant or Presenter, or his or her Immediate Family Member, is an owner, director or officer of; or an employee or agent who has decision-making authority in, a corporate entity, the Value of which will or is likely to be impacted by the code change application that is pending before the Panel.
         2. *Individual* – The Applicant or Presenter, or his or her Immediate Family Member, will or is likely to receive any Value based on the decision on the code change application that is pending before the Panel.
         3. *Specialty Society* – The Applicant or Presenter, or his or her medical specialty society, will receive any Value for the Applicant or Presenter’s consulting on, advising on or strategizing about the code change application that is pending before the Panel.
      3. *Developmental Interest* – The Applicant or Presenter, or his or her Immediate Family Member, has a Developmental Interest in the code change application that is pending before the Panel.
      4. *Other* – Any other interest that a reasonable person would consider relevant to or potentially impacting the judgment or decisions of the disclosing Applicant or Presenter in the context of Panel business.
3. ***Other Definitions.***
   1. ***“Applicant”*** means each individual and corporate entity identified as an applicant or co-applicant on a code change application. For the purposes of the disclosure below, an Applicant must make a disclosure only in his or her individual capacity.
   2. ***“Developmental Interest”*** means the Applicant and Presenter’s, or his or her Immediate Family Member’s, involvement in study or research development, execution of testing or studies, or authorship of published literature related to the code change application that is pending before the Panel and in connection with which such has received Value or a promise of future Value from a pharmaceutical, biological or medical device manufacturer outside of a research grant in which the individual’s literature will be cited. Developmental Interest excludes the subject individual’s membership on a safety or a monitoring committee (or its equivalent) for a research grant.
   3. ***“Immediate Family Member”*** means a spouse, domestic partner, parent, child, brother or sister. Requirements for disclosure of interests of Immediate Family Members apply to the extent such interests are known by the disclosing person.
   4. ***“Presenter”*** means an Applicant’s designee to make an oral or written presentation to the Panel on a code change application. Presenter includes a Preparer who prepares all or a portion of a code change application for presentation to the Panel.
   5. ***“Value”*** means money, goods or any other item or service of value, whether the same increases or decreases. Value is aggregate, and includes but is not limited, to:
      1. Sales
      2. Intellectual property valuation, royalties or other rights
      3. Funding support, including grants
      4. Stock value, only if the stock is included in an actively managed personal investment account
      5. Consulting fees
      6. Gifts including meals, paid travel and speaking bureau participation
      7. Fees or other compensation for speaking engagements, including honoraria
      8. Salary or salary support
      9. Expert testimony payment

Value excludes any payment or reimbursement of expenses received from a medical specialty society for services that are educational or generally applicable to all members of such society and that are otherwise not for the benefit of any individual of such society.

**Disclose all Interests below:**

**INTERESTS**

* + - * + Identify all Interests held by you and your Immediate Family Members

**I affirm that I have read and understand the CPT Conflict of Interest Policy. Each of my, and my Immediate Family Members’, Interests at this time are set forth below. I understand that I have a continuing obligation to comply with the CPT Conflict of Interest Policy and will update this form, as needed, during the course of the year and annually at the request of the Chair of the Editorial Panel.**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Statement on Lobbying**  Applicants and other interested parties must not engage in “lobbying” for or against code change applications. “Lobbying” means **unsolicited** communications of any kind made at any time (including during Editorial Panel meetings) for the purpose of attempting to influence either (1) the CPT Advisors’ evaluation of or comments upon a code change application or (2) voting by members of the Editorial Panel on a code change application. **Lobbying is strictly prohibited. Violation of the prohibition on lobbying may result in sanctions such as being barred from further participation in the CPT process.** Information that accompanies a code change application, presentations or commentary to the full Editorial Panel during an open meeting and responses to inquiries from a Panel member or a AMA staff member do not constitute “lobbying.”  In order for the CPT Editorial Panel to effectively review and act on proposed changes to the CPT code set, code change applications must be reviewed by the CPT Advisors and the Editorial Panel based on the information contained in the application and available clinical literature. AMAstaff is responsible for organizing and submitting information to the CPT Advisors and the Editorial Panel for consideration. Information relating to a code change application must be submitted to AMA staff no later than thirty days prior to the start of the Editorial Panel meeting at which the code change application will be considered. In some cases, the Chair of the Editorial Panel may establish rules which allow for supplemental submissions of information to workgroups or facilitation sessions established by the Chair or for postponed or appealed agenda items.  (A facilitation session is an informal meeting requested by the Chair during a CPT Editorial Panel meeting to allow interested parties to confer and attempt to reach a consensus recommendation for presentation at the meeting.) During development of a code change application, an applicant may seek input or assistance from staff or advisors of medical specialty societies but may not engage in “lobbying” as defined above. Medical specialty societies may have their own policies governing interactions with applicants or other interested parties regarding code change applications. The AMA encourages medical societies to work with applicants from both industry and other medical specialty societies to assure that code change applications are complete, coherent and consistent with current medical practice. Contacts with consulting medical societies should be limited to that which is necessary to construct and submit the code change application. After the date a code change application is posted for review and comment by the CPT Advisors and the Editorial Panel, contact between an applicant and medical society representatives should be confined to communications pertaining to feedback from the AMA staff or Advisors’ comments regarding the application. If an applicant or other interested party wishes the CPT Advisors or the Editorial Panel to consider additional information, that information must be submitted to AMA staff and not directly to the CPT Advisors or the Editorial Panel.  Applicants and other interested parties are invited to participate in open CPT Editorial Panel meetings and present their views on code change applications when recognized by the Chair during the course of the meeting. The views of applicants and other interested parties may be sought during work group or facilitation sessions established by the Chair and participation in a workgroup or a facilitation session is not considered lobbying.  [return](#lobbypage1)  **Attestations**  I hereby attest to each of the following:   1. I understand that my code change application will be evaluated by the CPT Editorial Panel, CPT/HCPAC Advisors, Members of Advisory Committees, as applicable, and AMA staff. I will timely cooperate with requests from the CPT Editorial Panel, CPT/HCPAC Advisors, committee members and AMA staff for clarification and information. 2. I understand that it is recommended that I consult with national medical societies and other qualified healthcare professional organizations that will typically provide the proposed procedure(s)/service(s) requested in this application to obtain comments on the type of work and potential for development of relative value units (RVUs) by the AMA Specialty Society RVS Update Committee (RUC) ***prior to the submission*** of this application to comply with the [CPT Statement on Lobbying](https://www.ama-assn.org/practice-management/statement-lobbying). 3. I understand that this application is not complete until I and the other co-Applicants and Preparers (if applicable) named on this code change application have electronically completed the **CPT Confidentiality Agreement**, the **Copyright Assignment** and a **CPT Conflict of Interest Policy Compliance Statement**. Failure to submit a complete application and the requested documentation within the requested timeframe will prevent AMA staff from processing my code change application. If the code change application is not submitted in time for the upcoming Panel meeting, or it is incomplete, I understand that my application will not be considered at the next Panel meeting, but that the application may be resubmitted for consideration by the Panel at a later date. 4. I understand that, after I submit this code change application, I may withdraw this application up until the time that the CPT Editorial Panel takes up the agenda item at a CPT Editorial Panel meeting. At that time, the application falls under the authority of the Editorial Panel, and may not be withdrawn. 5. I understand that “Applicant” or “Preparer,” as used in this code change application, means both me individually and the company, society or other legal entity for whose benefit I am acting as an authorized representative. In this code change application, “I”, “you”, “my”, “myself” and “organization” shall be understood to mean “Applicant” or “Preparer” unless otherwise specified.   **I, the Applicant, acknowledge and agree.**  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Copyright Assignment** All proprietary rights including copyright in and to CPT codes, modifiers, text descriptors, cross references, guideline language, parentheticals and other materials, created by submission of this code change application and through the CPT code development process shall be owned by the American Medical Association. By checking below, I acknowledge the AMA’s proprietary rights including copyright and I hereby assign to the AMA any right, title and interest in and to such copyrightable works. **I, the Applicant, acknowledge and agree.** **Final Attestations**  By submitting this code change application, I, the Applicant, confirm that the information provided in this application is true, correct and complete, and to the best of my knowledge, accurately depicts current clinical and surgical practice. I also confirm that I have authority to sign this application in both an individual and organizational capacity.  I understand that "Applicant" or "Preparer", as used in this code change application, means both me individually and the company, society or other legal entity for whose benefit I am acting as an authorized representative. In this code change application, "I", "you", "my", "myself" and "organization" shall be understood to mean "Applicant" or "Preparer" unless otherwise specified.   |  |  | | --- | --- | | Signature |  | | Print Name |  | | Organization (if applicable) |  | | Date |  |  |  |  | | --- | --- | | 11-0258 AMA electronic-chgo_lh | American Medical Association  CPT Coding, Editorial and Regulatory Services  AMA Plaza  330 N. Wabash Avenue, Suite 39300  Chicago, IL 60611-5885  Phone (312) 464-5486  Fax (312) 224-6916 |   If you have any questions concerning the requirements on the Coding Change Application, please consult with AMA staff prior to the submission of your application.  An incomplete application may delay processing of your request and may cause it to be returned.  **AMA CPT Editorial Research and Development**  **Voice (312) 464-5486, fax (312) 224-6916** | |
| **Instructions for Submitting your Code Change Application** |

Email the application (including signature pages) and supporting documentation/literature to [ccappsubmit@Z.ama-assn.org](mailto:ccappsubmit@Z.ama-assn.org).